Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL025-221	A. BUILDING: ________ B. WING ________	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HAVEN	**1025 PLYMOUTH DRIVE NEW BERN, NC 28562**

(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 follow up survey was attempted on October 3, 2022. According to the Licensee there are no clients being served at the facility. No clients had been served at the facility since last attempted survey. The previous attempted survey indicated the last time clients were served at the facility was September 27, 2022. This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. Interview on 01/06/23 the Licensee stated: - There were no current clients being served at the facility. - She had not admitted any clients since the previous survey. - She had one client currently living with her. - She was planning to admit clients to the facility in the future. - She was aware to notify the Division of Health Service Regulation when clients were admitted to the facility.	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE