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	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hill Top Home of Comfort Inc	95 Hill Top Dr Killdeer, ND 58640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, and staff interviews, the facility failed to ensure residents remained free from resident to resident abuse for 1 of 2 sampled residents (Resident #48), 1 supplemental resident (Resident #34), and 1 of 2 closed records (Resident #210). Failure to identify physical or sexual abuse placed residents at risk for possible mental and emotional distress, and/or physical injury. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 08/16/23. The IJ was identified when nurse's notes in Resident #34's and #210's medical records, dated 08/16/23, identified the residents had engaged in kissing and touching. A second nurse's note in Resident #48's medical record, dated 10/26/23, identified he led a female resident (Resident #34) into his room and barricaded the door with a chair. This finding placed residents in immediate danger due to the potential for mental and emotional distress and/or physical injury. *07/11/24 at 10:05 a.m. The survey team notified the administrator of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *07/12/24 at 1:37 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Conducted interviews with Resident #34 and Resident #48 in regards to the resident to resident altercations. *Reviewed care plans for Resident #34 and Resident #48 to ensure resident behaviors were identified and interventions implemented. *Implemented behavior logs to be filled out by nurses to identify potential behaviors/abuse situations. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Education provided to all staff on 07/11/24 by the Director of Nursing (DON) and the Social Services Designee (SSD). Staff not available for education will complete education prior to their next scheduled shift. Education specifically focused on how to identify what constitutes resident to resident abuse or the potential of such abuse and the importance of implementing procedures to ensure the safety of the resident involved as well as the potential for all residents in the facility. *Implemented monitoring of the behavior logs by the SSD to ensure all behaviors are addressed and assessed for potential abuse. *07/16/24 at 11:40 a.m. The survey team verified the implementation of the removal plan as of 07/11/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 06/26/24. This policy, dated October 2019, stated, . to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse . 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. 'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. The components of the facility abuse prohibition plan are . Screening . Prospective residents will be screened . An assessment of the individual's functional and mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission.The facility will implement policies and procedures to prevent and prohibit all types of abuse . that achieves: . Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the [sic] identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded . Identifying, correcting and intervening in situations in which abuse . is more likely to occur . The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict . The facility will have [sic] assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse . An immediate investigation is warranted when suspicion of abuse . or reports of abuse . occur . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: . increased supervision of the alleged victim and residents . Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, and post traumatic stress disorder. An annual Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. The care plan stated, . A history of trauma affects me negatively. I had an abusive husband and will talk about at times. Triggers that have the potential to re-traumatize me include: Sound . Smell . Touch . Once I have experienced a trigger, I may display these signs/symptoms: . Anxiety/Edginess . Overwhelming fear . Anger/Irritability . Changes in mood state . Confusion/Disorientation . The frequency or severity of my trauma-related signs and symptoms will not increase through next review. The care plan failed to address the resident's wishes for engaging in physical contact with other residents. Nursing progress notes for Resident #34 included the following: * 08/16/23 at 10:57 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. * 08/16/23 at 2:15 p.m., Son . was called and notified of situation that occurred earlier with another male resident. Son appreciative of call and indicated his mother has always been drawn to companionship. He expressed no concern about the situation as long as resident is showing happiness . - Review of Resident #210's medical record occurred on all days of survey, and included a diagnoses of dementia. An admission MDS, dated [DATE], identified severely impaired cognition. The care plan stated, I have the following behavior problem . physically abusive . verbally abusive . wandering . sexually inappropriate . The care plan failed to address the resident's wishes for engaging in physical contact with other residents. Nursing progress notes for Resident #210 included the following: * 08/15/23 at 5:01 p.m., Resident seen today by [physician name] on routine rounds for admit appointment. Assessment