STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or dorace from	IDENTIFICATION NOMBER.	A. BUILDING: _		
		MHL080035	B. WING		R 08/27/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TIMBER R	RIDGE TREATMENT CEN	TER	KES FERRY R	OAD	
	OLIMANA DV. OT		_, NC 28071	DROWNERIO DI ANI OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	don 8/27/19. One of the complaints was substant #NC154183, NC#154 cited. This facility is licensed category: 10A NCAC				
	Wilderness Camp.				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112		
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.				

Division of Health Service Regulation

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED			
				R				
		MHL080035	B. WING		08/27/2019			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
TIMBER F	RIDGE TREATMENT CEN	TER	KES FERRY R	OAD				
			L, NC 28071					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE			
V 112	Continued From page	e 1	V 112					
	facility failed to ensurimplemented to addres of 1 former client (FC). Review on 8/13/19 ar revealed; -admission date of 5/3/7/21/19; -diagnoses of Post Tr and Major Depression-admission assessmed demonstrated behavious verbal and physical aself-injurious behavious ideation(SI); -treatment plan dated to decrease episodes address negative self of emotional dysregul running away, address interpersonal relations potential, address his substance abuse asstreatment recommence-staff strategies includit reatment environment assist in increase skill	iew and interviews, the e strategies were ess client needs affecting 1 #4). The findings are: and 8/19/19 of FC#4's record extended exten						
	Review on 8/19/19 of 7/2/19 regarding FC#	a Nursing Note dated 4 documented the						

Division of Health Service Regulation

STATE FORM 6899 0KDZ11 If continuation sheet 2 of 5

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
		1					
		B WING		R			
		MHL080035	B. WING		08/27/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE			
	10115211 011 001 1 21211		, ,	, and the second			
TIMBER R	IDGE TREATMENT CEN	TER	OKES FERRY R	COAD			
		GOLD HII	LL, NC 28071				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	, , ,		
PREFIX	*	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD			
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	SIATE		
				22.10.2.101)			
V 112	Continued From page	e 2	V 112				
	fallacciones IID anidont a						
	~	c/o(complains) bites to body.					
	Calagel applied."						
		a undated letter faxed to					
		from a physician regarding					
	FC#4 revealed the fo	•					
	-FC#4 has multiple in						
	-need to wash his bed						
		th dilute bleach solution;					
	-FC#4 has been pres	cribed triamcinolone					
	ointment to help with	the intense itching;					
	-FC#4 can apply Calamine lotion to bites as						
	needed;						
	-FC#4 need to apply bug spray sat least twice a						
	day and before bed.						
	ady and sololo sou.						
	Interview on 8/21/19	with client #1 revealed:					
	-everyone has bug bi	tes:					
	-live in woods;	,					
	-staff give us gel and spray anytime we need it;						
	-FC#4 never asked to						
	-1 O#+ HEVEL ASKEU IO USE IL.						
	Interview on 8/19/19 with client #2 revealed:						
	-staff carries ointment and bug spray in the med						
	bag at all times;						
	-can ask to use at any time;						
	-staff will let use it whenever ask for it.						
	-stan will let use it whenever ask for it.						
	Interview on 9/10/10	with client #3 revealed:					
		and ointment at all times;					
	-stair has bug spray a -can ask to use it;	and ominition at all tilles,					
		ah) anytima if nace to for					
	-	ch) anytime if need to for					
	any injuries.						
	Internation 0/40/40						
	Interview on 8/19/19	with the Group Work					
	Supervisor revealed:						
		g bites as are in the woods;					
	-all clients and staff h						
	-use bug spray, gel st	ticks and ointment to					

Division of Health Service Regulation

STATE FORM 6899 0KDZ11 If continuation sheet 3 of 5

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		B. WING		R		
		MHL080035	B. WING		08/27/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			OKES FERRY R			
TIMBER R	RIDGE TREATMENT CEN	TER		COAD		
	Г	GOLD HI	LL, NC 28071			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	, ,	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
IAG	REGOLATORT OR E	100 IDENTIF TING INFORMATION)	IAG	DEFICIENCY)	NATE	
				,		
V 112	Continued From page	e 3	V 112			
	address bug bites;					
	_	itaa than athan alianta.				
		ites than other clients;				
		the same prevention aids				
	as other clients.					
		with the Med Tech revealed:				
		once with a complaint of				
	bug bites;					
	-she applied ointment	t to the bites;				
	-encouraged FC#4 to	use the bug spray in the				
medication bag staff had with them at all		nad with them at all times;				
	-FC#4 reported he did not like the bug spray as it made him feel "sticky;" -staff med bags have ointment, bug spray, gels					
	and all clients have access anytime need it.					
		-				
	Interview on 8/19/19	with staff #1 revealed:				
	-FC#4 never complain	ned to her about bug bites;				
	-never asked for the	_				
		available to clients at all				
	times.					
	unios.					
	Interview on 8/20/19	with staff #2 revealed:				
	-FC#4 had bites on him;					
	-would not stop scrate	•				
	-had poor hygiene;					
		ntment and enray:				
	-refused to use the ointment and spray;-scratched until bleeding;-kept refusing medication to address it.					
	-kept relusing medica	tion to address it.				
	Interview on 8/20/10	with staff #3 revealed:				
	-FC#4 had bug bites					
		•				
	-never used bug spra					
	_	sprays and ointment in bag				
	at all times on camp s	site.				
		.::H- FO#4				
	Interview on 8/26/19	with FC#4 revealed:				
	-had bug bites;					
	-itched and he scratcl	hed until bleeding;				

Division of Health Service Regulation

STATE FORM 6899 0KDZ11 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MUI 090035	B. WING		R 08/27/2019		
NAME OF PROVIDER OR SUPPLIER STREET ADD			RESS, CITY, STA	JE ZIP CODE	1 08/27/2019		
	14225 STOKES FERRY ROAD						
TIMBER RIDGE TREATMENT CENTER GOLD HILL			., NC 28071	T			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE		
V 112	Continued From page	2 4	V 112				
	-nothing available to h	nim for it.					
	Review on 8/13/19 and and incident reports re- no documentation of medications to prever and treat intensive scumo documentation of FC#4's refusal to use	nd 8/19/19 of progress notes evealed:					

Division of Health Service Regulation

STATE FORM 6899 0KDZ11 If continuation sheet 5 of 5