STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-264	A. BUILDING: _____ B. WING _____	R 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST AT BLUE RIDGE	32 KNOX ROAD RIDGECREST, NC 28770

(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 limited follow up survey for the Type B was completed on Septermber 13, 2024. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirements (V118) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V118). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4300 Therapeutic Community. This facility is licensed for 85 and has a current census of 56. The survey sample consisted of audits of 5 current clients.	V 000		