completed, chart and VS [vital signs] reviewed. Reported occasional behaviors/outbursts. Reported resident will be seen . on psych rounds next Wednesday. [Physician name] gave orders to increase Seroquel [antipsychotic medication] to 75 mg [milligrams] . BID [two times daily]. Orders faxed to pharmacy. * 08/16/23 at 10:56 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. During an interview on 06/26/24 at 12:45 p.m., two administrative nurses (#1 and #2) confirmed they did not identify the actions between Resident #34 and Resident #210 as sexual abuse. - Review of Resident #48's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and anxiety. A discharge MDS, dated [DATE], identified moderately impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nursing progress notes for Resident #48 included the following: * 10/26/23 at 2:45 p.m., Resident was seen leading another female resident [Resident #34] . into his room. Redirection was unsuccessful . Resident then started to be aggressive and screaming.while walking towards this writer with a fist closed. Resident then brought the female resident [Resident #34] to his room, closed the door, and barricaded it using another chair. This writer tried to knock on the door and asked if he could let the female resident [Resident #34] out as she looks frantic. Resident started yelling and screaming . DON was told of the incident on the unit and came right away. * 10/26/23 at 4:00 p.m., . When entered unit [Resident #48] had barricaded his room door with a chair with another female resident in the room. began to verbally scream and yell at staff outside of the room in the hallway. Administrator of facility was able to get door open a small amount and could see female resident sitting on [Resident #48's] bed . After many attempts [Resident #48] continued to refuse to open the door . Administrator pushed door open. [Resident #48] stepping backwards from door fell on to right knee and buttock. He quickly stood up and refused to have anyone enter his room and would not allow to have female resident leave the room. staff assisted female resident away from [Resident #48's] room. [Resident #48] began to follow staff and female resident down the hallway screaming and swung at face of staff member. He is placing residents. at risk to be hurt. [Resident #48's] wife indicated.has a hx [history] of getting very upset and aggressive. Call placed to 911 with police presence to send [Resident #48] into ER [emergency room] for evaluation. During interviews on 06/26/24 at 9:08 a.m. and 9:20 a.m., two administrative staff members (#2 and #3) confirmed they did not identify the actions of Resident #48 towards Resident #34 as physical abuse. The facility failed to have a system and policy and procedures in place for assessing all residents' needs, desires, and usual preferences to determine how to care plan according to the assessment. 47896

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, and staff interview, the facility failed to report potential abuse to the State Survey Agency (SSA) for 1 of 2 sampled residents (Resident #48), 1 supplemental resident (Resident #34), and 1 of 2 closed records (Resident #210). Failure to report potential abuse between cognitively impaired residents to the SSA, placed Resident #34, #48, #210, and other residents at risk for possible abuse and/or injury. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 08/16/23. The IJ resulted from facility staff failing to report physical and sexual abuse between Resident #34, Resident #48, and Resident #210 to the SSA. These findings placed residents in immediate danger due to the potential for mental and emotional distress and or/physical injury. *07/11/24 at 10:05 a.m. The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *07/12/24 at 1:37 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Conducted interviews with Resident #34 and Resident #48 in regards to the resident to resident altercations. *Reviewed care plans for Resident #34 and Resident #48 to ensure resident behaviors were identified and interventions implemented. *Implemented behavior logs to be filled out by nurses to identify potential behaviors/abuse situations. *Education provided to all staff on 07/11/24 by the Director of Nursing (DON) and the Social Service Designee (SSD). Staff not available for education will complete education prior to their next scheduled shift. Education specifically focused on identifying abuse or potential for abuse, how and who to report abuse to, including administration, physician's, resident representatives and the SSA, and the timeframes for reporting allegations of abuse. *Implemented monitoring of the behavior logs by the SSD to ensure all behaviors are addressed and assessed for potential abuse. *07/16/24 at 11:40 a.m. The survey team verified the implementation of the removal plan as of 07/11/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a policy titled Abuse, Neglect and Exploitation occurred on 06/26/24. This policy, dated October 2019, stated, . