STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080035	A. BUILDING: _____ B. WING _____	02/13/2019

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TIMBER RIDGE TREATMENT CENTER	14225 STOKES FERRY ROAD GOLD HILL, NC 28071

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V 000	INITIAL COMMENTS A complaint and annual survey was completed on 2/13/19. The complaint was unsubstantiated (Intake NC#147815). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5200 Therapeutic Wilderness Camp	V 000		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored separately for each client affecting 4 of 5 audited current clients (#2, #3, #4, #5). The findings are:	V 120	(see attached) P.O.C DHSR - Mental Health MAR 04 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas A C Hilbert — TITLE: CEO — (X6) DATE: 2/28/2019

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V 120	Continued From page 1 Review on 1/28/19 of clients' record revealed; -client #2 was admitted of 11/16/18 with diagnoses of Conduct Disorder, Impulsive Control Disorder and Unspecified Disruptive Disorder; -client #3 was admitted on 3/9/18 with diagnoses of Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder(ADHD); -client #4 was admitted on 5/1/18 with diagnoses of ADHD and Disruptive Mood Dysregulation Disorder(DMDD); -client #5 was admitted on 11/21/18 with Autism, DMDD and Depressive Disorder. Observations on 1/30/19 at 3:40pm revealed: -medications stored in bubble packs for each day in a strip, all medications for that dosing time in one bubble pack; -medications also stored in one sheet bubble packs for a single medication for a month; -all bubble packs labeled with client's names; -bubble strips for clients #3, #4 and #5 laying flat in the middle right shelf of the medication cabinet; -client #2's bubble pack for his medication Melatonin stored with other bubble packs on the lower right shelf of the medicine cabinet. Review on 1/28/19 and 1/29/19 of the facility incident reports revealed no incidents regarding client medication errors with mixing up client medications. Interview with the camp nurse revealed: -the medications are separated by the bubble packs; -all bubble packs are individual; -the bubble strips are the last part of the medication bubble book that comes for each client; -never mix client medications, always check to	V 120		

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V 120	Continued From page 2 ensure medications given correctly; -will rearrange to ensure all medications including bubble packs are separated by client.	V 120		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure prior to hiring health care personnel, the facility shall access the Health Care Personnel Registry(HCPR) for 2 of 6 staff (#1, #2). The findings are: Review on 1/29/18 of personnel files revealed the following: -staff #1 was hired on 12/6/18 with the job title of Group Leader and the HCPR was accessed on 12/8/18; -staff #2 was re-hired on 4/26/18 with the job title of Group Leader and the HCPR was accessed on 5/9/18. Interview on 2/13/19 with Administrative Staff revealed not aware the HCPR was accessed late.	V 131		

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V 278	Continued From page 3	V 278		
V 278	27G .5203 Res. Tx. Camp - Operations 10A NCAC 27G .5203 OPERATIONS (a) Each facility shall develop and implement written policies and procedures on basic care and safety. (b) In accordance with the schedules developed by the Program Director, staff shall maintain the following distance from the campers: (1) During waking hours, staff shall be within sight or voice range of the campers. (2) During sleeping hours, staff shall be located within voice range of the campers. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to implement written policies and procedures on basic care and safety affecting 1 of 2 audited former clients (FC#7). The findings are: Review on 1/30/19 of a policy and procedure titled "Suicide Screening and Prevention Procedures" documented the following: - "11) Any resident who does in fact harm himself should be secured and safeguarded immediately, the psychiatric staff should be notified immediately, and an assessment made to review his need for higher level of care. The resident should not be left unattended for any length of time whatsoever, and be placed in as safe a location at camp as is possible until transportation can be arranged. The nurse and family counselor will be notified. The nurse will contact the attending physician and evaluate the need for a more secure setting;" - "13) Should a resident pose a direct threat to himself, an evaluation by a psychiatrist will be made before that resident is returned to the	V 278		

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V 278	Continued From page 4 program." Review on 1/29/19 of FC#7's record revealed: -admission date of 9/19/18 with discharge date of 11/20/18; -age 17 years old; -diagnoses of Major Depressive Disorder, Cannabis Abuse Disorder and Intermittent Explosive Disorder; -admission assessment dated 8/20/18 documented FC#7 was defiant, noncompliant, controlling, immature, low self-esteem, steals, victim of neglect, anxious, had history of inpatient psychiatric hospitalization for suicidal ideation (SI) with a clear plan, poor anger management skills, poor boundaries, use of marijuana, witnessed domestic violence, had multiple placements in group homes, therapeutic fostercare and PRTF(Psychiatric Residential Treatment Facility); -Suicide Risk Screening Tool completed on 9/19/18 with no SI. Review on 1/29/19 of FC#7's treatment plan dated 9/5/18 revealed the following goals: -reduce episodes of emotional dysregulation, reduce SI, reduce suicide threats, reduce suicide attempts; -address poor quality interpersonal relationships, reduce aggression, reduce defiance, reduce stealing, reduce intimidation and manipulation, reduce engaging in negative peer behaviors; -reduce episodes of depressive behaviors; -perform to academic potential and achieve educational objectives; -participate in substance abuse assessment and if applicable, participate in program sessions individual and group twice a month. Further review on 1/30/19 of FC#7's record revealed:	V 278		

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V 278	Continued From page 5 -admitted to local inpatient psychiatric hospital on 10/25/18 for suicide attempt by using a belt to try to strangle himself, discharged back to camp on 10/29/18 with no SI present; -admitted to a crisis recovery program on 11/2/18 for stabilization after incidents of trying to tie a scarf and a small blanket around his neck and trying to cut his wrist with a rock, discharged back to camp on 11/8/18 stable with no SI; -admitted to local inpatient psychiatric hospital on 11/17/18 after calling 911 himself and telling dispatcher he needs to go to hospital and he was having suicidal thoughts, discharged on 11/20/18; -on the way back to the camp in the car with two staff, FC#7 jumped out of the car and ran, police were called, FC#7 was transported back to the hospital. Review on 1/29/19 of the facility's incident reports from 11/1/18-1/29/19 revealed an incident report regarding FC#7 dated 11/14/18 with the following documented: -"This morning after flip/strip [FC#7] had went back into his room...when about to evaluate, staff was making sure everyone on deck and [FC#7] wasn't. One of [FC#'7s] peers seen him with something around his neck but when staff got to him he was laid out on the floor. [FC#7] was still choking so staff tried to figure out why, staff unzipped his jacket and seen a shoestring around his neck, so staff removed it. [FC#7] was purple in the face before removing the string from around his neck. Staff made sure [FC#7] was still responsive and had pulse and heartbeat. Staff called for supervisor's assistance;" -"Witnesses to this incident" signed by staff #3 and staff #6; -"Person completing this report"signed by staff #3; -signed off by FC#7's Family Counselor;	V 278		

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V 278	Continued From page 6 -not signed off by the Nurse or the Doctor. Interview on 2/1/19 with staff #6 revealed: -worked day of incident with FC#7; -everyone had slept uptrail due to cold weather, returned to campsite for chores around 7:30am; -rooms were inspected, FC#7 had some clothes he needed to fold and put up, FC#7 went to his tent to complete task; -called the morning huddle as usual, waiting on FC#7 to finish his task in his tent and join huddle, peer went to tell FC#7 to come join huddle; -one of peers said he thought he saw something around FC#7's neck; -saw FC#7 fall over in his tent, everyone rushed over to him; -FC#7 had his hoodie tied tight around his neck, had to get it loosened; -could not see shoestring at first, got FC#7 rolled over; -noticed FC#7's face losing and changing color; -removed shoestring, took FC#7 a few minutes to breathe normal; -called supervisor, they arrived and took FC#7 uptrail; -removed all the shoestrings and anything else he could use; -the day before, FC#7 never made any suicidal statements and acted fine; -earlier that morning, FC#7 was acting fine. Interview on 2/1/19 with staff #3 revealed: -worked with staff #6 when incident happened with FC#7; -everyone was out on deck, FC#7 had gone back to his tent to put up some pants; -called huddle and a peer was facing FC#7's tent and said, "[FC#7], what are you doing;" -FC#7 was looking out of his tent door, then fell over backwards into his tent;	V 278		

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V 278	Continued From page 7 -FC#7 was choking, there was a string around his neck, FC#7 was not responding to them; -positioned him so they could remove the string, his face was losing color; -moved FC#7 out of his tent onto the deck, called the supervisors; -FC#7 went with the supervisors uptrail. Interview on 1/29/19 with the GWS (Group Work Supervisor) revealed: -received a call from staff #3 regarding FC#7; -went to campsite, discovered FC#7 had tied a string around his neck and fell out in his tent; -FC#7 appeared to be unconscious, but then was alert; -was able to get up on his own, large in body, weighed around 270 pounds; -walked him uptrail to the dining room; -FC#7 was placed in "Unit 8" which is one on one supervision; -did not see any injuries or marks to FC#7's neck; -had history of making suicidal statements and having suicidal ideation; -knew FC#7 was taken to the hospital a few times during his camp stay; -thought he went after this incident, not sure, the camp nurse may have checked him out. Interview on 1/30/19 with the camp nurse (Certified Nursing Assistant/Medication Technician) revealed -never was made aware of the incident on 11/14/18 regarding FC#7; -never received the incident report, if review incident reports, always sign off on the incident report form; -if had received the incident report or been made aware of the incident, would have recommended FC#7 go to the local hospital for evaluation.	V 278		

