

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20040012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2023
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NAME OF PROVIDER OR SUPPLIER BRYNN MARR HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE JACKSONVILLE, NC 28546
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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
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and limited follow up survey for the Type A1 was completed on April 24, 2023. This was a limited follow up survey, only 10A NCAC 27G .1901 SCOPE (V314) and 10A NCAC 27G .1902 STAFF (V315) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .1901 SCOPE (V314) and 10A NCAC 27G .1902 STAFF (V315). The complaint was substantiated (intake #NC00199466). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.</p> <p>This facility is licensed for 18 and currently has a census of 11. The survey sample consisted of audits of 3 current clients.</p>	V 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____