

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL036-371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/20/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AUBREY'S SAFE HAVEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>837 LYNHAVEN DRIVE</b> <b>GASTONIA, NC 28052</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>A follow up survey was completed on 11/20/2023. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p> <p>The Surveyor was unable to determine if the previously cited deficiencies (V123, V294, and V299) were corrected during this survey due to insufficient time to review for compliance.</p>	V 000		

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