Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMILETED
		MHL080-223	B. WING		R <b>02/21/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
STEPPING	S STONE SERVICES	512 WES	T HORAH STREE	т	
OTEL TIM	JOTONE GERVIGES	SALISBU	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
		up survey was completed . Deficiencies were cited.			
		d for the following service 27G .1700 Residential re for Children or			
		d for 4 and currently has a rey sample consisted of ents.			
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108		
	10A NCAC 27G .0202 REQUIREMENTS	2 PERSONNEL			
	(g) Employee training	nimum, shall consist of the			
	(2) training on client delineated in 10A NC 10A NCAC 26B;	rights and confidentiality as AC 27C, 27D, 27E, 27F and			
	client as specified in t	he mh/dd/sa needs of the he treatment/habilitation			
	plan; and (4) training in infection bloodborne pathogen	S.			
	.5602(b) of this Subcl	ed under 10a NCAC 27G napter, at least one staff			
	times when a client is				
	member shall be trair				
	_	nagement, currently trained			
		onary resuscitation and			
		h maneuver or other first aid			
		nose provided by Red Cross,			
	the American Heart A	ssociation or their			

Division of Health Service Regulation

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						R
		MHL080-223	B. WING		02	/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
STEPPING	G STONE SERVICES		THORAH STREE	ΞT		
	T		RY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 108	equivalence for reliev (i) The governing boo implement policies ar reporting, investigatin	ing airway obstruction.	V 108			
	facility failed to ensur #2, the Associate Pro Qualified Professional trained to meet the in clients as specified in plan. The findings are Review on 2/21/24 of -A hire date of 12/26/A job description of F-No training on sexual Review on 2/21/24 of -A hire date of 8/31/2A job description of F-No training on sexual	ews and interviews, the e 4 of 5 staff (staff #1, staff fessional (AP) and the ll/Licensee (QP/L) were dividualized needs of the the treatment/habilitation e: f staff #1's record revealed: 23 Paraprofessional lized behaviors f staff #2's record revealed: 2 Paraprofessional lized behaviors f the AP's record revealed: 2 AP				
	Review on 2/21/24 of -A hire date of 5/6/21 -A job description of 0					

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 2 of 17

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY LETED
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
						R
		MHL080-223	B. WING		02/	21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		512 WES	T HORAH STRE	ET		
STEPPING	S STONE SERVICES		RY, NC 28144			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE DATE
V 108	Continued From page	÷ 2	V 108			
	-An admission date of -Diagnoses of Attention Disorder (ADHD), Che Disorder, Generalized History of Alcoholism Disorder, Disruptive Moisorder, Moderate Dest-Traumatic Stresser Borderline Intellectual Child Sexual Abuse -Age 17 -An assessment date previously in a Psych Facility (PRTF), wantown, biological paren 24/7 residential service and point level system that participates in his schedule depending time to shower, has of its responsible for ensure the basket, is responsible for ens	on Deficit Hyperactivity ild Neglect, Conduct d Anxiety Disorder (GAD), , Impulsive Personality Mood Dysregulation Depression Disorder, s Disorder (PTSD), I Functioning and Victim of  d 1/27/23 noted "was iatric Residential Treatment s to get a job when he is on ts were neglectful, needs ces that has rules, structure m, does not have any family on his level, has a scheduled one assigned chore per day, uring his dirty clothes are in sible for making his bed and is not employed, needs to sportation to and from any ppointment needs, has and mental health care as , does not use alcohol but raping and having cigarettes, inistered by staff, needs accept responsibility, needs quences before making a of risk he could be putting story of being assaultive, should complete all levels of				
		four states of treatment, full				
	and responsible ackn	owledgment of sexual	1			

