

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL012-134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/22/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FLYNN RECOVERY COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>721 WEST UNION STREET MORGANTON, NC 28655</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was attempted on April 22, 2026. According to the Licensee, there are no clients being served at the facility.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.</p> <p>Interview on 4/22/26 with the Executive Director revealed:</p> <ul style="list-style-type: none"> <li>-Confirmed that the last client served at the facility was on 4/8/26.</li> <li>-The facility was "remodeling" and he had a tentative date of 5/18/26-6/1/26 for the facility to begin serving clients again.</li> </ul>	V 000		

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