Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043-089	A. BUILDING: ______ B. WING ______	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDEMPTION ALTERNATIVE LIVING CENTER	**410 WEST EDGERTON STREET DUNN, NC 28334**

(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	INITIAL COMMENTS An annual survey was attempted on 4/12/18. According to the Licensee, there were no clients being served at the facility. The last time clients were served at the facility was 4 or 5 months ago. This facility is licensed for the following service category: 10A NCAC 27G .10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities During interview on 4/12/18, the licensee revealed: -She did not have any clients in the facility. -The last client was discharged 4 or 5 months ago. -Client was placed temporary. -She was the direct care worker. -Pending new clients from the local management entity.	V 000		

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