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 3 of 17

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_	<del></del>	
					R
		MHL080-223	B. WING		02/21/2024
			•		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
OTERRING	OTONE CERVICES	512 WEST	HORAH STRE	ET	
STEPPING	S STONE SERVICES	SALISBUI	RY, NC 28144		
044) 15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	·	DROVIDER'S DI ANI OF CORRECTIO	d own
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 108	Continued From page	e 3	V 108		
	abuse thinking errors	dovolopment of coverel			
		s, development of sexual			
	empathy, completion				
	prevention plan to low				
	re-offense and needs	9			
	improvements in expr	essing his feels in a healthy			
	way and recognizing	the causes to help minimize			
	emotional outbursts, i	s very manipulative and			
	deceitful with past age	gressive behaviors towards			
		ault (rape in the first degree			
		ature) towards a sibling			
	(younger sister)."	ataro, torrarao a olemig			
	,	it plan dated 1/10/24 noted			
		healthy skills in areas of			
		re, social skills, and problem			
	solving through partic	- <del>-</del>			
		related to Basic Living			
	Skills, Social Skills, In	terdependent Living Skills,			
	Self-Care, Lifestyle C	hanges and Recovery			
	Principals, will utilize:	skills learned by displaying			
	an ability to control be	ehavior that is unproductive			
	-	s anger in a healthy manner			
	in the moment, under				
		r and display ability to			
	-	ate basic living skills and			
		participate in therapeutic			
	program services whi	·			
	. •				
		creasing rule violations in			
		community from 5 out of 7			
	days per week."				
		client #2's record revealed:			
	-An admission date of				
	-Diagnoses of Autism	Spectrum Disorder,			
	Conduct Disorder, Op	positional Defiant Disorder			
	(ODD), Severe, ADHI				
	Borderline Intellectual				
	-Age 17	· · · · · · · · · · · · · · · · · · ·			
	_	d 11/6/23 noted "is a 17 year			
		al education) who has been			
	olu alli grader (specia	ii education) who has been	1		

Division of Health Service Regulation

referred for residential treatment secondary to

STATE FORM 6899 MHCI11 If continuation sheet 4 of 17

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COWIFE	ETED
					F	₹
		MHL080-223	B. WING		02/2	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
OTEDDING	OTONE CERVICES	512 WES	T HORAH STRE	ET		
STEPPING	S STONE SERVICES	SALISBU	RY, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 108	Continued From page	<del>2</del> 4	V 108			
V 108	verbal and physical a impulse control, extre and maladaptive behaviors, head banging failed group home plainpatient psychiatric hyear, has successfully treatment program and verbal aggression maladaptive behavior fecal smearing or toile amounts of cursing, in banging and minor arbehaviors, has Autism environment that is st following the rules and the important of the phim residential and commit to attend school in a phis level and abilities school with a strong with a strong with a strong with rules and home, community and the next six months be completing schoolwood home, refraining from drugs/contraband, indicigarettes and vaping required, will attend the	ggression, mood swings, me oppositional defiance, aviors (fecal smearing, g) which has resulted in a acement as well as one prior aspitalization in the last y completed a residential and has alleviated his physical in, diminished his is to include no instances of eting issues, limited in instances of head mounts of oppositional in and does well in an arructured, does a good job of ind helping others understand wing rules, was adopted at all skills and academic well III residential placement, individual and family therapy, see a psychiatrist for eight, would also benefit from a bridge the gap between unity living, should continue forogram commensurate with and would benefit from a rocational program and full in expectations of the group in the dischool consistently over y attending school daily, rick, completing chores in the use of any cluding smoking, marijuana, will shower daily and as herapy as indicated and	V 108			
	medication managem a Mentor to help him residential and comm to attend school in a p his level and abilities school with a strong v range IQ score of 64. -A treatment plan date comply with rules and home, community and the next six months b completing schoolwool	nent, would also benefit from bridge the gap between unity living, should continue brogram commensurate with and would benefit from a vocational program and full "  led 11/29/23 noted "will I expectations of the group d school consistently over y attending school daily, rk, completing chores in the				
	drugs/contraband, inc cigarettes and vaping required, will attend the required, will attend n	cluding smoking, marijuana, , will shower daily and as				

