

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL081-091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/20/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KELLY'S CARE #8</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1366 COOPER'S GAP ROAD RUTHERFORDTON, NC 28139</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
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An Annual and follow up survey were attempted on 6/19/18- 6/20/18. According to the licensee, there are no clients being served at this facility. The last time clients were served at the facility was on April 14, 2018.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Interviews on 6/19/18 and 6/20/18 revealed:</p> <ul style="list-style-type: none"> <li>-The Qualified Professional had mailed paperwork into the State about not serving any clients;</li> <li>-The last client was served on 4/14/18;</li> <li>-The last client served had moved to another facility that was licensed as 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities and under the same licensee;</li> <li>-The facility was being remodeled with a plan to admit clients again the end of August, 2018.</li> </ul>	V 000		

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