

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL074-070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER EAST COAST COUNSELING, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 620 LYNNDALE COURT, SUITE C GREENVILLE, NC 27858
---	--

(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 January 22, 2020. According to the Facility Director there are no clients are being served at the facility. The facility has never served clients under its current license.</p> <p>This facility is licensed for the following service 10A NCAC 27G .3700 Day Treatment Facilities for Individuals with Substance Abuse Disorders.</p> <p>Interview on January 22, 2020 the Facility Director stated she has submitted the renewal for the license for the last 13 years and the facility had always provided DWI assessments, ADETS and counseling services under the license. A day program has never operated in this facility under the current license. Clients may have presented for assessments periodically at the program, ADETS and counseling services for DWI services were made available in the afternoon and evenings.</p> <p>Observations of the facility on January 22, 2020 at approximately 11:30am revealed a small waiting room and a clerical/medical records area. Observations included several small offices which the Facility Director identified as assessments and counseling areas.</p>	V 000		

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