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V 278	Continued From page 8 Interview on 1/30/19 with FC#7's Family Counselor revealed: -been in his current position since 8/2018; -registered with the Licensed Clinical Social Worker licensing board in 12/2018; -reviewed the incident report for 11/14/18 on FC#7; -saw FC#7 on 11/14/18 after the incident along with the Program Director to process what happened and put in place precautions; -discussed the incident with FC#7, did a safety plan with FC#7; -talked with the staff about FC#7's safety; -talked daily with the Program Director and other administrative staff regarding FC#7; -FC#7 tried to hurt himself several times while at camp; -wanted to get out of camp and used suicidal threats to try to get out of camp; -FC#7 was trying to manipulate the system by using SI; -did not document the session with FC#7 on 11/14/18; -do not have the signed safety plan for FC#7 in response to the incident on 11/14/18 but have the one he created on his computer; -FC#7 also placed on "Unit 8" to address the situation; -no documentation to show FC#7 on "Unit 8;" -FC#7 not taken to the hospital for evaluation; -was trained on the Suicide Policy. Review on 1/30/19 of a printed out safety plan produced by FC#7's Family Counselor revealed the following: -documented on the form: "I, [FC#7], understand that due to my recent behavior suicidal attempts and unsafe aggression, there is a reason to be concerned about me keeping myself safe. I agreed to keep myself safe by: 1. Talking to my	V 278		

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V 278	Continued From page 9 Group Leaders about my feelings and ways to stay safe 2. Deal with my emotions in a safe way by: (talking with my group, making sure my needs are met, taking time to yourself, drawing, talking to people that I trust.) 3. Asking for help when I need it. If I fail to abide by this contract, I understand that the following consequences are likely to occur: I could go to a PRTF, I could go to Jail for attacking someone. Timeline for good behavior: 11/22/18 get contact with Sister again 12/6/18 have conversation about visiting your sister;" -there was no signature by FC#7 on the form; -there was no signature by any staff on the form. -date at bottom of form was 11/8/18. Review on 1/30/19 of FC#7's Family Counselor documentation of sessions with FC#7 revealed no documentation of the session on 11/14/18 in response to FC#7's suicide attempt. Review on 1/30/19 of FC#7's daily progress notes from 9/19/18-11/17/18 revealed: -no documentation of FC#7 placed in "Unit 8" for one on one supervision in response to the incident on 11/14/18; -no documentation FC#7 was evaluated by any psychiatric staff/medical physician in response to the incident on 11/14/18. Interview on 1/30/19 with the Program Director revealed: -sat with FC#7 and his Family Counselor and discussed the incident on 11/14/18; -did discuss a safety plan with FC#7; -assumed FC#7's Family Counselor was documenting the meeting; -do remember FC#7 was also placed on "Unit 8" for one on one supervision; -all strings/anything that can be tied was removed	V 278		

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V 278	Continued From page 10 from FC#7; -discovered FC#7 did not go to the hospital in response to the incident on 11/14/18, FC#7 went to the hospital on several other occasions in response to other incidents; -current policy is confusing, there are not psychiatric staff at camp; -physician is also not on site at all times to do assessments; -need to revisit policy and retrain staff on protocols regarding suicide and documentation. Interview on 2/4/19 with FC#7 revealed: -tied a shoestring from his shoe around his neck at camp; -passed out; -a male and female staff was there when he did it; -he woke up and was taken uptrail by the Group Work Supervisor; -don't remember talking to his Family Counselor; -remember talking to the Program Director; -don't remember doing a safety plan; -do remember being in "Unit 8" with one on one staffing; -don't remember how long he was on "Unit 8;" -remember they took away all his shoestrings and belt; -did not see a doctor or the camp nurse after he tied the shoestring around his neck; -did not go to the hospital after he tied the shoestring around his neck; -did not tell anyone he was going to tie a shoestring around his neck and try to kill himself before he did it. Review on 2/8/19 of a Plan of Protection received on 2/7/19 completed by the Program Director revealed the following documented: "Person Responsible for Implementation: [Program Director]	V 278		

