STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-418	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBREY'S SAFE HAVEN LLC 2	115 ROXIE LANE BELMONT, NC 28012

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V 000	INITIAL COMMENTS A complaint survey was completed on April 22, 2025. The complaint was substantiated (intake #NC00228945). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and has a current census of 1. The survey sample consisted of audits of 1 FC #1.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to implement strategies for 1 of 1 Former Client (FC#1). The findings are:

Review on 4/8/25 of Former Client #1's record revealed:
-Admission date of 1/3/25.
-Diagnoses of Posttraumatic Stress Disorder, Oppositional Defiant Disorder and Conduct Disorder.
-16 years old.
-History of suicidal ideation.
-Discharged on 3/31/25.
-Person Centered Plan (PCP) updated on 3/25/25.
-PCP: "3.25.2025 Update: She actively participates in both individual and group therapy and is scheduled to begin family therapy shortly. The therapist will work with the client using dialectical behavior therapy (DBT) techniques to enhance interpersonal effectiveness, build emotional resilience, and address unresolved trauma. The client struggles immensely with self-harm and suicidal ideations."
-"As a last resort, to ensure the safety of [FC #1] & others, CPI interventions (Crisis Prevention Institute) and/or therapeutic holds may be used as a planned restrictive intervention. CPI

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V 112	Continued From page 2	V 112		

therapeutic holds will be utilized whenever he (she) presents an imminent danger to himself (herself) and/or others and less restrictive behavioral interventions have failed or are not appropriate. Please contact the trained First Responder to assist with emergency response and crisis stabilization."

Review on 4/4/25 of a Call for Service Report dated 3/31/25 from the local police revealed:
-FC #1 was threatening self-harm/suicide.
-Mobile Crisis called the local police for assistance.
-Police Officer took FC #1 to the local hospital to be assessed.

Review on 4/3/25 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-On 3/31/25 FC #1 physically assaulted the Executive Director (ED)/Licensee and made suicidal threats.
-"Client was being seen for crisis due to make suicide indention while we waiting for EMS client was aggressive towards and verbal aggressive."

Interview on 4/10/25 with FC #1 revealed:
-"I had been telling them (staff) that I wanted to harm myself for a couple of weeks, but they (staff) didn't listen."
-On 3/31/25 she and Staff #4 got into an argument because Staff #4 told her to, "Shut the f**k up."
-"I tried to talk to [ED/Licensee] about the situation with [Staff #4] but [ED/Licensee] started getting loud and taking her shoes off, and saying the incident was my fault."
-ED/ Licensee said, "If you want to put your hands on my staff, put your hands on me."
-Did not want to fight ED/Licensee.
-Told ED/Licensee she felt like harming herself

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V 112	Continued From page 3	V 112		

after the verbal exchange but was ignored.
-Called her Department of Social Services (DSS) Legal Guardian (LG) and told her DSS LG she felt like self-harming.
-DSS LG called the facility and informed staff (she did not know who) she (FC #1) wanted to harm herself and to take her to the hospital.
-ED/Licensee and Staff #4 said, "No, because there was nothing wrong with me."
-Called her DSS LG again to tell her about her thoughts of self-harming.
-DSS LG called Mobile Crisis to the facility because staff would not take her to the hospital.
-"She (ED/Licensee) was pulling on me because I was trying to leave with Mobile Crisis, so I pushed her."
-The police took her to the hospital.

Interview on 4/7/25 with FC #1's DSS LG revealed:
-On 3/31/25 FC #1 called her and said she (FC #1) wanted to harm herself.
-Called the facility and asked staff (did not know who the staff was) to take FC #1 to the hospital to be assessed.
-FC #1 called her back and said the staff (did not say who) would not take her to the hospital.
-Called back to the facility and requested for them (staff) to take FC #1 to the hospital and the staff (did not know who) said, "[ED/Licensee] said no."
-Called the ED/Licensee and asked her to take FC #1 to the hospital and ED/Licensee said, "No, there is nothing wrong with her (FC #1). She's just saying that (she wanted to harm herself) because she got a talking to earlier."
-ED/Licensee said she would have staff monitor FC #1 closely.
-"I asked her (ED/Licensee) to call Mobile Crisis since she refused to take her (FC #1) to the hospital and she said,"you can call them.""

