DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G018	A. BUILDING _____ B. WING _____	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAXTER HOUSE	POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624

(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
W 000	INITIAL COMMENTS	W 000	The Facility manager immediately on 06/27/18 met with the staff person involved in the incident and reminded her why medication should never be touched with bare hands and how the medication becomes contaminated. The staff person completed a medication refresher training on 07/10/18. A program staff meeting was completed on 07/30/18 where the above was reiterated to all staff by the Facility Manager. All staff are required to complete medication ~~requir~~ refresher trainings and will continue to do so.	

An unannounced annual Medicaid ICF/ID recertification survey was conducted 06/26/18 through 06/27/18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Intellectually Disabled. The Life Safety Code survey report will follow.

The census in this 12 certified bed facility was 12 Individuals at the time of survey. The survey sample consisted of 4 current Individual reviews (Individuals #1 through #4).

W 341 NURSING SERVICES
CFR(s): 483.460(c)(5)(ii)

Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to maintain effective infection control practices during a medication pass and pour observation for one of 4 Individuals, Individual #4

The findings included:

During a medication pass and pour observation RT (residential technician) #1 touched the Individuals medication with her bare hands and placed it into the Residents medication cup for

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

Andrea R. Lee | Facility Manager | 07/31/18

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
	49G018	A. BUILDING _____ B. WING _____	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAXTER HOUSE	POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624

(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
W 341	Continued From page 1	W 341		

administration.

Individual #4 had been admitted to the facility 03/08/2006. Diagnoses included, but were not limited to, moderate intellectual disabilities, downs syndrome, and autism.

On 06/27/18 at approximately 750 a.m., the surveyor observed RT #1 and RT #2 during a medication pass and pour observation. During this observation, RT #1 was observed by the surveyor to touch Individual #4's medication V-C Forte with her bare hands prior to dropping it into the medication cup for administration. This medication cup included five other medications that had already been prepared and placed into the cup.

After placing the V-C Forte into the cup RT #1 picked up the medication cup and placed it on the ledge to allow RT #2 to administer the medication to Individual #4. At this point the surveyor stopped the medication observation and asked RT #1 how many medications she had touched. RT #1 stated just the last one. RT #1 then obtained a white plastic spoon and started to remove the pill from the cup. The surveyor then asked RT #1 if she was going to administer the other medications. RT #1 stated they were probably all contaminated and she would discard them and start over.

On 06/27/18 at approximately 8:20 a.m. the facility manager was notified of the issue regarding infection control during the medication pass and pour observation.

On 06/27/18 at approximately 8:35 a.m., the surveyor interviewed RN (registered nurse) #1 who was the QIDP (qualified intellectual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G018	A. BUILDING _____ B. WING _____	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAXTER HOUSE	POST OFFICE BOX 621 KEEN MOUNTAIN, VA 24624

(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
W 341	Continued From page 2 disabilities professional) and completed the staff training for medication administration. When asked what she would have expected of the staff. RN #1 stated she would have expected the staff person to waste the pill. RN #1 stated that the staff were given a 32-hour medication administration class and were taught never to touch the Individuals medications. No further information regarding this issue was provided to the surveyor prior to exit.	W 341		