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes . not later than 2 hours after the allegation is made, if the event that cause allegation involve abuse . or . Not later than 24 hours if the events that cause allegation do not involve abuse and do no result in serious bodily injury. - Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia, post-traumatic stress disorder and anxiety. An annual Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Nursing progress notes for Resident #34 included the following: * 08/16/23 at 10:57 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. * 08/16/23 at 2:15 p.m., Son . was called and notified of situation that occurred earlier with another male resident. Son appreciative of call and indicated his mother has always been drawn to companionship. He expressed no concern about the situation as long as resident is showing happiness . - Review of Resident #210's medical record occurred on all days of survey, and included a diagnosis of dementia. An admission MDS, dated [DATE], identified severely impaired cognition. Nursing progress notes for Resident #210 included the following: * 08/15/23 at 5:01 p.m., Resident seen today by [physician name] on routine rounds for admit appointment. Assessment completed, chart and VS [vital signs] reviewed. Reported occasional behaviors/outbursts. Reported resident will be seen . on psych rounds next Wednesday. [Physician name] gave orders to increase Seroquel [antipsychotic medication] to 75 mg [milligrams] . BID [two times daily]. Orders faxed to pharmacy. * 08/16/23 at 10:56 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. The record lacked evidence the facility reported the above incident to the SSA as possible abuse. During an interview on 06/26/24 at 12:45 p.m., two administrative nurses (#1 and #2) confirmed the facility failed to report the interaction between Resident #34 and Resident #210 to the SSA. - Review of Resident #48's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and anxiety. A discharge MDS, dated [DATE], identified moderately impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nursing progress notes for Resident #48 included the following: * 10/26/23 at 2:45 p.m., Resident was seen leading another female resident [Resident #34]. into his room. Redirection was unsuccessful . Resident then started to be aggressive and screaming.while walking towards this writer with a fist closed. Resident then brought the female resident [Resident #34] to his room, closed the door, and barricaded it using another chair. This writer tried to knock on the door and asked if he could let the female resident [Resident #34] out as she looks frantic. Resident started yelling and screaming . DON was told of the incident on the unit and came right away. * 10/26/23 at 4:00 p.m., . When entered unit [Resident #48] had barricaded his room door with a chair with another female resident in the room. began to verbally scream and yell at staff outside of the room in the hallway. Administrator of facility was able to get door open a small amount and could see female resident sitting on [Resident #48's] bed . After many attempts [Resident #48] continued to refuse to open the door . Administrator pushed door open. [Resident #48] stepping backwards from door fell on to right knee and buttock. He quickly stood up and refused to have anyone enter his room and would not allow to have female resident leave the room. staff assisted female resident away from [Resident #48's] room. [Resident #48] began to follow staff and female resident down the hallway screaming and swung at face of staff member. He is placing residents. at risk to be hurt. [Resident #48's] wife indicated.has a hx [history] of getting very upset and aggressive. Call placed to 911 with police presence to send [Resident #48] into ER [emergency room] for evaluation. The record lacked evidence the facility reported the above incident to the SSA as possible abuse. During interviews on 06/26/24 at 9:08 a.m. and 9:20 a.m., two administrative staff members (#2 and #3) confirmed the facility failed to report the interaction between Resident #34 and Resident #48 to the SSA. 47896

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, and staff interviews, the facility failed to investigate resident to resident abuse for 1 of 2 sampled residents (Resident #48), 1 supplemental resident (Resident #34), and 1 of 2 closed records (Resident #210). Failure to investigate alleged violations of resident to resident abuse, ensure residents were protected during each investigation, and implement corrective actions/evaluate their effectiveness following each investigation, placed Resident #34, #48, #210, and other residents at risk for possible mental and emotional distress and/or physical injury. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 08/16/23. The IJ resulted from facility staff failing to investigate physical and sexual abuse for resident to resident altercations between Resident #34, Resident #48, and Resident #210. The IJ was identified when nurse's notes in Resident #34's and #210's medical record, dated 08/16/23, identified the residents had engaged in kissing and touching. A second nurse's note in Resident #48's medical record, dated 10/26/23, identified he led a female resident (Resident #34) into his room and barricaded the door with a chair. Failure to investigate incidents of potential abuse may result in unwanted physical and/or sexual contact and my cause residents mental and emotional distress and/or physical injury. *07/11/24 at 10:05 a.m. The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. *07/12/24 at 1:37 p.m. The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Conducted interviews with Resident #34 and Resident #48 in regards to the resident to resident altercations. *Reviewed care