

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/22/2022
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NAME OF PROVIDER OR SUPPLIER FIRST STEP FARM-MEN	STREET ADDRESS, CITY, STATE, ZIP CODE 109 FIRST STEP FARM DRIVE CANDLER, NC 28715
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(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	<p>INITIAL COMMENTS</p> <p>A limited follow up survey for the Type A2 was completed on 6/22/22. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Administration (V118) with cross reference 10A NCAC 27G .0209 Medication Storage (V120) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 Medication Administration (V118) with cross reference 10A NCAC 27G .0209 Medication Storage (V120). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.</p> <p>This facility is licensed for 22 and currently has a census of 17. The survey sample consisted of audits of 3 current clients.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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