Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-319	A. BUILDING: _____ B. WING _____	06/28/2018

DHSR - Mental Health
JUL 23 2018
Lic. & Cert. Section

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J EDWARDS HOME	4633 TOBACCO STREET WINSTON SALEM, NC 27106

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6/28/18. The complaint was unsubstantiated (intake # NC00139791). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living with Adults with Developmental Disabilities.	V 000	Top Priority Care Services will ensure that the establish deficiencies will be corrected as follows. It is the policy of Top Priority Care Services to ensure that all employees are aware of how to recognize critical incidents and the appropriate follow-up procedures to ensure compliance with State rules and regulations and accreditation standards. TPCS will completely document information related to an incident. TPCS will include in incident recordings, a description of the event, actions taken on behalf of the client, and client's condition following the event. Supervisors will appropriately investigate the issue by conducting a treatment team meeting to gather facts about the incident. During this time, the Supervisor will also determines any remedial actions that must take place to prevent incident from recurring. Supervisor will complete an Incident Report using the IRIS Reporting System as soon as possible but no later than 72 hours to the Local	7/19/18
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.	V 366		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	RNC	7/19/18

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V 366	Continued From page 1 (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose	V 366	Management Entity. To ensure this will not occur again, each Top Priority Coordinator/ Team Lead will communicate all reported incidents to the Site Director and/or Human Resources to follow up and make sure proper protocol was followed. The monitoring of this will take place quarterly. This Plan of Correction is submitted to meet the requirements established by Division of Health Service Regulation.	

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V 366	Continued From page 2 catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement their written policy governing their response to Level II incidents affecting 1 of 2 clients (#1). The findings are: Review on 6/27/18 of client #1's record revealed: - An admission date of 10/7/15	V 366		

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V 366	Continued From page 3 - Diagnoses of Profound Mental Retardation; Cerebral Palsy; Asthma; Imperforate Anus; Hypospadia; Seizure Disorder; Hypothyroidism and Vision Deficit Review on 6/28/18 of staff #1's record revealed: - A hire date of 2/19/13 as a Paraprofessional Review on 6/28/18 of Former Staff #1's (FS #1's) record revealed: - A hire date of 1/23/18 as a Paraprofessional - A termination date of 6/6/18 Review on 6/28/18 of the Qualified Professional's (QP's) record revealed: - A hire date of 12/6/06 as a QP No attempt was made to interview client #1 during the course of this survey due to client #1's developmental disabilities, to include being non-verbal. An interview was conducted with his legal guardian on 6/27/18 instead. Interviews on 6/25/18 and on 6/27/18 with staff #1 revealed: - On 6/8/18, client #1's legal guardian telephoned him and reported that she had received a telephone call from a representative with a Local Management Entity (LME) who informed her the LME had received a complaint alleging staff #1 had "struck [client #1] on the buttocks" and pushed him." - The legal guardian stated she reported to the LME that the allegation was most likely from staff who had been recently terminated and that she had no concerns regarding staff #1's treatment of client #1 - It was staff #1's understanding the legal guardian planned to contact the facility's Qualified Professional (QP) on the same date (6/8/18) and	V 366		

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V 366	Continued From page 4 inform her of her contact with a representative with the LME and the allegation being made against staff #1 - He had never pushed or harmed client #1 in any manner - He had not participated in an internal investigation regarding the incident and he had continued to work with client #1 since the allegations against him had been made known to the QP, who was his supervisor. Interview on 6/8/18 with client #1's legal guardian revealed: - She spoke with the QP on 6/8/18 to inform her of the conversation she'd had with a representative from the LME and the allegation staff #1 had abused client #1. Interview on 6/28/18 with the QP revealed: - She was aware that FS #1 had made an allegation that staff #1 had abused client #1 - FS #1 had reported to her in May 2018 that he had concerns regarding staff #1's treatment of client #1 (i.e., staff #1 had "pushed" client #1) - She believed that FS #1 had been motivated by other reasons to make the allegation; however, she did not elaborate on what those reasons were - As she did not believe there was any validity to the allegation, no internal investigation was completed and no incident report was submitted via IRIS to the LME - Staff #1 had continued to work with the client even after she was made aware of the allegation against him. Review on 6/28/18 of the facility's policy and procedure manual revealed: - The "Critical Incident and Critical Incident Reporting Policy and Procedure created on	V 366		

