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
	MHL080-035	A. BUILDING: _____ B. WING _____	09/26/2023

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 A complaint survey was completed on 9/26/23. The complaint was unsubstantiated (intake #NC00207429). 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 1 current client.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132	See attached Plan of Correction	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas Whitlock — TITLE: CEO — (X6) DATE: 10-3-23

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
	MHL080-035	A. BUILDING: _____ B. WING _____	09/26/2023

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 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Department (HCPR) was notified of allegations against facility staff, provide evidence that the allegation was investigated, and report the finding of the investigation to the Department within five working days of making the initial report. The findings are: Review on 9/22/23 of client #1's record revealed: -An admission date of 10/7/22 -Diagnoses of Post-Traumatic Stress Disorder, Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, Oppositional Defiant Disorder, Unspecified Bipolar and Child	V 132		

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 _____	09/26/2023

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 132	Continued From page 2 Sex Abuse -Age: 15 Attempted review on 9/22/23 of the facility's initial notification to the Department revealed: -No documentation of a completion of an investigation into client #1's allegation of physical abuse by staff #1 within 5 working days -No documentation of reporting the incident to the Department within 5 working days Interview on 9/26/23 with the Assistant Program Director (APD) revealed: -"I was not aware that any allegation against the staff needed to be a level III incident report. I am familiar that they have to be reported to the HCPR...if we make a mistake, we learn from it and correct it..." Interview on 9/26/23 with Program Director revealed: -The APD completed the internal investigation -Would ensure the APD notified the Department of the allegations against staff #1 today (9/26/23)	V 132		
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	V 367		

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 _____	09/26/2023

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 367	Continued From page 3 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; (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	V 367		

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 _____	09/26/2023

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 367	Continued From page 4 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 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 a level III incident report within 72 hours of becoming aware of the	V 367		

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 _____	09/26/2023

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 367	Continued From page 5 incidents. The findings are: Review on 9/22/23 of the North Carolina Incident Response Improvement System revealed: -No documentation a level III incident report of client #1's allegation of physical abuse by staff #1 Review on 9/22/23 of the facility's Restraint Incident Report/Internal Investigation, undated and written by the Assistant Program Director (APD), revealed: -On July 16, 2023, the Program Director (PD) was made aware of client #1's allegation of physical abuse by staff #1 -"Findings: Staff (#1) attempted to place (client #1) in a restraint that was unsuccessful and could have been avoided. Although the client has a history of verbal aggression, defiance, making threatening remarks and becoming physically aggressive by punching a wall, lesser-restrictive intervention techniques should have been applied (i.e., use of appropriate language, tone and deportment) while proving the client with appropriate de-escalating strategies to assist him in calming down and becoming more complaint." -"Action: Staff members involved were counseled on July 18, by [Mr. Little], [Mr. High] and [Mr. Campbell] on what a therapeutic relationship should look like and the importance of being professional at all times while respecting clients' boundaries. The importance of using time and space in order to give clients the opportunity to calm down when frustrated or upset was also discussed. [Staff #1] was reminded how going back and forth with a client or making antagonistic remarks could damage her therapeutic relationship and often triggers anger episodes with residents. [Staff #1] was retrained on the importance of allowing clients the opportunity to calm down by providing them with	V 367		

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 _____	09/26/2023

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 367	Continued From page 6 alternative coping strategies (i.e., time and space, journaling, etc.)." Interview on 9/26/23 with the Assistant Program Director -"I wrote up the report (internal investigation. Normally when we have allegations, I am the one that does the investigations. I look at the allegations. I investigate each one. I interview all the players. Both the accuser, the staff and then any witnesses. I find out what their stories are and get written statements. I come to the conclusion just based on the facts the allegation was unsubstantiated...I was not aware that any allegation against the staff needed to be a level III incident report..." Interview on 9/26/23 with the PD revealed: -Was made aware of the allegation immediately -Was not sure if a level III incident report was completed -Would ensure the APD completed the level III incident report today (9/26/23)	V 367		

TIMBER RIDGE TREATMENT CENTER, INC.

Complaints Survey completed: September 26, 2023
Timber Ridge Treatment Center, 665 Timber Trail, Gold Hill, NC 28071
MHL #080-035
E-mail Address: lauriehibbert@trtc.net
Intake #NC00188125

Plan of Correction

I. V – 132| G.S. 131E-256(G) HCPR – Notification, Allegations, & Protection

A. Corrective Action:

1) Allegations of abuse or neglect and evidence that the allegation against staff, including injuries of unknown source, will be reported to HCPR immediately. All allegations will be investigated and a report of the findings and evidence will be submitted to HCPR within five working days of making the initial report.

B. Prevention:

1) Training will be conducted to ensure all supervisors and direct care staff are aware of HCPR notification requirements in the event of allegations of abuse or neglect and made aware of applicable documentation that need to be completed within 5 working days of making the initial report.

2) Continue ongoing Resident Abuse and Neglect Policy training during monthly staff meetings

C. Monitoring:

1) The Facility Administrator will generate a monthly report measuring the frequency and timeliness of the HCPR reporting, to be reviewed monthly by the Leadership Committee.

2) A Client's Rights Suggestion Box is posted in the Dining Hall and monitored daily by supervisors to ensure all resident concerns or addressed.

2. V – 367 27G.0604 Incident Reporting Requirements

A. Corrective Action:

1) Re-train all direct care and support staff on Incident Reporting Requirements; the importance of completing the applicable initial Level III and/or Level II incident report(s), and submitting them to the appropriate authorities within 24 hours of becoming aware of incident.

2) Areas of concern, particularly abuse or neglect, will be immediately reported by direct care staff to the Program Director and Facility Administrator to ensure appropriate actions are taken (e.g. proper forms and reports completed and processed within 24 hours) and enforce the Progressive Discipline Policy as it pertains to abuse and neglect.

3) All supervisors will receive training by the Training Specialist concerning in-the-field monitoring of the direct care staff to ensure competence is demonstrated and de-escalation strategies are utilized in lieu of restraints.

B. Prevention:

1) The Training Specialist will place increased emphasis on relationship building and using de-escalation strategies for newly hired staff (during training week) as an alternative to restrictive interventions.

2) The Facility Administrator will meet with program staff on a monthly basis to review staff competence, identify problem areas, and implement corrective actions.

3) The Program Director, and/or Assistant Program Director will take progressive disciplinary actions against staff that deviate from their training and fail to utilized de-escalation practices prior to initiating physical restraints.

C. Monitoring:

1) The Facility Administrator will generate a monthly report monitoring the frequency and timeliness of Level II & III incident reports to be reviewed monthly by the Leadership Committee.

2) Client's Rights Suggestion Box is posted in the Dining Hall and monitored by supervisors daily to ensure all resident concerns are addressed.