

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-087 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/23/2018 |
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| NAME OF PROVIDER OR SUPPLIER KELLY'S CARE 6 | STREET ADDRESS, CITY, STATE, ZIP CODE 156 US HWY-122-A FOREST CITY, NC 28043 |
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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>INITIAL COMMENTS</p> <p>An annual survey was completed on 8/23/18. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G.5600 C Supervised Living for Individuals of All Disability Groups.</p> | V 000 | | |

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