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						
74101 1244	or contraction	ibertii io/tiiottitombetti	A. BUILDING: _								
		MHL080035	B. WING		R 06/25/2018						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
TIMBER RIDGE TREATMENT CENTER 14225 STOKES FERRY ROAD											
GOLD HILL, NC 28071											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE					
V 000	INITIAL COMMENTS		V 000								
	on 6/25/18. The comp (Intake #NC139868). This facility is license category: 10A NCAC	w up survey was completed plaint was substantiated A deficiency was cited. d for the following service 27G .5200 Residential or Children and Adolescents									
	of All Disability Group	s									
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131								
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh	alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.									
	failed to access the H	as evidenced by: ew and interview, the facility lealth Care Personnel r to hire for 1 of 9 staff (#3).									
	Review on 6/20/18 of -staff #1 was rehired -the HCPR was access	•									
	revealed: -not aware HCPR wa	with Administration staff s completed late; Il be completed as required.									

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 06/27/2018 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED						
MHL080035		B. WING			R 06/25/2018							
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TIMBER RIDGE TREATMENT CENTER 14225 STOKES FERRY ROAD GOLD HILL, NC 28071												
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	E CORRECTION	0/5)						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE						
V 131	Continued From page 1		V 131									
	This deficiency consti and must be correcte	tutes a re-cited deficiency d within 30 days.										

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STATE FORM 6899 QP1711 If continuation sheet 2 of 2