Division of Health Service Regulation

activities in the home as scheduled and indicated,

STATE FORM 6899 MHCI11 If continuation sheet 5 of 17

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY PLETED
			A. BOILDING	7. 501251110.		
		MHL080-223	B. WING		02	R 2 <b>/21/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E. ZIP CODE		
			T HORAH STREE			
STEPPING STONE SERVICES			RY, NC 28144	.1		
0/10/15	SLIMMADV ST		<del>,</del>	PROVIDER'S PLAN OF	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 108	Continued From page	÷ 5	V 108			
	will identify and proce to increase self-regular feelings in therapy se counselor, with the suguardian and service behaviors that do not will work towards increskills (obtaining a job/money) to support hir member of his communication by masolving problems, em	ass feelings when they occur ation, will process these ssions with an identified apport from family, legal providers, will exhibit safe necessitate hospitalization, easing independent life volunteering, managing in in becoming an active unity, and will improve his aking informed decisions, pathizing with others and aging my life in a healthy				
	-An admission date of -Diagnoses of ADHD, Specified Learning Di Disorder -Age 16 -An assessment date previously at a facility sexual harm behavior psychiatric, behaviore difficulties, since he was been concerns with haliving, anger outbursts impulsive and has troemotions, wants to we believe the rules apple the Department of So contact with his adopt assault of the adoptive conflicts, poor physical others, conflict with cafigures."	Impulse Control Disorder, sorder and Conduct  d 6/23/23 noted "was that focused on addressing as as well as co-occurring al and trauma related was a young child there have is aggression, stealing, and overall behavior, is uble regulating his ork on his triggers, does not you him, is in the custody of cial Services and has no tive family due to sexual e mother,, has peer al boundaries, manipulates aregivers and authority				
	"wants to learn to den	nt plan dated 2/13/24 noted nonstrate the ability to ely with school staff, his				

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 6 of 17

Division of Health Service Regulation

Division	of Health Service Regu	lation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_	<del></del>	
					R
		MHL080-223	B. WING		02/21/2024
		OTDEET A	DDE00 01TV 0TA	TE 710 000E	
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	TE, ZIP CODE	
STEDDING	S STONE SERVICES	512 WES	T HORAH STRE	ET	
SIEFFING	3 3 TONE SERVICES	SALISBU	IRY, NC 28144		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(710)
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 108	Continued From page	e 6	V 108		
	formally and bounds of any man				
		es and peers by talking in an			
		eing able to express his			
	feelings, being able to	share personal details			
	without losing his tem	per and getting aggressive			
	90% of the time over	the next three months, will			
		pliance and communication			
	appropriately with oth				
		ram rules/expectations by			
		rough with directives within 2			
		_			
	prompts and maintair	- ·			
	communication with s	•			
	·	utic activities, appointments			
	J .	n reasonable efforts to			
	improve the ability to	control his behaviors and			
	improve relationships	with authority figures, will			
	improve his anger by	identifying triggers, learning			
	and implementing effe				
		when he becomes angry or			
		rting to anger outbursts or			
		ors, will increase focus and			
		ng to directions/directives			
	within two prompts re				
		•			
	completing daily tasks	•			
		physical, social, emotional,			
	0, 10	e, sportsmanship and			
	independent living ski	ills with same age peers, will			
	go to bed on time, be	ing quiet after lights out and			
	going to sleep or rest	ring quietly throughout the			
	night and will not exhi				
	inappropriate behavio				
		aff report after bedtime."			
	accumentation and st	an report and bouline.			
	Interview on 2/20/24:	with client #1 revealed:			
		ocked facility in another			
	state for "my anger ar	nd my sexual behaviors."			
	Interview on 2/20/24	with client #2 revealed:			
	-"I was in a locked fac	cility because of my sexual			
	behaviors. I complete	-			1

Division of Health Service Regulation

treatment."

STATE FORM 6899 MHCI11 If continuation sheet 7 of 17

Division of Health Service Regulation

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.	<del></del>	R	
		MHL080-223	B. WING		<b>I</b>	1/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
STEPPING	S STONE SERVICES		HORAH STRE	ET		
			RY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
V 108	Continued From page	÷ 7	V 108			
	-"I was in a locked factor and chargesI was or rape. I really don't like Interview on 2/20/24 -Was aware the client -"I have not had any tobehaviors."  Interview on 2/20/24 -Was aware the client -"No, I have not witner (sexualized behaviors -Had not had training Interview on 2/21/24 - Professional revealed	with staff #1 revealed: its had sexualized behaviors rainings on sexualized  with staff #2 revealed: its had sexualized behaviors. its seed anything like that its by the clients." on sexualized behaviors.  with the Associate its had sexualized behaviors				
	behaviors -"In groups, if the clie in that setting, I give t therapy. We discuss I opposite sex, commu appropriate ways to e most of the clients ha trauma"	had a history of sexualized  Ints are struggling with topics hem the opportunity for 1:1 healthy relationships with the nication, and the most engage in relationships since we some sort of abuse and  taff had received training on				
	Interview on 2/21/24	with the QP/L revealed:				

