PRINTED: 07/19/2021 FORM APPROVED

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	
74121 2741	or dorate of the transfer of t	ibertii io/tiiot itombert	A. BUILDING: _			
		MHL080035	B. WING		R 07/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TIMBER R	RIDGE TREATMENT CEN	TER	KES FERRY R ., NC 28071	OAD		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	completed on 7/13/21	and follow-up survey was 1. The complaint was ke #178608). Deficiencies				
	category: 10A NCAC	d for the following service 27G .5200 Residential tive) Camps for Children and sability Groups.				
V 131	G.S. 131E-256 (D2) I Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring hea health care facility or health care facility sh Personnel Registry a	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care nd shall note each incident opriate business files.				
	facility failed to ensur Registry(HCPR) was of 7 staff (#2, #7) and Supervisors(GWS#1) Review on 6/30/21 of -staff #2 was hired or Group Leader(GL), d	ew and interviews, the e the Health Care Personnel accessed prior to hire for 2 d 1 of 2 Group Work b. The findings are: spersonnel records revealed: a 3/4/21 with the job title of ocumentation staff #2 b/11/21 and the HCPR check				

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

(X6) DATE TITLE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080035	B. WING		07	R //13/2021	
	ROVIDER OR SUPPLIER	14225 S	ADDRESS, CITY, STATE TOKES FERRY ROA IILL, 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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
V 131	GL, documentation st 2/4/21 and the HCPR 2/4/21; -GWS#1 was hired or GL, was promoted to HCPR check was cor Interview on 7/1/21 w been on his job for tw been on his job a few Interview on 7/12/21 w been on his job for 4 Interview on 7/13/21 revealed: -will ensure HCPR chire date; -will change how com	a 2/3/21 with the job title of aff #7 reported to work on check was completed on a 8/15/19 with the job title of GWS on 3/15/21 and the inpleted on 8/16/19. A with GWS#1 revealed he had months as a GL. With staff #2 revealed he had months as a GL. With Administrative staff ecks are completed prior to inpleting the hiring process.	V 131				
V 277	who has: (1) a minimum child or adolescent s campers' needs; and (2) who has ca has educational preparations.	•	V 277				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
1.12 / 2.11 0/ 00/11/20/10/1			A. BUILDING: _			
		MHL080035	B. WING		R 07/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		14225 ST	OKES FERRY R	OAD		
TIMBER R	RIDGE TREATMENT CEN	TER	L, NC 28071			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE	
V 277	Continued From page 2		V 277			
	the facility. (e) An emergency or available by page and within one hour. (f) Staff assigned to the staff assif as a staff assigned to the staff assigned to the staff assigned	cal treatment shall be				
	This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure a minimum of two staff members were on duty for every eight or fewer campers. The findings are: Interview on 7/1/21 with client #1 revealed: -Been here three weeks;					
	-have three GLs(Group Leaders) right now;-sometimes have one GL;					
	-have night shift staff;					
	-a week ago only one					
	-staff work here three	days then off three days.				
	Interview on 7/1/21 w been here six and a h -seven kids in his gro -one to two GLs at ca -GLs work three days -GWS(Group Work S	up; amp; on, three days off;				
	Interview on 7/1/21 w -been here three mor -four kids in his group -feel safe here; -staff tx him good; -usually two GLs, but because his group is	or, one GL for right now				

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MHL086		MHL080035	B. WING		R 07/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TIMBER RIDGE TREATMENT CENTER 14225 STOR		KES FERRY R L, NC 28071	OAD			
(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 277	Continued From page	e 3	V 277			
		GLs at his camp was three, GLs at his camp was one. ith client #5 revealed: d two months; work at a time; with staff #1 revealed: e 1/2021; s were made; stead of going to the round with their kids; ck-up;				
	-been on his job for a -have heard groups of -only ever seen the management of -heard if ten clients have (Group Leaders); -have worked some supervisors who can -have his clients in consupervisors who can -interview on 7/13/21 of revealed:	an have up to ten clients; nost of eight clients; ave to have three GLs chifts alone with four clients; t camp site alone; mmunity close to assist with supervision. with administrative staff				
	-had large staff turnov-in process of hiring n-will ensure staffing m	new staff;				

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