STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	C 04/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the complaint investigation, completed on 04/20/15, the sample included 3 current residents and 1 closed record for review.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to implement interventions to prevent resident-to-resident abuse for 1 of 3 sampled residents (Resident #2) whose personal history rendered them at risk for abusing other residents. Failure to develop and implement interventions to prevent abuse resulted in Resident #2 displaying inappropriate sexual behavior toward Resident #1. Findings include: Review of the facility policy "Abuse and Neglect Prohibition Policy" occurred on 04/20/15. The policy, dated January 2002, stated, ". . . Hill Top Home of Comfort, Inc. [incorporated] respects the right of each resident to be free from abuse . . . Residents must not be subjected to abuse by	F 224	F224 1. Resident #1 is showing no adverse effects from incident that occurred on 2/4/15. Resident #2 was discharged from Hill Top Home of Comfort on 2/4/15 at 10:30 a.m. 2. All resident's have to potential to be affected. A behavior meeting involving the nursing management, social services and activities will be conducted monthly to discuss current behaviors of all residents and any interventions needed. 3. Hill Top will continue to educate all new employees and travel staff about the abuse policy upon hire and a minimum of yearly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-11-15

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 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.

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F 224	Continued From page 1 anyone, including, but not limited to, facility staff, other residents . . . Hill Top Home of Comfort will do whatever is within its control to prevent mistreatment, neglect and abuse of residents . . . 5. Upon receiving reports of abuse [sic] of physical or sexual abuse, the Charge Nurse shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical records. . . . 6. . . b. Examples of action for residents could include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents, an assessment of appropriate intervention strategies to prevent occurrences, monitoring the resident for any changes that would trigger abusive behavior and reassessment of the strategies on a regular basis through care planning . . ." Information provided by the complainant identified, at approximately 5:30 a.m. on 02/04/15, a female resident (Resident #1) was "groped" by a male resident (Resident #2) while they were alone together in a lounge on the special care unit (SCU). - Resident #1's medical record, reviewed on 04/20/15, identified diagnoses including Alzheimer's Disease, anxiety state, nonorganic psychosis, and episodic mood disorder. An annual Minimum Data Set (MDS), dated 12/05/14, identified the resident with severe cognitive impairment, sometimes understood and sometimes understands, required supervision of one person for walking in the room and corridor, extensive assistance of one person for dressing, displayed no behaviors, and wandered daily. The resident's care plan, dated 12/05/14, stated, "Res. [resident] has hx [history] of wandering . . .	F 224	4. The Director of Nursing and or Social Worker will interview 5 employees on appropriate responses of suspected abuse bi weekly x 4 weeks then monthly x 5 months. Findings will be reported to the QA nurse and to the QA committee at the quarterly QA meeting. 5. Completion date 5/25/2015 On February 26, 2015 an All Staff meeting was held. All Staff was provided education and review re: Resident Abuse Neglect & Prohibition Policy. Examples of abuse and Hill Tops policy when a resident abuse is suspected, reported and/or witnessed was discussed. All Staff are required to either attend meeting or watch the video if not in attendence the day of the meeting. JL	

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F 224	Continued From page 2 Attempts to wander throughout the facility . . . Res will attempt to disrobe when hot - Putting on lighter weight clothing will resolve behavior . . ." Resident #1's Social Services progress notes identified the following: * 02/04/05 at 7:00 a.m.: "It was reported by CNA [Certified Nursing Assistant] (#2 - a travel CNA) to SSD [Social Services Designee] (#4) upon arrival this am [sic] that an incident occurred with [Resident #2]. [Resident #2] was reported to be touching res inappropriately on upper chest. Residents were separated by CNA. SSD immediately went to observe residents in Carous [sic] Court [special care unit]. Residents remained separated. [Resident #1] was eating breakfast showing no signs of distress. Investigation in progress." * 02/04/15 at 5:45 p.m.: "CNA (#2) reported that [Resident #1] had been up much of the night. She came out of her room with her pants in her hand wearing her pj [pajama] shirt and brief. CNA took res back to room . . . and put her bottoms back on and put res back into bed. Within 10 min [minutes] [Resident #1] was sitting in the tv [television] lounge with all her buttons on her pj top undone. CNA (#2) buttoned them back up. Shortly before 5 am [sic] . . . [Resident #1] was sleeping in tv lounge. [Resident #2] went to sit in the tv lounge. CNA was needed in another room. Upon leaving the 2 res were not sitting by each other. When CNA (#2) returned [Resident #2] was seen by [Resident #1] touching her bare breast. [Resident #2] was startled by CNA and CNA explained to [Resident #2] that he should not touch anyone like that and asked him to sit away from [Resident #1] and he did. CNA buttoned [Resident #1's] top back up. CNA went to assist another res and was gone about 10 min	F 224		

