

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL025-221</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>02/28/2023</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BLESSED HAVEN</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1025 PLYMOUTH DRIVE</b><br><b>NEW BERN, NC 28562</b> |
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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 |
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| V 000              | <p><b>INITIAL COMMENTS</b></p> <p>A follow up survey was attempted on February 28, 2023. 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.</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 02/28/23 the Licensee stated:</p> <ul style="list-style-type: none"> <li>- There were no current clients being served at the facility.</li> <li>- She had one client currently living with her.</li> <li>- She was aware to notify the Division of Health Service Regulation when clients were admitted to the facility.</li> </ul> | V 000         |   |                    |

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