

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 R 04/10/2024
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NAME OF PROVIDER OR SUPPLIER KELLY'S CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2073 HARRIS-HENRIETTA ROAD MOORESBORO, NC 28114
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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 limited follow up survey for the Type B was completed on April 10, 2024. This was a limited follow up survey, only 10A NCAC 27G.0209 Medication Requirements (V118) with cross references 10A NCAC 27G.0209 (V116), 10A NCAC 27G.0209 (V119), and 10A NCAC 27G.0209 (V120) were reviewed for compliance. The following were brought back into compliance 10A NCAC 27G.0209 Medication Requirements (V118) with cross references 10A NCAC 27G.0209 (V116), 10A NCAC 27G.0209 (V119), and 10A NCAC 27G.0209 (V120). 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 Disability .</p> <p>The facility is licensed for 6 and currently has a census of 6. 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
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