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V 278	Continued From page 11 Plan of Protection-implemented on 02/04/2019 1. To protect clients from potential harm or injury through compliance with Timber Ridge Treatment Center Suicide Prevention Procedures Policy No. 535.0: a. Revise Policy 535.0 to comprehensively reflect our response to clients displaying suicidal behavior. Policy no. 535.0 was revised on 02/04/2019. b. After any report of suicidal gestures/acts the Treatment Team will immediately meet to assess the situation and systematic follow the guidelines and procedures outlined in Timber Ridge Suicide Prevention Procedures Policy. c. Train all employees on the elements of the Suicide Prevention Policy within one week and thereafter on a monthly basis during staff meeting. Also retrain staff on the documentation of suicidal attempt and the proper chain of command for both working and nonworking hours (i.e. Group Work Supervisor, Family Therapist, Nurse, Program Director, and/or Assistant Program Director). 15 staff members were trained on the Suicide Prevention Policy on 02/06/2019. The night staff will receive training on 02/10/2019, while the remaining day staff will complete training by 02/15/2019. d. Use the Resident One on One Supervision Form (i.e. the reason resident requires one on one supervision, behavioral expectations to return to group and evaluation of those behavioral expectations to return to group) when clients are separated from group for safety reasons. This will include the date the resident was separated from group, dates of behavioral evaluation, and the date it was deemed by treatment team (i.e. Family Therapist, Program Director and/or Assistant Program Director.) that the client was safe to return to group. The One-on-One supervision formed was devised and	V 278		

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V 278	Continued From page 12 implemented on 02/04/2019. e. When the Treatment Team deems necessary, additional staffing resources will be allocated for Client who displays suicidal/self harming behavior. f. Ensure Client immediately complete Safety Contracts with the supervisory staff (Group Work Supervisors, Family Therapist, Program Director, Assistant Program Director, or Nurse), immediately communicate this to Direct Care Staff and Group Work Supervisors to ensure immediate follow through on safety precautions and suicide prevention (i.e. One on One Supervision, moving Client to safe location etc.) to prevent harm. g. Work collectively with all staff to complete all supporting documentation including Safety Plan, Staff Supervision, Client Supervision, Family Counseling Notes, Level II Incident Reports, Unusual Occurrence Report, and One on One Supervision Form. h. The Treatment Team will convene as needed to assess Client's progress on his safety contract, ensure follow through from direct care staff and develop transition plan if higher level of care is warranted." Review on 2/13/19 of documentation provided during the survey exit discussion revealed the following: -form titled "Resident One on One Supervision Plan;" -revised Suicide Policy and Protocol; -In-Service Trainings for staff in Policies and Procedures on Suicide dated 2/6/19 and 2/13/19; -In-Service Training with Group Work Supervisors on Suicide Policies and Procedures, Risky Behaviors, Documentation, One on One Supervision dated 2/9/19.	V 278		

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TIMBER RIDGE TREATMENT CENTER	14225 STOKES FERRY ROAD GOLD HILL, NC 28071

(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 278	Continued From page 13 FC#7 had a history of suicidal ideation, suicide attempts and inpatient hospitalizations prior to admission to the facility. On 10/25/18, FC#7 tried to choke himself with a belt, was sent to the hospital for psychiatric evaluation, was admitted for psychiatric treatment and was discharged back to the facility on 10/29/18. Five days later, FC#7 was admitted to a crisis recovery center on 11/2/18 for stabilization and psychiatric treatment after incidents of trying to choke himself with a scarf and a blanket and was discharged back to the facility on 11/8/18. Six days later on 11/14/18, FC#7 tied a shoestring around his neck, lost consciousness with his skin changing color. Staff were able to get FC#7 to regain consciousness. In response to this serious incident, FC#7 was placed with one on one staffing, had his shoestrings removed and talked with his Family Counselor and the Program Director. However, FC#7 was not evaluated by psychiatric and medical staff prior to returning to the facility, the nurse was not notified and the physician was not notified as instructed in the facility policies and procedures on suicide and no additional measures were put in place to prevent additional suicide attempts. Four days later on 11/17/18, FC#7 called 911 and reported he needed to go to the hospital due to suicidal ideation and as a result, was admitted to the hospital. The failure to implement the facility's suicide policy and not put any additional measures in place to prevent additional suicide attempts constitutes serious neglect and failure to protect from harm. This deficiency constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty of $6,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080035	A. BUILDING: _____ B. WING _____	02/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER RIDGE TREATMENT CENTER	14225 STOKES FERRY ROAD GOLD HILL, NC 28071

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TIMBER RIDGE TREATMENT CENTER, INC.