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F 224	Continued From page 3	F 224		

[minutes]. When she returned [Resident #2] was touching [Resident #1] on top of her pj top on the breast. CNA (#2) asked [Resident #2] to go to his room. . . . CNA dressed [Resident #1] noting no bruising . . . After breakfast SSD, DON [Director of Nursing] and MDS coordinator assessed [Resident #1] for bruising and noted none. . . . Conference held later in day with [Resident #1's son]. Visited about more staff education in handling an incident like this. He feels res should have been separated. . . ."

Resident #1's record lacked evidence the charge nurse performed an immediate assessment of the resident and recorded it in the medical record, as per facility policy. The record lacked documentation of the incident by the nurse on duty at the time the incident occurred.

- Resident #2's medical record, reviewed on 04/20/15, identified diagnoses including schizoaffective disorder, borderline intellectual function, dementia, and episodic mood disorder. A quarterly MDS, dated 01/17/15, identified the resident with severe cognitive impairment, usually understands and usually understood, inattention, disorganized thinking, delusions, displayed "other behaviors" on 4 to 6 days of the seven day look-back period, and required supervision with walking in the room and corridor. The resident's care plan, dated 04/17/14, identified a problem: "[Resident #2] has socially inappropriate/disruptive behavioral symptoms . . . Hx: sexual behavior . . . served jail time for inappropriate sexual behavior." The care plan included interventions for the intrusive/disruptive behaviors, but lacked interventions or procedures if the inappropriate sexual behavior re-ocurred.

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F 224	Continued From page 4	F 224		

A director of nursing progress note, dated 02/04/15 at 4:56 p.m. stated, "Late entry: CNA (#2) on night shift had reported to night charge nurse about incident occurring in early AM [morning] starting at 5:15 am [sic]. At this time resident was seen touching a female residents bare chest while seated next to her in TV lounge on Carus Court. Female resident had her night shirt unbuttoned. When resident saw CNA he immediately pulled his hand away. CNA (#2) reports she instructed resident to stop this behavior. Resident denied the behavior. CNA told resident she did see this behavior and it is wrong. She instructed resident to move accross [sic] the room which he did. CNA reports that she had just assited [sic] resident in with [sic] cares and dressing before he came out into lounge 10 minutes previous. CNA (#2) then went into another room to check on a noise she heard and came out 10 minutes later to wittness [sic] resident touching same female resident's chest through her clothes. Resident was instrucated [sic] to go to his room and he did. He denied touching resident as he was going to his room. He went to his room . . . and went to bed. . . . He was not left alone in lounges without staff present after incident."

Resident #2's record lacked documentation of the details of the incident by the nurse on duty at the time the incident occurred.

Record review showed staff contacted Resident #2's physician and received orders to transfer the resident to a local emergency room (ER). A telephone order, dated 02/04/15 (no time identified), stated, "Send to [hospital name] ER for psych [psychiatric] eval [evaluation] . . . Discharge [Resident #2] from Hill Top. The record

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F 224	Continued From page 5 showed law enforcement transported the resident to the ER on 02/04/15 at 10:30 a.m. During an interview on 04/20/15 at 11:37 a.m., the CNA (#3) who came on duty at 5:30 a.m. on 02/04/15 (immediately after the incident) stated usual staffing in the SCU on the night shift is one CNA. She stated the CNA carries a walkie-talkie to call for assistance when needed. The CNA (#3) stated when she came on duty on 02/04/15, the night CNA (#2) gave her the walkie-talkie and it was functioning correctly. Resident #2's record lacked evidence the night CNA (#2) attempted to call for assistance rather than leaving the residents unattended in the lounge. Review of the facility's investigation of the incident occurred on 04/20/15 and lacked evidence the facility educated staff regarding closely monitoring the residents in the minutes immediately following the incident and/or calling for assistance when the CNA had to leave the area to care for another resident. Facility staff failed to ensure Resident #1's safety and protect her from abuse when staff left her alone with Resident #2 immediately after the CNA (#2) observed him touching her bare breast. This failure resulted in Resident #2 inappropriately touching Resident #1's breast a second time within minutes of the first episode. During an interview on 04/20/15 at 3:25 p.m., an administrative nurse (#1) stated staff dealt with the situation immediately. When asked if the facility educated staff regarding closely monitoring the residents and not leaving them alone	F 224		

