STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY	
THE PERIOD CONNECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
			B WING				
MHL080-223		B. WING		04/	19/2022		
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE	0.11	10/2022	
		512 WEST H					
STEPPING	S STONE SERVICES						
(X4) ID	CLIMMADY OTA	SALISBURY					
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		V 000				
	on 4-19-22. The comp (NC00187410). Defici This facility is licensed category: 10A NCAC 2 Secure for Children ar This facility is licensed currently has a census	I for the following service 27G 1700 Residential Staff and Adolescents.		RECEIVED By cvhicks at 10:10 am, A	Apr 20	5, 2022	
	by telephone or page. able to reach the facilit times. (b) The minimum required when children and awake is as follow (1) two direct car for one, two, three or for adolescents; (2) shall be present for five children or adolescents (3) four direct car nine, ten, eleven or two adolescents. (c) The minimum num during child or adolesc follows:	MINIMUM STAFFING  of essional shall be available A direct care staff shall be by within 30 minutes at all  number of direct care staff or adolescents are present s: re staff shall be present our children or three direct care staff e, six, seven or eight s; and re staff shall be present for elve children or ber of direct care staff ent sleep hours is as  re staff shall be present e for one through four	V 296	On 4-19-22 I was cited for having of in the facility on 4/8/22. As of 4/19 have corrected this error by making two staffs are on duty while there a consumers in the facility.	/22 I g sure	4/25/22	

V 296	Continued From pag		V 296			
(2) two direct care staff shall be present and both shall be awake for five through eight children						
or adolescents; and						
	(3) three direct care staff shall be present which two shall be awake and the third may be					
	asleep for nine, ten,	eleven or twelve children or				
	adolescents. (d) In addition t	o the minimum number of				
	direct care staff set f	orth in Paragraphs (a)-(c) of				
	this Rule, more direction the facility based of	et care staff shall be required on the child or adolescent's				
	individual needs as s	specified in the treatment plan.				
		shall be responsible for of children or adolescents				
	when they are away	from the facility in accordance				
		escent's individual strengths ed in the treatment plan.				
	and needs as specin	ed in the treatment plan.				
	TI: D					
	This Rule is not met Based on interviews	as evidenced by: and observation the facility				
	failed to maintain the ratio of two staff for up to					
	four clients. The findings are:					
	Observation on 4-8-2 revealed:	22 at approximately 4:00pm				
	-Owner/Director	of the facility working by				
	himself.  Interview on 4-8-22 with Client #1 revealed: -Sometimes there are two staff and sometimes one. They are never there by					
	themselves.	and more by				
	Service Regulation					
where contract parameters are the contract parameters and the contract parameters are the contract parameters and the contract parameters are the contract parameters and the contract parameters are		TO NOTE SET AND ADDRESS OF THE PARTY OF THE	09J511	If cont	inuation sheet 2 of 3	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MHL080-223						
		B. WING			04/19/2022	
		RESS, CITY, STAT	TE, ZIP CODE	04	13/2022	
			ORAH STREI			
STEPPING STONE SERVICES SALISBURY, NC 28144						

(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 296	Continued From page 2  Interview on 4-8-22 with Client #2 revealed:     -It was "mostly" two staff working a shift.  Interview on 4-8-22 with Client #3 revealed:     -Usually there are two staff, sometimes only one.  Interview on 4-8-22 with the Owner/Director revealed:     -The other staff had just run to the store and would be back at the facility in a few minutes.     -There were two people working.	V 296		
	n Service Regulation			

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S

SIGNATURE

TITLE

(X6) DATE

STATE FORM			6899 09	DJ511	If continuation sheet 1 o	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PRO	OVIDER OR SUPPLIER	MHL080-223	B. WING		04/19/2022	
	S STONE SERVICES		RESS, CITY, STATE			
		SALISBURY	, NC 28144			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	

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4/25/2022