

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-076	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2021
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NAME OF PROVIDER OR SUPPLIER KELLY'S CARE II	STREET ADDRESS, CITY, STATE, ZIP CODE 521 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139
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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>INITIAL COMMENTS</p> <p>A complaint survey was completed on 1/29/21. The complaint was unsubstantiated (Intake ID # NC00172735 & NC00173283). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27 G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		

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