STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-035	A. BUILDING: _____ B. WING _____	R-C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER RIDGE TREATMENT CENTER	665 TIMBER TRAIL 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 000	INITIAL COMMENTS A complaint and follow up survey was completed on 11/16/22. The complaints were unsubstantiated (intakes # NC00194378 and # NC00194448). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5200 Residential Therapeutic Camps - Children & Adolescents - all Disability Groups. This facility is licensed for 60 and currently has a census of 31. The survey sample consisted of audits of 2 current clients.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident;	V 367		

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V 367	Continued From page 1 (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided	V 367		

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V 367	Continued From page 2 by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit Level II incident reports to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 11/16/22 of the facility's incident reports revealed: -No documentation of an incident report for 10/14/22 regarding clients #1 or #2; -Documentation of a level I incident dated 10/20/22 included, "[client #1] and a peer (client #2) fought over a cone in capture the flag and [client #1] hit his peer (client #2) in the chest. They approached each other aggressively and	V 367		

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V 367	Continued From page 3	V 367		

staff held [client #1] to stop a fight."

Review on 11/17/22 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No documentation of level II incident reports for 10/14/22 or 10/20/22 for clients #1 or #2.

Interview on 11/16/22 with client #1 revealed:
-On 10/14/22, he exposed himself to client #2 on accident when he grabbed the shower curtain rather than his towel;
-On 10/20/22, he touched client #2's genitals and hit him in the stomach on accident during a game.

Interview on 11/16/22 with client #1's Guardian Representative revealed:
-Her agency was notified by a facility staff member (name unknown) of 2 incidents that involved clients #1 and #2;
-On 10/14/22, client #1 exposed himself to client #2 in the shower;
-On 10/20/22, client #1 "grabbed [client #2's] penis."

Interview on 11/16/22 with client #2 revealed:
-On 10/14/22, he exited a shower stall and observed client #1 in the shower stall across from him with his shower curtain half open and he was standing nude while watching him;
-On 10/20/22, his group was playing a game on the recreation field and client #1, "grabbed my you know (genitals)."

Interview on 11/16/22 with the Family Counselor revealed:
-"In one of our sessions last month, he (client #1) did lay out a story where he grabbed his best friends penis. Immediately after having that discussion he went right out and created the

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V 367	Continued From page 4 same incident with [client #2]. He grabbed [client #2's] penis;" -"Prior to that when they were in the shower... [client #1] opened up his shower when he heard [client #2] open his shower and [client #1] was nude." Interview on 11/16/22 with the Clinical Director revealed: -She was aware of the incidents that occurred on 10/14/22 and 10/20/22 that involved clients #1 and #2; -She was not aware that the 2 incidents should have been reported to the LME; -"They (2 incidents) wouldn't be in IRIS because it's not physical like restraints."	V 367		