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 _____	06/15/2023

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 An annual and follow up survey was attempted on June 15, 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. This facility is licensed for the following service category 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. Interview on 06/15/23 the Licensee stated: - There were no current clients being served at the facility. - She would have clients in the facility by September to renew her license. - She was aware to notify the Division of Health Service Regulation (DHSR) when clients were admitted to the facility. - She had been working with DHSR staff to change information on the license.	V 000		