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 _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 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
E 000	Initial Comments A recertification survey conducted on 06/25/2024 found Hill Top Home of Comfort Inc in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.	E 000		

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

Electronically Signed | 07/01/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	**95 HILL TOP DR** **KILLDEER, ND 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
K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 18 New Health Care Occupancies and Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction surveyed using Chapter 19 Existing Health Care Occupancies. A one-story addition of Type V (111) construction was attached to the south side of the existing building in 2023 and was separated from the existing building by a wall having a two-hour fire resistance rating. The 2023 addition was surveyed using Chapter 18 New Health Care Occupancies. The entire facility was protected by wet/dry automatic fire sprinkler systems designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. An assisted living building was attached to the west side of the facility. A two-hour fire rated wall assembly separated the facility from the adjoining assisted living building.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		7/1/24

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	**95 HILL TOP DR** **KILLDEER, ND 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
K 293	Continued From page 1 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. 7.10.1.2.1. The facility failed to ensure exits were marked by approved signage that was readily visible from any direction of exit access and that obviously and clearly identified the exit. Observation determined A door obviously leading to the outside from the Dining Room in the Caris Wing was not identified with an "EXIT" sign, or a "NO EXIT" sign. The exit discharge met the requirements of the Life Safety Code. The door was not a required exit from the building. Failure to provide exit signage as required increases the risk of death or injury due to fire. The deficiency affected exiting from one (1) of numerous doors in the facility.	K 293	1. On July 1 , 2024 an approved exit sign was installed on the exit door Dining Room in Carrus Wing. 2. All exit doors that require exit signs in building have the potential to affected. 3. Administrator, maintenance supervisor and maintenance department have been educated on if any doors are replaced in the future exit signs need to be replaced as well. 4. The maintenance supervisor/or designee have completed a complete walk through of the entire building to ensure all doors requiring exit signs have appropriate signage. 5. Completed on 7/1/2024	