PRINTED: 04/22/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		MHL080-223	B. WING		04/19/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
STEPPING	S STONE SERVICES	512 WES	ST HORAH STREE	т		
OTETT III	S OT ONE DERVIOLO	SALISBI	JRY, NC 28144			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE	
V 000	INITIAL COMMENTS		V 000			
	on 4-19-22. The comp (NC00187410). Defici This facility is licensed category: 10A NCAC	d for the following service 27G 1700 Residential Staff				
V 296	27G .1704 Residentia Staffing	ıl Tx. Child/Adol - Min.	V 296			
	telephone or page. A able to reach the facil times.  (b) The minimum nur required when childre present and awake is  (1) two direct cone, two, three or four  (2) three direct for five, six, seven or adolescents; and  (3) four direct conine, ten, eleven or two adolescents.  (c) The minimum nur during child or adoles follows:  (1) two direct controls.	sional shall be available by direct care staff shall be ity within 30 minutes at all on the or adolescents are as follows: are staff shall be present for a children or adolescents; care staff shall be present eight children or are staff shall be present for velve children or				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL080-223	B. WING		04/1	9/2022	
	ROVIDER OR SUPPLIER	512 WEST	DRESS, CITY, STATE, ZIP CODE  HORAH STREET  NY, NC 28144				
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 296			V 296				
	failed to maintain the four clients. The findin Observation on 4-8-2 revealed:	and observation the facility ratio of two staff for up to					
		rith Client #1 revealed: e are two staff and r are never there by					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL080-223	B. WING		04	/19/2022		
	NAME OF PROVIDER OR SUPPLIER  STEPPING STONE SERVICES  STEPPING STONE SERVICES  SALISBURY, NC 28144							
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE		
V 296	Interview on 4-8-22 w -It was "mostly" to Interview on 4-8-22 w -Usually there are one.  Interview on 4-8-22 w revealed: -The other staff h	wo staff working a shift.  with Client #3 revealed: we two staff, sometimes only  with the Owner/Director and just run to the store and facility in a few minutes.	V 296					

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