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
	MHL032-608	A. BUILDING: _____ B. WING _____	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGING THE GAP RESIDENTIAL SERVICES	716 POPLAR STREET DURHAM, NC 27703

(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 survey was completed on November 23, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000	Management will remove the lock from the closet. Management will also review the clinical team and human rights committe interventions that can be put in place if any. Management will conduct training with staff. This has been scheduled for 12/8/21. Management has also posted clients rights information in the facility. Management and Team Leads will monitor during weekly house checks and/or as needed. Marshelia Morgan 12/8/21	
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S.	V 500		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 500	Continued From page 1 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to implement interventions to address behaviors which did not restrict the rights for one of three clients (#2). The findings are: Observation of facility on 11/23/21 at	V 500		

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V 500	Continued From page 2 approximately 1:25 pm revealed: -The closet in bathroom #1 was locked. This closet contained clothing for clients #2 and #4. Review on 11/23/21 of General Statue 122C-62 revealed "A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional (QP) at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's records." Review on 11/23/21 of client #2's record revealed: -Admission date of 7/6/16. -Diagnoses of Moderate Intellectual Disability, Autism, Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder and Allergic Rhinitis. -There was no evidence of a written statement for client #2 detailing restrictions of personal possessions or evidence of an evaluation of each restriction reviewed at least every seven days by the Qualified Professional. Interview with staff #1 on 11/23/21 revealed: -The closet was locked due to client #2's issues with his clothing. Client #2 would go into the closet and pull down all the clothes and tear up the closet. -Client #2 had full access to the closet, they just keep it locked to keep him from constantly going into it. -The closet had been locked for over 6 months. -He confirmed client #2's rights were being restricted.	V 500		

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V 500	Continued From page 3 Interview on 11/23/21 with the Manager revealed: -The closet was locked because client #2 would pull down the clothes in the closet. Client #2 would break the hangers and tear up the closet. -They had been locking the closet for over a year. -She confirmed client #2's rights were being restricted.	V 500		

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DHSR - Mental Health
DEC 15 2021
Lic. & Cert. Section

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

DHSR - Mental Health
DEC 15 2021
Lic. & Cert. Section

November 29, 2021

Marshelia Morgan
Bridging the Gap Residential Services, LLC
2945 South Miami Boulevard, Suite 114
Durham, NC 27703

Re: Annual Survey completed November 23, 2021
Bridging the Gap Residential Services IV, 716 Poplar Street, Durham, NC 27703
MHL # 032-608
E-mail Address: bridgingthegapllc@gmail.com

Dear Ms. Morgan:

Thank you for the cooperation and courtesy extended during the Annual survey completed November 23, 2021.

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 1/22/22.

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 Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR@Alliancebhc.org
qmemail@cardinalinnovations.org
Pam Pridgen, Administrative Assistant

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

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Sincerely,

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Pam Pridgen, Administrative Assistant