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 _____	09/03/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 9/3/19. The facility was in substantial compliance with 42 CFR Part 483.475, Condition of Participaton for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000		
W 000	INITIAL COMMENTS An unannounced annual Medicaid ICF/ID recertification survey was conducted 09/03/2019. 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 3 current Individual reviews (Individuals #1 through #3).	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the day support staff failed to implement the active treatment plan regarding	W 249		

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

Andrea Ripe | Facility Manager | 9/25/19

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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W 249	Continued From page 1 fluid intake for 1 of 3 Individuals, Individual #1. The findings included: For Individual #1, the staff at the day support program failed to implement the Individuals plan to receive liquids 1 ounce at a time. The face sheet revealed that Individual #1 had been admitted to the facility 04/22/2004. Diagnoses included but were not limited to, mood disorder, impulsive aggression/poor tolerance, moderate intellectual disabilities, retinitis pigmentosa of both eyes, diabetes, hiatal hernia with mild reflux, hearing loss, and chronic obstructive pulmonary disease. Individual #1's ISP (individual support plan) with a start date of 01/29/2019 and an end date of 01/28/2020 (part 5 pages 9-10) "Service: Group Day Services/Center Based" included the outcome 03.2 "...To receive liquids by having one ounce at a time in a cup and once swallowed to repeat giving him one ounce at a time due to fast drinking..." On 09/03/2019 at approximately 11:00 a.m., the staff at the day support program were observed preparing and administering Individual #1's medication for administration. During this observation, DSP (direct support professional) #1 and #2 measured 8 ounces of water in a clear measuring cup and poured it into a cup for Individual #1 to drink. DSP #1 handed this cup to Individual #1 and Individual #1 drank the water. Individual #1 tolerated the water without difficulty. On 09/03/2019 at 12:05 p.m., the surveyor	W 249	On September 4, 2019, the Facility Manager, RN immediately met with the Group Day Services Assistant Manager and DSP #1 and #2 to go over individual #1's outcome 03.2, located in part 5 of his PCP. DSP #1 and #2 both stated correctly and demonstrated correctly how individual #1 is to receive all liquids. It was	9/4/19

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W 249	Continued From page 2 interviewed the assistant program manager, DSP #1, and DSP #2. DSP #2 verbalized to the surveyor that Individual #1 had received an entire cup of water and should have only received an inch at a time. DSP #1 stated they usually gave the Individual an inch of water at a time. The assistant program manager stated she thought the Individual had a problem with aspiration and they would drink to fast but she had never seen them get choked. The senior team leader at the group home was notified of the issue regarding the Individuals fluid intake on 09/03/2019 at 3:00 p.m. The facility manager was notified on 09/03/2019 at 3:50 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	W 249	Also discussed with both DSP the complications that can arise if the outcome isn't implement correctly at any time the individual is receiving liquids. Both DSP #1 and #2 verbally stated they have a complete understanding of the individual's outcome and the importance of it. The Group Day Service's Manager and Assistant Manager have scheduled a mandatory staff meeting for October 2, 2019 where it will be stressed again to all staff the importance of implementing outcomes of this nature correctly. The QIDP and Facility Nurse will also be present to answer questions and reiterate the complications that can arise if outcomes of this type are followed at all times.	10/2/19
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and clinical record review, the day support staff failed to follow physician order in regards to fluid intake for 1 of 3 Individuals, Individual #1. The findings included: For Individual #1, the staff at the day support program failed to follow physician orders. The Individual received 8 ounces of water at one time	W 339		

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W 339	Continued From page 3 when the physicians order was to receive liquids 1 ounce at a time. The face sheet revealed that Individual #1 had been admitted to the facility 04/22/2004. Diagnoses included but were not limited to, mood disorder, impulsive aggression/poor tolerance, moderate intellectual disabilities, retinitis pigmentosa of both eyes, diabetes, hiatal hernia with mild reflux, hearing loss, and chronic obstructive pulmonary disease. This face sheet also included a diet order to indicate the Resident was to receive 1 ounce of liquid at a time in a cup. Individual #1's 90 day renewal of orders dated 07/10/2019 included a diet order that read in part, "...fluids, receive 1 oz. (ounce) at a time in cup once swallowed repeat with 1 oz. at a time." The Individual's "Annual Nutritional Review" dated 01/29/2019 read in part, "...liquids are to be give 1 oz at a time due to fast drinking..." The annual nursing assessment completed on 01/29/2019 also included the information "To receive 1 oz. of a liquid at a time in a cup, once swallowed repeat with 1 oz. at a time." On 09/03/2019 at approximately 11:00 a.m., the staff at the day support program were observed preparing and administering Individual #1's medication for administration. During this observation, DSP (direct support professional) #1 and #2 measured 8 ounces of water in a clear measuring cup and poured it into a cup for Individual #1 to drink. DSP #1 handed this cup to Individual #1 and Individual #1 drank the water.	W 339	In addition, DSP #1 and #2 will each receive a written warning for failing to implement an individual's outcome correctly. The Group Day Service's Assistant Manager will continue to monitor the correct implementation of individual outcomes by regular observation.	

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W 339	Continued From page 4 Individual #1 tolerated the water without difficulty. On 09/03/2019 at 12:05 p.m., the surveyor interviewed the assistant program manager, DSP #1, and DSP #2. DSP #2 verbalized to the surveyor that Individual #1 had received an entire cup of water and should have only received an inch at a time. DSP #1 stated they usually gave the Individual an inch of water at a time. The assistant program manager stated she thought the Individual had a problem with aspiration and they would drink to fast but she had never seen them get choked. The senior team leader at the group home was notified of the issue regarding the Individuals fluid intake on 09/03/2019 at 3:00 p.m. The facility manager was notified on 09/03/2019 at 3:50 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	W 339		