

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20040012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/02/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRYNN MARR HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>192 VILLAGE DRIVE JACKSONVILLE, NC 28546</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 and complaint survey was completed on October 2, 2024. One complaint was substantiated (intake #NC 00221865) and one complaint was unsubstantiated (intake #NC 00221863). 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 15. The survey sample consisted of audits of 5 current clients and 1 discharged client.</p>	V 000		

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