

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043-089	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER REDEMPTION ALTERNATIVE LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>An annual survey was attempted on 8/26/25. According to the Licensee, there were no clients being served at the facility. The last time clients were served at the facility was 7/1/24.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>Interview on 8/26/25 the Licensee stated: -She did not have any clients at the facility. -The last client was discharged 7/1/24. -She was aware that she needed to call DHSR if she would be getting a new client. -She did not plan to renew her license at the end of the year.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE