

Division of Health Service Regulation

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| 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 C 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER BRYNN MARR HOSPITAL | | STREET ADDRESS, CITY, STATE, ZIP CODE 192 VILLAGE DRIVE JACKSONVILLE, NC 28546 | | |
| (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>A complaint survey was completed on April 23, 2025. The complaint was unsubstantiated (Intake #NC00228801). 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