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 _____	06/13/2018

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 6/13/18. According to the Licensee, there were no clients being served at the facility. The last time clients were served at the facility was 12/29/2017. 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 6/13/18, the licensee revealed: -She did not have any clients. -The last client was discharged 12/29/2017. -She was the direct care worker. -An attempt had been made two months ago by another surveyor, but she also did not have any clients at the time. -She was pending new clients from the local management entity. -She was aware that she needed to call DHSR whenever she would be getting a new client.	V 000		