

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2026
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NAME OF PROVIDER OR SUPPLIER VANCE RECOVERY	STREET ADDRESS, CITY, STATE, ZIP CODE 932 WEST ANDREWS AVENUE HENDERSON, NC 27536
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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 4/2/26. The complaint was unsubstantiated (Intake# NC00236097). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Opioid Treatment.</p> <p>This facility has a current census of 337. The survey sample consisted of audits of 16 current clients.</p>	V 000		

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