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 8 of 17

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPLI	
			A. BOILDING			,
		MHL080-223	B. WING		02/2	1/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
STEPPING	S STONE SERVICES		HORAH STRE	ET		
			RY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 108	Continued From page	e 8	V 108			
	sexualized behaviors -"We were trained on We have not had any sexualized behaviors alone in the same pla appropriate boundarie all times."  Further interview on 2 revealed: -"I plan to get togethe have a staff meeting s we will try to set up tre behaviors then."	the population we serve. detailed training in We don't allow them to be ce, we monitor for es and supervised them at  2/21/24 with the QP/L  wr with [LP] next week. We scheduled for Tuesday and aining on sexualized				
V 296	telephone or page. A able to reach the facil times. (b) The minimum nur required when childred 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.	MINIMUM STAFFING sional shall be available by a direct care staff shall be ity within 30 minutes at all mber of direct care staff on or adolescents are as follows: are staff shall be present for r children or adolescents; care staff shall be present eight children or	V 296			

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 9 of 17

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
741012741	or contraction	IDENTIFICATION TO A TO	A. BUILDING: _			
		MHL080-223	B. WING		I	R <b>21/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
STEPPING	S STONE SERVICES		T HORAH STRE	ET		
			RY, 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 296	Continued From page	9	V 296			
	during child or adolest follows:  (1) two direct coand one shall be aware children or adolescent  (2) two direct coand both shall be aware children or adolescent  (3) three direct of which two shall be asleep for nine, ten, eadolescents.  (d) In addition to the care staff set forth in Rule, more direct care the facility based on to individual needs as splan.  (e) Each facility shall supervision of childrent are away from the face	cent sleep hours is as  are staff shall be present ke for one through four ts; are staff shall be present ake for five through eight ts; and care staff shall be present awake and the third may be eleven or twelve children or  minimum number of direct Paragraphs (a)-(c) of this e staff shall be required in the child or adolescent's pecified in the treatment  be responsible for ensuring or adolescents when they cility in accordance with the individual strengths and				
	interviews, the facility number of direct care or adolescents are pr findings are:	ns, record reviews and failed to have the minimum staff required when children esent and awake. The				
	Observations on 2/20	/24 from 1:25pm to 2:32pm				<b></b>

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 10 of 17

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL080-223	B. WING		02/21/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		512 WES	T HORAH STRE	ET	
STEPPING	S STONE SERVICES		RY, NC 28144		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
V 296	Continued From page	e 10	V 296		
	of the facility revealed				
	-Client #1 and the Qu				
	Professional/Licenses				
	-There was no other s	staff at the facility			
		on 2/20/24 from 2:32pm to			
	2:55pm of the facility				
		n, a second staff arrived at			
	the facility.				
	-At 2/20/24 at 2:38pm facility.	n, a third staff arrived at the			
		n, a fourth staff arrived at the			
	facility.	i, a lourtii stali allived at tile			
	raomty.				
	Review on 2/21/24 of	client #1's record revealed:			
	-An admission date o	f 1/27/23			
	•	on Deficit Hyperactivity			
	Disorder (ADHD), Ch				
		d Anxiety Disorder (GAD),			
	_	, Impulsive Personality			
	Disorder, Disruptive N				
	Disorder, Moderate D Post-Traumatic Stres				
		I Functioning and Victim of			
	Child Sexual Abuse	Transcerning and violant of			
	-Age 17				
	-An assessment date	d 1/27/23 noted "was			
	previously in a Psych	iatric Residential Treatment			
		s to get a job when he is on			
		ts were neglectful, needs			
		ces that has rules, structure			
		n, does not have any family			
		s therapy, is on a daily			
		on his level, has a scheduled one assigned chore per day,			
		uring his dirty clothes are in			
		sible for making his bed and			
	-	is not employed, needs to			
		sportation to and from any			
	T	ppointment needs, has			

