

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL074-167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2018
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NAME OF PROVIDER OR SUPPLIER GREENVILLE RECOVERY CENTER, LLC (GRC	STREET ADDRESS, CITY, STATE, ZIP CODE 150 ARLINGTON BOULEVARD, SUITE C GREENVILLE, NC 27858
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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>An Annual and Follow Up Survey was completed 05/15/18. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Methadone; and 10A NCAC 27G .3300, Outpatient Detoxification.</p> <p>The client census for the .3600 service was 210.</p> <p>No clients were enrolled for the .3300 service.</p>	V 000		

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