STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20040012	B. WING		09/0	1/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
D DVAIAL A	AADD HOODITAL	192 VILLA	GE DRIVE			
BRYNN	MARR HOSPITAL	JACKSON	IVILLE, NC	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	1, 2022. One comp (intake #NC001919 substantiated (intak deficiency was cited This facility is licens category: 10A NCA Residential Treatme Adolescents.	sed for the following service C 27G .1900 Psychiatric ent for Children and sed for 18 and currently has a				
V 440	audit of 1 current cl		V 440			
V 116	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name;	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be lely after administration. The	V 118			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20040012	B. WING		09/0	01/2022
	NAME OF PROVIDER OR SUPPLIER BRYNN MARR HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE JACKSONVILLE, NC 28546					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	(D) date and time the (E) name or initials drug. (5) Client requests checks shall be rec	ge 1 administering the drug; ne drug is administered; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	failed to ensure me as ordered by the p audited (client #1). Review on 8/31/22 record revealed: -15 year old female -Diagnoses include dysregulation disord unspecified. Review on 9/1/22 o and physician programmers.	view and interview, the facility dications were administered hysician affecting 1 of 1 client The findings are: and 9/1/22 of client #1's admitted 1/24/22. d disruptive mood der, and impulse disorder, f client #1's physician orders ress notes between 6/30/22				
	on each physician pmedication order to or changedProgress notes we physicianProgress note date Topamax Tablet, 10	ed: were listed under "Treatment" progress note listing each be continued, discontinued, ere electronically signed by the ed 6/30/22 read, "Increase 00 MG (milligrams), 1 tablet at off label used for obesity)				

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STATE FORM 9PVX11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		20040012	B. WING		09/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
BRYNN MARR HOSPITAL 192 VILLAGUE 192 VILLAGUE 192 VILLAGUE 192 VILLAGUE 193 VILLAGU				28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	-Progress notes da and 8/25/22 read, "MG, 1 tablet at bed -Progress note data Abilify Tablet, 20 M (antipsychotic med -Progress notes da read, "Continue Ab bedtime" -There was no order gat bedtime doc progress notes or p-Verbal order dated form to discontinue 15 mg at bedtimeVerbal order dated form to administer 20 mg at bedtime. Review on 8/31/22 2022 and August 2 -Client #1 continue and Ability 15 mg uwere increased to respectivelyTopamax 100 mg administered from Interview on 9/1/22 Manager #2 stated -The facility had no progress notes to in-There was no produced orders documented notes and the med followedThe Topamax had pharmacy system for medication had bed	ted 7/7/22, 7/14/22, 8/18/22, Continue Topamax Tablet, 100 ltime" ed 6/30/22 read, "Increase G, 1 tablet at bedtime" icine; lability) ted 7/7/22/22 and 7/14/22 ilify Tablet, 20 MG, 1 tablet at er to discontinue Topamax 100 umented on the physician order forms. I 7/14/22 on a physician order Topamax 50 mg and Abilify I 7/14/22 on a physician order Topamax 100 mg and Abilify and 9/1/22 of client #1's July 022 MARs revealed: d to receive Topamax 50 mg ntil 7/14/22 when the dosages 100 mg and 20 mg had not been documented as 8/14/22 - 8/31/22. Nurse Manager #1 and Nurse : t considered the physician nclude orders. cess in place to reconcile the d on the physician progress ication orders that were being an "auto stop" in the for 8/14/22; therefore, the	V 118			

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STATE FORM 9PVX11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT CON		(X3) DATE COMF	E SURVEY MPLETED	
		20040012	B. WING		09/0	1/2022	
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE JACKSONVILLE, NC 28546						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 118	the physician before	e a medication was l on the "auto stop" feature.	V 118				

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