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 11 of 17

Division of Health Service Regulation

	or periornoise		(VO) MUUTIDUE	CONCERNATION	T(Y2) DATE CUDVEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
, , , , , , , , , , , , , , , , , , , ,		1.52.11.11.10.11.10.11.52.11.	A. BUILDING: _		00 22.25
					R
		MHL080-223	B. WING		02/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIP CODE	
TWINE OF T	NOVIDER OR COLL FIELD		HORAH STRE		
STEPPING	S STONE SERVICES		RY, NC 28144	:E1	
			KI, NC 20144	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF	
				DEFICIENCY)	
V 296	Continued From page	. 11	V 296		
V 230			V 290		
	access to health care	and mental health care as			
		, does not use alcohol but			
		aping and having cigarettes,			
		inistered by staff, needs			
	_	ake positive choices, needs			
		accept responsibility, needs			
		uences before making a			
		of risk he could be putting			
		story of being assaultive,			
		should complete all levels of			
	sexual abuse specific	•			
		four states of treatment, full			
	-	owledgment of sexual			
	_	s, development of sexual			
	empathy, completion				
	prevention plan to low				
	re-offense and needs				
		ressing his feels in a healthy			
		the causes to help minimize			
		s very manipulative and			
		gressive behaviors towards			
		sault (rape in the first degree			
	_	ature) towards a sibling			
	(younger sister)."				
	•	nt plan dated 1/10/24 noted			
		healthy skills in areas of			
	_	re, social skills, and problem			
		ipation/attendance of			
		related to Basic Living			
		terdependent Living Skills,			
		hanges and Recovery			
	I	skills learned by displaying			
	_	ehavior that is unproductive			
		s anger in a healthy manner			
	in the moment, under				
	I	r and display ability to			
		ate basic living skills and			
		participate in therapeutic			
	program services whi				
	program rules and de	creasing rule violations in			

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 12 of 17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						R
		MHL080-223	B. WING		02	/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		512 WES	T HORAH STRE	ET		
STEPPING	S STONE SERVICES	SALISBU	RY, NC 28144			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 296	Continued From page	e 12	V 296			
	the home, school and days per week."	community from 5 out of 7				
		client #2's record revealed:				
	-An admission date of					
	-Diagnoses of Autism					
		ppositional Defiant Disorder				
	Borderline Intellectual	D and Encopresis and				
	-Age 17	i i unctioning				
		d 11/6/23 noted "is a 17 year				
		al education) who has been				
		l treatment secondary to				
		ggression, mood swings,				
	_ · · · · · · · · · · · · · · · · · · ·	me oppositional defiance,				
	and maladaptive beha	aviors (fecal smearing,				
		g) which has resulted in a				
		cement as well as one prior				
		ospitalization in the last				
		y completed a residential				
		nd has alleviated his physical				
	and verbal aggression					
		s to include no instances of				
	fecal smearing or toile amounts of cursing, n	•				
		nounts of oppositional				
	behaviors, has Autism	• •				
		ructured, does a good job of				
		d helping others understand				
	_	ving rules, was adopted at				
	age 4, has poor socia	- ·				
	problems, needs a lev	vel III residential placement,				
		ndividual and family therapy,				
	needs to continue to					
	_	ent, would also benefit from				
		bridge the gap between				
		unity living, should continue				
		program commensurate with				
		and would benefit from a				
	Eschool with a strong v	ocational program and full	1			1

