STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-078	A. BUILDING: _____ B. WING _____	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD HOUSE	221 BEDFORD STREET EDEN, NC 27288

(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 survey was attempted on 4/23/24. According to the Qualified Professional and the Manager, there are no clients being served at the facility. The last time clients were served at the facility was 5/19/23. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. Observation of the facility on 4/23/24 at 9 am revealed: - No answer at the door Interview on 4/23/24 with the Qualified Professional (QP) revealed: - There had been no clients served at the facility since 5/19/23 - Plans were to admit clients to the facility in the coming months Interview on 4/23/24 with the Manager revealed: - Confirmation of what the QP had reported regarding no clients having been served at the facility since 2023 - Plans were to admit clients within the coming months - His agency would inform the Division of Health Service Regulation when a client or clients were admitted to the facility	V 000		