plans for Resident #34 and Resident #48 to ensure resident behaviors were identified and interventions implemented. *Implemented behavior logs to be filled out by licensed nurses to identify potential behaviors/abuse situations. *Education provided to all staff on 07/11/24 by the Director of Nursing (DON) and the Social Worker Designee (SSD). Staff not available for education will complete education prior to their next scheduled shift. Education specifically focused on identifying abuse or potential abuse, and conducting and documenting an investigation in order to ensure resident safety and appropriate interventions are put in place. *Implemented monitoring of the behavior logs by the SSD to ensure all behaviors are addressed and assessed for potential abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*07/16/24 at 11:40 a.m. The survey team verified the implementation of the removal plan as of 07/11/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of a policy titled Abuse, Neglect and Exploitation occurred on 06/26/24. This policy, dated October 2019, stated, . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse . occur. Written procedures for investigations include . Investigating different types of alleged violations . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and . Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: . Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed . Increased supervision of the alleged victim and residents . - Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia. An annual Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Nursing progress notes for Resident #34 included the following: * 08/16/23 at 10:57 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. * 08/16/23 at 2:15 p.m., Son . was called and notified of situation that occurred earlier with another male resident. Son appreciative of call and indicated his mother has always been drawn to companionship. He expressed no concern about the situation as long as resident is showing happiness . - Review of Resident #210's medical record occurred on all days of survey. Diagnoses included dementia. An admission MDS, dated [DATE], identified severely impaired cognition. Nursing progress notes for Resident #210 included the following: * 08/15/23 at 5:01 p.m., Resident seen today by [physician name] on routine rounds for admit appointment. Assessment completed, chart and VS [vital signs] reviewed. Reported occasional behaviors/outbursts. Reported resident will be seen . on psych rounds next Wednesday. [Physician name] gave orders to increase Seroquel [antipsychotic medication] to 75 mg [milligrams] . BID [two times daily]. Orders faxed to pharmacy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* 08/16/23 at 10:56 a.m., [Resident #34] was found in the room of [Resident #210]. [Resident #34] was discovered halfway undressed, pants and brief were on the floor, socks thrown on opposite sides of the room, and was engaged in physical contact with [Resident #210]. Both were kissing/touching, [Resident #210] was in the process of pulling down his pants when staff walked in. Both residents were assisted with putting their clothes back on and [Resident #34] was guided out of the room. The facility lacked evidence they started and/or completed an investigation into the incident between Resident #34 and #210. During an interview on 06/26/24 at 12:45 p.m., two administrative nurses (#1 and #2) confirmed the facility failed to complete and document an investigation of the interaction between Resident #34 and Resident #210. - Review of Resident #48's medical record occurred on all days of survey. Diagnoses included dementia, Alzheimer's disease, and anxiety. A discharge MDS, dated [DATE], identified moderately impaired cognition. Nursing progress notes for Resident #48 included the following: * 10/26/23 at 2:45 p.m., Resident was seen leading another female resident [Resident #34]. into his room. Redirection was unsuccessful . Resident then started to be aggressive and screaming.while walking towards this writer with a fist closed. Resident then brought the female resident [Resident #34] to his room, closed the door, and barricaded it using another chair. This writer tried to knock on the door and asked if he could let the female resident [Resident #34] out as she looks frantic. Resident started yelling and screaming . DON was told of the incident on the unit and came right away. * 10/26/23 at 4:00 p.m., . When entered unit [Resident #48] had barricaded his room door with a chair with another female resident in the room. began to verbally scream and yell at staff outside of the room in the hallway. Administrator of facility was able to get door open a small amount and could see female resident sitting on [Resident #48's] bed . After many attempts [Resident #48] continued to refuse to open the door . Administrator pushed door open. [Resident #48] stepping backwards from door fell on to right knee and buttock. He quickly stood up and refused to have anyone enter his room and would not allow to have female resident leave the room. staff assisted female resident away from [Resident #48's] room. [Resident #48] began to follow staff and female resident down the hallway screaming and swung at face of staff member. He is placing residents. at risk to be hurt. [Resident #48's] wife indicated . has a hx [history] of getting very upset and aggressive. Call placed to 911 with police presence to send [Resident #48] into ER [emergency room] for evaluation. The facility lacked evidence they started and/or completed an investigation into the incident between Resident #34 and #48. During interviews on 06/26/24 at 9:08 a.m. and 9:20 a.m., two administrative staff members (#2 and #3) confirmed the facility failed to document an investigation of the interaction between Resident #34 and Resident #48. 47896

