

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/02/2022 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER KELLY'S CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 2073 HARRIS-HENRIETTA ROAD MOORESBORO, NC 28114 |
|---|---|

| (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>An annual survey was completed on June 2, 2022. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The survey sample consisted of audits of 3 current clients.</p> | V 000 | | |

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