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F 224	Continued From page 6 together, the nurse (#1) stated the facility provided no staff education following the incident. The facility identified two male residents currently residing on the SCU who displayed sexual behaviors towards staff. Failure to provide staff education and implement interventions regarding inappropriate sexual behaviors may result in further episodes of resident-to-resident abuse.	F 224		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 02/20/14 and 02/04/15.	F 280	F280 1) Resident's # 4 careplan was reviewed and revised by nursing management and now reflect information and interventions about inappropriate sexual behaviors. Resident #2(closed record) will not be updated due to resident no longer residing at facility. 2) All Resident's careplans have the potential to be affected. 3) All Care Plans continue to be brought to interdisciplinary team report so changes can be placed on all resident's care plans immediately. Care plan education again will be distributed to all Charge nurse's in	

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F 280	Continued From page 7 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 1 of 3 sampled residents (Resident #4) and one closed record (Resident #2). Failure to revise the care plan limited staffs' ability to communicate care needs and ensure continuity of care for each resident. Findings include: The facility "Care Plan" policy, dated 10/20/99, stated, ". . . Plan must identify problems/needs . . . approaches and evaluation . . . Care Plans are to be updated as problems/needs change or new problems/needs arise . . ." - During an interview on 04/20/15 at 10:35 a.m., an administrative nurse (#1) stated Resident #2 had a history of inappropriate sexual behavior and was excluded from attending activities or events involving children. Resident #2's closed medical record, reviewed on 04/20/15, identified diagnoses including dementia, borderline intellectual functioning, schizoaffective disorder, and anxiety. Resident #2's care plan, dated 04/17/14, identified problems: "[Resident #2] has socially inappropriate/disruptive behavioral symptoms: . . Hx [history] sexual behavior involving children . . . inapp [inappropriate] sexual behaviors . . ." and "[Resident #2] prefers activities that identify with prior lifestyle. . . ." The care plan lacked approaches to address the resident's history of inappropriate sexual behaviors and to prevent future incidents of sexual behaviors.	F 280	a memo. The Care plans will continue to be reviewed and revised by all disciplines(MDS Coordinator/Assistant, Social Services, Dietary, Activities) with all Admission, Quarterly, Annual and Significant Change MDS that are completed. A Behavior meeting is conducted monthly where care plans are updated and ensure information on care plan reflects resident current status. 4) The MDS Coordinator and/or Assistant will continue with current audit scheduled already in place and monitor resident care plans reviewing 5 resident care plans bi weekly x 4 weeks and 5 resident's care plans monthly x 5 months. Findings will be reported to the QA nurse and to the QA committee at the quarterly QA meeting. 5) Completion date 05/25/2015	

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F 280	Continued From page 8 - Review of Resident #4's medical record occurred on 04/20/15. Resident #4's medical diagnoses included Alzheimer's disease with behavioral disturbance, dementia with behavior disturbance, and mental/behavioral problem - inappropriate behavior. Resident #4's current comprehensive care plan stated, ". . . Problem . . . Behavioral Symptoms . . . Resident has a dx [diagnosis] of dementia, and is occasionally delusional. He thinks that his pickup is in the parking lot and will attempt to leave the facility looking for it . . . 2/17/15 . . . Res [resident] has adjusted well to [name of unit]. Res is content and enjoys sitting in TV [television] lounge. Res did kick a CNA [certified nurse assistant] recently because he refused to get out of bed . . ." Review of Resident #4's nurse progress notes, dated 03/13/15, stated, ". . . resident shower night was tonight, CNA was give [sic] shower and resident tried to grab her breast, corner her, touch her all over and would not stop even after she told him to stop . . . [another staff member] was passing med [medication] and came in and had CNA leave room and finished resident's shower, he did try to be sexually aggressive with her but she told resident to stop and he did . . ." Resident #4's current care plan failed to address the resident's inappropriate sexual behaviors toward staff and lacked approaches to prevent future incidents.	F 280		
F9999	FINAL OBSERVATIONS Based on record review, review of facility policy, and staff interview, the complainant's concern regarding resident-to-resident abuse was substantiated.	F9999		

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