STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR PO BOX 780, KILLDEER, North Dakota, 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 08/25/25 and concluded on 08/27/25.	F0000		09/12/2025
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of the medical record, and review of facility policy, the facility failed to ensure that each resident receives the necessary respiratory care and services in accordance with professional standards of practice for 1 of 1 sampled resident (Resident #29) observed with oxygen. Failure to follow physician's orders regarding oxygen tubing changes at scheduled intervals has the potential to cause respiratory infections or adverse effects. Findings include: Review of the facility policy, "Oxygen Administration" occurred on 08/28/25. This policy, dated 03/28/25, stated, "Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans . . . " Review of Resident #29's medical record occurred on all days of survey. Physician's orders, dated 11/18/23 stated, "Change oxygen tubing weekly and wash concentrator filter at NOC [night]. . . Once A Day on Fri [Friday]." Review of the care plan identified oxygen use and to keep oxygen saturations (level of oxygen in the blood) above 90%.	F0695	Nurse Management immediately changed to O2 tubing on Resident # 29 O2 Tubing 8/27/2025. It has since been changed weekly on Fridays as per ordered and signed off in TAR. The facility has determined that all residents with Oxygen Therapy have the potential to be affected. An in-service education Memo was prepared on 9/3/2025 by the Director of Nursing/Nurse Management team educating all nurses regarding Oxygen therapy and the requirement to change oxygen tubing weekly or as ordered. The Director of Nursing and the nursing management team will review each resident with oxygen orders to assure the presence of orders to change oxygen tubing weekly. The Nurse Management team, will complete audits on all resident's receiving oxygen therapy weekly x 4 week, then every 2 weeks x 2 months, then every month x 3 months. Results will be reviewed by the QAPI nurse and Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Completion date 9/12/2025	09/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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F0695 SS = D	Continued from page 1 Observations on all days of the survey showed Resident #29 wore oxygen per nasal cannula and tape on the tubing labeled with a date of 08/15/25. Review of the Treatment Administration Record (TAR) showed staff signed the TAR on 08/22/25 indicating staff changed the oxygen tubing however, date on the tubing identified 08/15/25. The facility failed to ensure staff changed the oxygen tubing according to the physician's orders.	F0695		