

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-454	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2025
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NAME OF PROVIDER OR SUPPLIER MAYRX RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 302 STONERIDGE BOULEVARD ASHEVILLE, NC 28804
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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 complaint survey was completed on October 21, 2025. The complaints were unsubstantiated (intake # NC00233596 and NC00233636). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program, and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment Program.</p> <p>This facility has a current census of 22. The .4400 Substance Abuse Intensive Outpatient Program (SAIOP) has a current census of 7 and the .4500 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) has a current census of 15. The survey sample consisted of audits of 1 current SAIOP client, and 2 current and 1 former SACOT client.</p>	V 000		

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