Annual and Complaints Survey completed February 13, 2019
Timber Ridge Treatment Center, Inc.
665 Timber Trail
Gold Hill, NC 28071
MHL #080-035
E-mail Address: tomhibbert@trtc.net

Tom Hibbert CEO 2/28/19

ID PREFIX TAG: V 120
27G. 0209E Medication Requirements

A. Corrective Action:

1) Medications shall be kept in a secure locked cabinet and separated for each client.

2) The separation of medications will be facilitated by the provision of dividers within the locked cabinet so that each client's medication is stored with its own unique space to separate it from other medications.

B. Prevention:

1) Continue to provide for the separation of medication.

2) The CFO will purchase the necessary supplies to maintain the separation on an ongoing basis.

C. Monitoring and Frequency

1) Nursing staff will note on a monthly medication management report the accomplishment of this goal.

2) This monitor will be reviewed on a monthly basis during the meeting of the quality review function, the Timber Ridge Leadership Committee. (TLC)

D. Completion Date

1) April 12, 2019

ID PREFIX TAG: V 131
GS 130 1E – 256 (D2) HCPR – Prior Employment Verification

A. Corrective Action:

1) The HCPR will be accessed and reviewed prior to the employment of all staff.

2) The Director of Human Resources will access the HCPR.

B. Prevention:

1) The Director of Human Resources will review pre-employment requirements and ensure that these are all met prior to employment.

C. Monitoring and Frequency

1) The Director of Human Resources will prepare a report for The Leadership Committee detailing the success of his efforts complete all pre-employment requirements including accessing the HCPR.

2) This report will be prepared monthly and reviewed monthly by The Leadership Committee.

D. Completion Date

1) April 12, 2019

ID PREFIX TAG: V 278
27 G .5203 Residential Treatment Camp Operations

A. Corrective Action:

1) To protect clients from potential harm or injury through compliance with Timber Ridge Treatment Center Suicide Prevention Procedures Policy No. 535.0.

a. Revise Policy 535.0 to comprehensively reflect our response to clients displaying suicidal behavior. ***Policy no. 535.0 was revised on 02/04/2019.***

b. After any report of suicidal gestures/acts the Treatment Team will immediately meet to assess the situation and systematically follow the guidelines and procedures outlined in the Timber Ridge Suicide Prevention Procedures Policy.

c. Train all employees on the elements of the Suicide Prevention Policy during orientation and the first week of employment. All staff will receive training on the Suicide Prevention Procedures Policy and its proper implementation on a monthly basis. Train

d. Use the Resident One on One Supervision Form (i.e. the reason resident requires one on one supervision, behavioral expectations to return to group and evaluation of those behavioral expectations to return to group) when clients are separated from group for safety reasons. This will include the date the resident was separated from group, dates of behavioral evaluation, and the date it was deemed by treatment team (i.e. Family Therapist, Program Director and/or Assistant Program Director.) that the client was safe to return to group.

B. Prevention:

1. To prevent potential harm from coming to our clients the following measures have been implemented:

a. When the Treatment Team deems necessary, additional staffing resources will be allocated for Client who displays suicidal/self harming behavior.

b. Ensure Client immediately complete Safety Contracts with the supervisory staff (Group Work Supervisors, Family Therapist, Program Director, Assistant Program Director, or Nurse), immediately communicate this to Direct Care Staff and Group Work Supervisors to ensure immediate follow through on safety precautions and suicide prevention (i.e. One on One Supervision, moving Client to safe location, seeking emergency services etc.) to prevent harm.

c. Work collectively with all staff to complete all supporting documentation including Safety Plan, Staff Supervision, Client Supervision, Family Counseling Notes, Level II Incident Reports, Unusual Occurrence Report, and One on One Supervision Form.

d. The Treatment Team will convene as needed to assess Client's progress on his safety contract, ensure follow through from direct care staff, and develop transition plan if higher level of care is warranted.

e. Timber Ridge will provide training on Suicide Prevention, Adverse Childhood Events and Trauma as it relates to self-destructive behaviors to our staff.

C. Monitoring and Frequency

1) The Program Director will prepare a monthly report detailing the successful completion of the plans for correction and prevention detailed above.

2) This report will be prepared monthly and reviewed monthly by the Timber Ridge Leadership Committee.

D. Completion Date

1) March 8, 2019