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 13 of 17

Division of Health Service Regulation

	or periornoiro		(VO) MILITIDI E	CONCEDUCTION	Toyou pate o	LIDVEV.
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND TERROR CONTROL TO THE PROPERTY OF THE PROP		A. BUILDING: _	A. BUILDING:		OCIVII LETED	
					R	2
		MHL080-223	B. WING		02/2	1/2024
	DOV (IDED OD OUDDU IED	0.70557.45	DD500 0171/ 074	TE 710 0005		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
STEPPING	S STONE SERVICES		T HORAH STRE	ET		
		SALISBU	RY, NC 28144			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	NEGOLATORT OR I	esciblisti fing in onwation)	TAG	DEFICIENCY)	MAIL	57.1.2
V 296	Continued From page	e 13	V 296			
	range IQ score of 64.	"				
		ed 11/29/23 noted "will				
		l expectations of the group				
		d school consistently over				
		y attending school daily,				
		rk, completing chores in the				
	home, refraining from					
	_	cluding smoking, marijuana,				
		, will shower daily and as				
		nerapy as indicated and				
		nedication management and				
	other appointments as required, participate in activities in the home as scheduled and indicated,					
		ess feelings when they occur				
		ation, will process these				
	_	ssions with an identified				
		ipport from family, legal				
		providers, will exhibit safe				
		necessitate hospitalization,				
		easing independent life				
		/volunteering, managing				
	, ,	n in becoming an active				
		unity, and will improve his				
		aking informed decisions,				
	solving problems, em	pathizing with others and				
	coping with and mana	aging my life in a healthy				
	way,"	- ·				
	Review on 2/21/24 of	client #3's record revealed:				
	-An admission date o					
		Impulse Control Disorder,				
	Specified Learning Di	sorder and Conduct				
	Disorder					
	-Age 16					
	-An assessment date					
		that focused on addressing				
		rs as well as co-occurring				
	psychiatric, behavioral and trauma related difficulties, since he was a young child there have					
	been concerns with h	is aggression, stealing,				

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 14 of 17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER:			COMPLETED	
					R	
		MHL080-223	B. WING		02/21/2024	
NAME OF D			ADDECC CITY CTA	TE 7/D 00DE	1	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
STEPPING	S STONE SERVICES		T HORAH STRE	EI		
	Г	SALISBU	RY, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 296	Continued From page	<del>:</del> 14	V 296			
V 296	living, anger outbursts impulsive and has tro emotions, wants to we believe the rules appl the Department of So contact with his adopt assault of the adoptiv conflicts, poor physica others, conflict with cafigures."  -An updated treatmer "wants to learn to den communicate effective family, authority figure appropriate manner be feelings, being able to without losing his tem 90% of the time over learn to increase com appropriately with oth compliance with proglistening, following the prompts and maintain communication with searticipate in theraper and meeting, put forth	s and overall behavior, is uble regulating his ork on his triggers, does not by to him, is in the custody of cial Services and has no tive family due to sexual emother,, has peer all boundaries, manipulates aregivers and authority  at plan dated 2/13/24 noted monstrate the ability to ely with school staff, his es and peers by talking in an eing able to express his or share personal details per and getting aggressive the next three months, will pliance and communication ers, will maintain ram rules/expectations by rough with directives within 2 uting respectful taff and peers, will utic activities, appointments in reasonable efforts to	V 296			
	improve relationships	control his behaviors and with authority figures, will				
	improve his anger by and implementing effe	identifying triggers, learning				
		when he becomes angry or				
		rting to anger outbursts or				
		ors, will increase focus and				
		ng to directions/directives				
	within two prompts re					
	completing daily tasks					
		physical, social, emotional,				
	team building, hygien	e, sportsmanship and				
		lls with same age peers, will ing quiet after lights out and				

