

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL025-221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/03/2022
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NAME OF PROVIDER OR SUPPLIER BLESSED HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 PLYMOUTH DRIVE NEW BERN, NC 28562
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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 follow up survey was attempted on October 3, 2022. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was September 27, 2022.</p> <p>This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Interview on 10/03/22 the Licensee stated:</p> <ul style="list-style-type: none"> - There were no current clients being served at the facility. - The last client was discharged on 09/27/22. - She also served as an Alternate Family Living facility provider at her home. - She was aware to notify the Division of Health Service Regulation when clients were admitted to the facility. 	V 000		

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