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	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hill Top Home of Comfort Inc	95 Hill Top Dr Killdeer, ND 58640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 15 sampled residents (Resident #20 and #51). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 to N-8 stated, . N0415: High-Risk Drug Classes: Use and Indication . Coding Instructions . N0415J1 Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident any time during the observation period. Review of Resident #51's medical record occurred on all days of survey. A physician's order, dated 01/24/24, stated, Metformin 500mg [milligrams] daily with breakfast. The quarterly MDS, dated [DATE], showed staff failed to identify Resident #51 received a hypoglycemic medication. During an interview on the afternoon of 06/25/24, an administrative nurse (#1) confirmed staff failed to document a hypoglycemic medication on the MDS. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages O-3 an O-4 stated, . Steps for Assessment . Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period . O0110C1, Oxygen therapy . Code continuous or intermittent oxygen administered . Review of Resident #20's medical record occurred on all days of survey. The medication administration record (MAR) showed Resident #20 received two liters of oxygen on all shifts daily from 03/25/24 - 04/08/24. A quarterly MDS, dated [DATE], lacked documentation of Resident #20's continuous oxygen use. During an interview on the afternoon of 06/25/24, an administrative nurse (#1) confirmed staff failed to document Resident #20's oxygen use on the MDS. 46964

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47896 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 2 of 15 sampled residents (Resident #48 and #56). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure continuity of care, and may negatively impact the care provided to residents. Findings include: Review of the facility policy titled Comprehensive Care Plans occurred on 06/26/24. This policy, revised 10/2021, stated, .care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment and PRN [as needed] with changes. - Review of Resident #48's medical record occurred on all days of survey. Diagnosis included Alzheimer's disease, anxiety disorder, delusional disorders, and dementia with psychotic disturbance. Review of progress notes from October 2023 to May 2024 identified Resident #48 exhibited verbal and physical behaviors on the following dates: *10/20/2023 at 8:48 p.m. stated, Incident. Staff reported resident initiated an argument with [another resident]. *10/26/23 at 2:45 p.m. stated, Resident was seen leading another female resident. into his room. Resident then started to be aggressive and screaming. while walking towards this writer with a fist closed. Resident then brought female resident to his rooms, closed the door, and barricaded it using another chair. Resident started yelling and screaming. *10/26/23 at 4:00 p.m. stated, .began to verbally scream and yell at staff outside of the room in the hallway. very upset swung to punch administrator of facility.began to follow staff and female resident down the hallway screaming and swung at face of staff member. *12/17/23 at 6:14 p.m. stated, Behavior. [another resident's spouse] was standing in hallway by her husband's closed room. This resident got close to her and shook his fist in her face without being instigated. *05/10/24 at 10:00 p.m. stated, Behavior Charting.started following around the 2 CNAs and would square up and/or swing fists at them but did not make contact. *05/13/24 at 7:06 p.m. stated, . Staff observed [Resident #48] yelling, screaming, and pushing against the wall. A discharge MDS, dated [DATE], identified physical and verbal behavioral symptoms directed towards others occurred 1 to 3 days. (continued on next page)

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	355092	A. Building B. Wing	07/16/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current care plan stated, .Behavioral symptoms. I am at risk for elopement as evidenced by: my exit seaking [sic] and wandering. The care plan failed to identify behavioral symptoms related to verbal and physical behavioral symptoms directed towards others. -Review of Resident #56's medical record occurred on all days of survey. Diagnosis included chronic obstructive pulmonary disease (COPD) and wheezing. A physician's order, dated 04/18/24, stated, Oxygen per NC [nasal cannula] to maintain O2 [oxygen] sat >90% [saturation greater than 90 percent]. In an interview on 06/24/24 at 12:36 p.m., Resident #56 confirmed she should have oxygen on continuously and placed nasal cannula on. The facility failed to update Resident #56's care plan regarding oxygen use. During an interview on 06/25/24 at 3:40 p.m., an administrative staff member (#1) confirmed the facility failed to update Resident 56's care plan related to oxygen use and resident's refusal to wear at times.