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 15 of 17

Division of Health Service Regulation

DIVISION	n Health Service Negu	ialion				
			(X3) DATE S			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLI	ETED	
					_	
			D WING		F	
		MHL080-223	B. WING		02/2	1/2024
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	TOVIDER OR SOLT LIER					
STEPPING	S STONE SERVICES		T HORAH STRE	ET		
		SALISBU	RY, NC 28144			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIAIE	DATE
				BEI IOIENOT)		
V 296	Continued From page	e 15	V 296			
	. •					
	going to sleep or resti	ring quietly throughout the				
	night and will not exhi	ibit any incidents of				
	inappropriate behavio	ors by shift note				
		taff report after bedtime."				
		•				
	Interview on 2/20/24 v	with client #1 revealed:				
	-Only one staff on 3rd					
		the morning, there is only				
	one staff."	the morning, there is only				
	one stan.					
	Intomious on 0/00/04 s	with aliant #O navealad.				
		with client #2 revealed:				
		there is usually 1 staff				
		issues at night and no				
		ay in the living room"				
	~	there was only one staff				
	working."					
	Interview on 2/20/24 v	with client #3 revealed:				
	-Staffing depended or	n how many kids were at the				
	facility.					
	-"At night, there is only one (staff) because we					
	are in bed."	. ,				
	-" There have been tir	mes when we have only one				
		se the other staff go to				
	college."	oo ano oano. otaan go to				
	•	with staff #1 and staff #2				
	revealed:	Will Stall #1 and Stall #2				
		O -1-#				
	-On each shift there a	ne∠ Stall.				
	Interview on 2/24/24:	with the Associate				
	Interview on 2/21/24					
	Professional revealed					
	-"There are usually 2	staff on every shift."				
	Interview on 2/21/24 v					
	Professional revealed	<del></del>				
	-"When I am at the fa	cility, typically, I see two				
	staff on shiftbut I ar	m not there at nighttime."				
		-				
	Interview on 2/20/24 v	with the Qualified				

Division of Health Service Regulation

Professional/Licensee (QP/L) revealed:

STATE FORM 6899 MHCI11 If continuation sheet 16 of 17

Division of Health Service Regulation

MHL080-223    B WINS   R   R   R   R   R   R   R   R   R	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  STEPPING STONE SERVICES  SALISBURY, NC 28144   (X4) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 296  Continued From page 16  -"Staff at the facility when on duty was at all times 2." -"On third shift last night (2/20/24), there was only one staff"  Further interview on 2/21/24 with the QP/L revealed: -For third shift staffing, "I have two (staff) scheduled. Sometimes they call out. What I do is use the college students as 'the sleepers' with the regular staff. They (the sleepers) may leave before the clients wake up. I will continue to have 2 staff on every shift. I have no first shift unless the clients are out of schoolThe sleepers have all been trained."  This deficiency constitutes a re-cited deficiency							
STEPPING STONE SERVICES    SUMMARY STATEMENT OF DEFICIENCIES SALISBURY, NC 28144     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     TAG   PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     V 296   Continued From page 16   V 296     -"Staff at the facility when on duty was at all times 2."   -"On third shift last night (2/20/24), there was only one staff"     Further interview on 2/21/24 with the QP/L revealed:   -For third shift staffing, "I have two (staff) scheduled. Sometimes they call out. What I do is use the college students as "the sleepers" with the regular staff. They (the sleepers) may leave before the clients wake up. I will continue to have 2 staff on every shift. I have no first shift unless the clients are out of schoolThe sleepers have all been trained."     This deficiency constitutes a re-cited deficiency			MHL080-223	B. WING		02	/21/2024
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)      V 296   Continued From page 16   V 296    -"Staff at the facility when on duty was at all times 2."  -"On third shift last night (2/20/24), there was only one staff"	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	E, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DATE      V 296	STEPPING	S STONE SERVICES			ĒΤ		
-"Staff at the facility when on duty was at all times 2."  -"On third shift last night (2/20/24), there was only one staff"  Further interview on 2/21/24 with the QP/L revealed: -For third shift staffing, "I have two (staff) scheduled. Sometimes they call out. What I do is use the college students as 'the sleepers' with the regular staff. They (the sleepers) may leave before the clients wake up. I will continue to have 2 staff on every shift. I have no first shift unless the clients are out of schoolThe sleepers have all been trained."  This deficiency constitutes a re-cited deficiency	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
	V 296	-"Staff at the facility w 2." -"On third shift last nigone staff"  Further interview on 2 revealed: -For third shift staffing scheduled. Sometime use the college stude regular staff. They (the before the clients wal 2 staff on every shift. the clients are out of all been trained."  This deficiency const	when on duty was at all times ght (2/20/24), there was only 2/21/24 with the QP/L g, "I have two (staff) es they call out. What I do is ents as 'the sleepers' with the le sleepers) may leave ke up. I will continue to have I have no first shift unless schoolThe sleepers have	V 296			

Division of Health Service Regulation

STATE FORM 6899 MHCI11 If continuation sheet 17 of 17