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V 366	Continued From page 5 6/15/07 and revised on 6/25/10 documented the following: - "...Critical Incident Categories - Consumer Death, Restrictive Intervention, Consumer Injury, Abuse, Med (Medication) Error, Consumer Behavior and other incidents considered critical..." - "...Critical incidents are events inconsistent with the routine operation of a service or care of a consumer that are likely to lead to adverse affects..." - "...TPCS (Top Priority Care Services) must report critical incidents using the Incident Reporting and Improvement System (IRIS) that occur while a consumer is under our care..." - "...Documentation of incidents includes information related to the incident will be recorded in the record to include, a description of the event, actions taken on behalf of the client, and client's condition following the event..." - "...Documentation is kept on file by the Site Director or other designated administrative staff..." - "...Supervisors must investigate the issue by conducting a treatment team meeting to gather facts about the incident. During this time, the Supervisor also determines any remedial actions that must take place to prevent the incident from recurring. The Supervisor completes an Incident Report using the IRIS Reporting System as soon as possible but no later than 72 hours to the Local Management Entity..."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all	V 367		

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V 367	Continued From page 6 level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information;	V 367		

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V 367	Continued From page 7 (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all level II incidents that occur during the provision of billable services or while the consumer is on the provider's premises to the LME (Local Management Entity) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 6/27/18 of client #1's record revealed: - An admission date of 10/7/15 - Diagnoses of Profound Mental Retardation; Cerebral Palsy; Asthma; Imperforate Anus; Hypospadia; Seizure Disorder; Hypothyroidism and Vision Deficit Review on 6/28/18 of staff #1's record revealed: - A hire date of 2/19/13 as a Paraprofessional Review on 6/28/18 of Former Staff #1's (FS #1's) record revealed: - A hire date of 1/23/18 as a Paraprofessional - A termination date of 6/6/18 Review on 6/28/18 of the Qualified Professional's (QP's) record revealed: - A hire date of 12/6/06 as a QP No attempt was made to interview client #1 during the course of this survey due to client #1's developmental disabilities and his being non-verbal. An interview was conducted with his legal guardian on 6/27/18 instead. Interviews on 6/25/18 and on 6/27/18 with staff #1 revealed: - On 6/8/18, client #1's legal guardian telephoned him and reported that she had	V 367		

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V 367	Continued From page 9 received a telephone call from a representative with a Local Management Entity (LME) who informed her the LME had received a complaint alleging staff #1 had "struck [client #1] on the buttocks" and pushed him." - The legal guardian stated that she reported to the LME that the allegation was most likely from staff who had been recently terminated and that she had no concerns regarding staff #1's treatment of client #1 - It was staff #1's understanding the legal guardian planned to contact the facility's Qualified Professional (QP) on the same date (6/8/18) and inform her of her contact with a representative with the LME and the allegation being made against staff #1. Interview on 6/8/18 with client #1's legal guardian revealed: - She spoke with the QP on 6/8/18 to inform her of the conversation she'd had with a representative from the LME and the allegation staff #1 had abused client #1. Interview on 6/28/18 with the QP revealed: - She was aware that FS #1 had made allegation that staff #1 had abused client #1 - FS #1 reported to her as early as May 2018 that he had concerns regarding staff #1's treatment of client #1 (i.e., staff #1 had "pushed" client #1) - She believed that FS #1 had been motivated by other reasons to make the allegation; however, she did not elaborate on what those reasons were - As she did not believe there was any validity to the allegation, no internal investigation was completed and no incident report was submitted via IRIS to the LME.	V 367		

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V 367	Continued From page 10 Review on 6/28/18 of the facility's policy and procedure manual revealed: - The "Critical Incident and Critical Incident Reporting Policy and Procedure created on 6/15/07 and revised on 6/25/10 documented the following: - "...Critical Incident Categories - Consumer Death, Restrictive Intervention, Consumer Injury, Abuse, Med (Medication) Error, Consumer Behavior and other incidents considered critical..." - "...Critical incidents are events inconsistent with the routine operation of a service or care of a consumer that are likely to lead to adverse affects..." - "...TPCS (Top Priority Care Services) must report critical incidents using the Incident Reporting and Improvement System (IRIS) that occur while a consumer is under our care..." - "...Documentation of incidents includes information related to the incident will be recorded in the record to include, a description of the event, actions taken on behalf of the client, and client's condition following the event..." - "...Supervisors must investigate the issue by conducting a treatment team meeting to gather facts about the incident. During this time, the Supervisor also determines any remedial actions that must take place to prevent the incident from recurring. The Supervisor completes an Incident Report using the IRIS Reporting System as soon as possible but no later than 72 hours to the Local Management Entity..."	V 367		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 12, 2018

Sharon P. Johnson, President
Top Priority Care Services, LLC
4401 Providence Lane
Winston-Salem, NC 27106

Re: Annual and Complaint Survey completed June 28, 2018
J. Edwards Home, 4633 Tobacco Street, Winston-Salem, NC 27106
MHL # 034-319
E-mail Address: sjohnson@topprioritysvc.com
gmartin@topprioritysvc.com
lmills@topprioritysvc.com
Intake #NC00139791

Dear Ms. Johnson:

Thank you for the cooperation and courtesy extended during the annual and complaint survey completed June 28, 2018. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is August 27, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at 336-861-6283.

Sincerely,

Debra M. Branton

Debra M. Branton, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File