

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL080035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/13/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TIMBER RIDGE TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>14225 STOKES FERRY ROAD GOLD HILL, NC 28071</b>
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(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
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint and follow-up survey was completed on 7/13/21. The complaint was unsubstantiated (Intake #178608). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5200 Residential Therapeutic (Habilitative) Camps for Children and Adolescents of All Disability Groups.</p>	V 000	<p><b>DHSR - Mental Health</b></p> <p><b>AUG 11 2021</b></p> <p><b>Lic. &amp; Cert. Section</b></p>	
V 131	<p>G.S. 131E-256 (D2) HCPR - Prior Employment Verification</p> <p>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY</p> <p>(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.</p>	V 131	<p><i>- See attached POC</i></p> <p><i>V-131 + V 277</i></p>	
	<p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Health Care Personnel Registry(HCPR) was accessed prior to hire for 2 of 7 staff (#2, #7) and 1 of 2 Group Work Supervisors(GWS#1). The findings are:</p> <p>Review on 6/30/21 of personnel records revealed: -staff #2 was hired on 3/4/21 with the job title of Group Leader(GL), documentation staff #2 reported to work on 3/11/21 and the HCPR check was completed on 3/9/21;</p>			

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Thomas Gilbert*

TITLE

*CEO*

(X6) DATE

*8/5/21*

Division of Health Service Regulation

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V 131	<p>Continued From page 1</p> <p>-staff #7 was hired on 2/3/21 with the job title of GL, documentation staff #7 reported to work on 2/4/21 and the HCPR check was completed on 2/4/21;</p> <p>-GWS#1 was hired on 8/15/19 with the job title of GL, was promoted to GWS on 3/15/21 and the HCPR check was completed on 8/16/19.</p> <p>Interview on 7/1/21 with GWS#1 revealed he had been on his job for two years.</p> <p>Interview on 7/2/21 with staff #7 revealed he had been on his job a few months as a GL.</p> <p>Interview on 7/12/21 with staff #2 revealed he had been on his job for 4 months as a GL.</p> <p>Interview on 7/13/21 with Administrative staff revealed: -will ensure HCPR checks are completed prior to hire date; -will change how completing the hiring process.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 131		
V 277	<p>27G .5202 Res. Tx. Camp - Staff</p> <p>10A NCAC 27G .5202 STAFF</p> <p>(a) Each facility shall have a program director who has:</p> <p>(1) a minimum of two years' experience in child or adolescent services specific to the campers' needs; and</p> <p>(2) who has camping experience, and who has educational preparation in administrative, education, social work, nursing, psychology or a related field.</p> <p>(b) A minimum of two staff members shall be on</p>	V 277		

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V 277	<p>Continued From page 2</p> <p>duty for every eight or fewer campers.</p> <p>(c) Emergency medical treatment shall be available within one hour of the facility.</p> <p>(d) Psychiatric consultation shall be available to the facility.</p> <p>(e) An emergency on-call staff shall be readily available by page and able to reach campers within one hour.</p> <p>(f) Staff assigned to the facility shall be trained to manage the children or adolescents individually and as a group.</p> <p>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:</p> <p>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 GL worked; -staff work here three days then off three days.</p> <p>Interview on 7/1/21 with client #2 revealed: been here six and a half weeks; -seven kids in his group; -one to two GLs at camp; -GLs work three days on, three days off; -GWS(Group Work Supervisor) fills in.</p> <p>Interview on 7/1/21 with client #3 revealed: -been here three months; -four kids in his group; -feel safe here; -staff tx him good; -usually two GLs, but one GL for right now because his group is small.</p>	V 277		

