

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/12/2019 |
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| NAME OF PROVIDER OR SUPPLIER ALCOHOL AND DRUG SERVICES-EAST | STREET ADDRESS, CITY, STATE, ZIP CODE 1101 CAROLINA STREET GREENSBORO, NC 27401 |
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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 |
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| V 000 | <p>INITIAL COMMENTS</p> <p>An annual and complaint survey was completed 3/12/19. The complaints, (Intake #NC0142137, Intake #NC00147179) were unsubstantiated 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 .4400 Substance Abuse Intensive Outpatient Program.</p> <p>The census was 167.</p> | V 000 | | |

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| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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