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 09/12/2023

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 An annual, complaint and follow up survey was completed on 9/12/23. The complaint was unsubstantiated (intake #NC00205320). No 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 3 current clients.	V 000		