

Division of Health Service Regulation

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 03/03/2020
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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
V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed 3/3/20. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .3600 Outpatient Opioid Treatment and 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program.</p> <p>The census was 179</p>	V 000		

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