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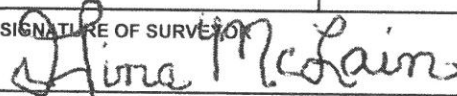
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 277	<p>Continued From page 3</p> <p>Interview on 7/1/21 with client #4 revealed: -been here a month; -the most number of GLs at his camp was three, -the least number of GLs at his camp was one.</p> <p>Interview on 7/1/21 with client #5 revealed: -been here a year and two months; -six kids in his group; -have one to two GLs work at a time; -feel safe here.</p> <p>Interview on 7/1/21 with staff #1 revealed: -been on this job since 1/2021; -worked a shift alone; -special arrangements were made; -keep congregated instead of going to the recreation field; -other GLs are also around with their kids; -have supervisory back-up; -worked alone with seven kids at a time.</p> <p>Interview on 7/12/21 with staff #2 revealed: -been on his job for about four months; -have heard groups can have up to ten clients; -only ever seen the most of eight clients; -heard if ten clients have to have three GLs (Group Leaders); -have worked some shifts alone with four clients; -on those shifts not at camp site alone; -have his clients in community close to supervisors who can assist with supervision.</p> <p>Interview on 7/13/21 with administrative staff revealed: -had large staff turnover past few months; -in process of hiring new staff; -will ensure staffing meets requirements.</p>	V 277		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL080035	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/13/2021	Y3
NAME OF FACILITY TIMBER RIDGE TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 14225 STOKES FERRY ROAD GOLD HILL, NC 28071		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix V0112	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 27G .0205 (C-D)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/30/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

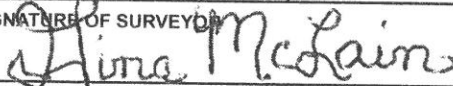
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 7/19/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/27/2019		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL080035	MULTIPLE CONSTRUCTION A. Building _____ B. Wing _____	DATE OF REVISIT 7/13/2021
NAME OF FACILITY TIMBER RIDGE TREATMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14225 STOKES FERRY ROAD GOLD HILL, NC 28071

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0537	Correction	ID Prefix _____	Correction
Reg. # 27E .0108	Completed	Reg. # _____	Completed
LSC _____	07/13/2021	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____

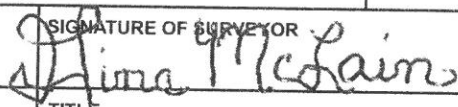
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	SIGNATURE OF SURVEYOR 	DATE 7/19/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	TITLE _____	DATE _____
FOLLOWUP TO SURVEY COMPLETED ON 11/15/2019		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER MHL080035	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 7/13/2021	Y3
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ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix V0110	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 27G .0204	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/13/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 7/19/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/20/2020		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		



TREATMENT CENTER, INC.

Plan of Correction  
Survey completed July 13, 2021  
Timber Ridge Treatment Center  
665 Timber Trail  
Gold Hill, NC 28071  
MHL #080-035  
E-mail Address: [tomhibbert@trtc.net](mailto:tomhibbert@trtc.net)  
Intake # NC 178608  
**ID PREFIX TAG: V131**

*Tom Hibbert*  
CEO 8/15/21

*8/15/21*  
8/15/21

**A. Corrective action:**

Prior to date of hire the Administrator will implement the following procedure: Access the Healthcare Personnel Registry and note each incident of the access in the appropriate personnel file.

**B. Prevention:** The CFO will check to make sure this is done prior to entering payroll data.

**C. Monitoring and Frequency:**

The CFO will complete a monthly report to be submitted to The Leadership Committee for review each month. This report will show the number of new hires the number of healthcare registry checks and the percentage of them completed prior to hire.

**ID PREFIX TAG: V277**

**A. Corrective action:**

The Administrator and Program Director will implement the following procedure:

1. Hire adequate number of staff to ensure that there are two or more staff for every eight or fewer residents.
2. This will include extra staff and supervisory staff to maintain staff ratios in the case of an unplanned absence.
3. The Program Director will prepare a monthly schedule to reflect that two staff members are present for every eight or fewer residents.

**B. Prevention:**

The Program Director will alert the Administrator of any staff who is at risk for leaving. The Program Director and supervisory staff will strategize ways to retain our staff.

**C. Monitoring and Frequency:**

The Administrator will provide a monthly report detailing: the number of staff we have hired, staff turnover, staff length of employment, and the number of staff required to maintain two staff for every eight or fewer residents. This report will be reviewed by The Leadership Committee on a monthly basis.