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V 112	Continued From page 4 -Called Mobile Crisis and had them go out to the facility to assess FC #1. -"The Therapist had assessed [FC #1] for suicide about a week or two ago and she scored high on the assessment. No one informed me." -Learned about the suicide assessment from the Therapist after FC #1 was discharged from the facility. Interview on 4/9/25 with the Therapist revealed: -FC #1 had a suicide assessment on 3/25/25 and 3/27/25. -"The first assessment was standard due to her history of SI (suicidal ideation). The assessment on 3/27/25 was because [FC #1] said she wanted to kill herself." -"At the time of the assessment she did not have a plan. I told [ED/Licensee] to remove all potential weapons from her (FC #1) room and monitor her closely, and if she (FC #1) says she wants to harm herself again to call the hospital and have her IVC'd (involuntary committed)." -"[FC #1] had been suspended from school for fighting, had been threatening staff and had lost visitation with her father all in the same week, and that is when she started expressing feeling suicidal." -The ED/Licensee was notified of FC #1's thoughts of self-harm on 3/27/25. Interview on 4/8/25 with the Associate Professional (AP) revealed: -He had interacted with FC #1 earlier in the day on 3/31/25 and she was upset about family and school. -FC #1 did not tell him she was having suicidal thought. -Was not aware of FC #1's history of suicidal ideation. -The Therapist completed the suicide	V 112		

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V 112	Continued From page 5	V 112		

assessment on 3/27/25 because FC #1 "Vocalized something about wanting to harm herself."

Interview on 4/10/25 with the Qualified Professional (QP) revealed:
-Responsible treatment plans.
-ED/Licensee did intake assessments.
-Was not aware that FC #1 had a history of suicidal ideation.
-"I didn't see anything about her history suicidal ideation on her intake assessment. Did she have a history of suicidal ideation?"
-It was mentioned during one of FC #1 Child Family Team (CFT) meetings (could not remember when) that FC #1 had mentioned wanting to harm herself, and the CFT team decided to monitor FC #1 closely.

Interview on 4/16/25 with the ED/Licensee revealed:
-Had no knowledge of FC #1 had been making suicidal threats before 3/31/25.
-On 3/31/21 FC #1 was upset because she was suspended from school and was court ordered to have no contact with her father.
-The Therapist advised her that FC #1 was making suicidal threats and FC #1 was put on a crisis plan.
-On 3/31/25 FC #1 wanted to speak to her but she was busy assisting another client experiencing a crisis.
-FC #1 was upset that she would not talk to her and called her DSS LG and expressed to her she was feeling suicidal.
-FC #1 never told her (ED/Licensee) she was feeling suicidal but FC #1 would make suicidal threats for attention or when she was not getting her way according to her DSS LG.
-On 3/31/25 FC #1's DSS LG called her and

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V 112	Continued From page 6 asked if FC #1 could be IVC'd due to FC #1 experiencing suicidal ideation. -"I explained to her that [FC #1] was upset over the events that happened that week with [Staff #4], school and her father, and if she wanted [FC #1] to go to the hospital she would take her but she would miss her neurology appointment for her seizures." -"Her (FC #1) social worker (DSS Guardian) said, "What about Mobile Crisis?" I told her that was fine and I asked her to call because I was still trying to assist the other client." -"I never refused to take her to the hospital. I just said if she goes, she will miss her neurology appointment."	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility.	V 132		

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V 132	Continued From page 7 d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of allegations of abuse and neglect. The findings are: Review on 4/8/25 of Former Client (FC) #1's record revealed: -Admission date of 1/3/25. -Diagnoses of Posttraumatic Stress Disorder, Oppositional Defiant Disorder and Conduct Disorder. -16 years old. -History of suicidal ideation. -Discharged on 3/31/25. Review on 4/8/25 of the Executive Director (ED)/Licensee's personnel record revealed: -Date of hire was 8/9/22. -Job title of Executive Director. Review on 4/3/25 of the Local Department of Social Service Report revealed: -Mobile Crisis reported that they witnessed the ED/ Licensee push FC #1. -Mobile Crisis reported that they witnessed the ED/Licensee tell FC #1 to "Get you sh*t and get	V 132		

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V 132	Continued From page 8 out of my house. You're not going to f*cking disrespect me." Review on 4/3/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -On 3/31/25 FC #1 physically assaulted ED/Licensee by pushing her and made suicidal threats. -FC #1 was taken to the hospital and discharged. -No report of the alleged abuse by the ED/Licensee. Interview on 4/10/25 with FC #1 revealed: -"I had been telling them (staff) that I wanted to harm myself for a couple of weeks, but they (staff) didn't listen." -On 3/31/25 she and Staff #4 got into an argument because Staff #4 told her to, "Shut the f**k up." -"I tried to talk to [ED/Licensee] about the situation with [Staff #4] but [ED/Licensee] started getting loud and taking her shoes off, and saying the incident was my fault." -ED/ Licensee said, "If you want to put your hands on my staff, put your hands on me." -Did not want to fight ED/Licensee. -Told ED/Licensee she felt like harming herself after the verbal exchange but was ignored. -Called her Department of Social Services (DSS) Legal Guardian (LG) and told her DSS LG she felt like self-harming. -DSS LG called the facility and informed staff (she did not know who) she (FC #1) wanted to harm herself and to take her to the hospital. -ED/Licensee and Staff #4 said, "No, because there was nothing wrong with me." -Called her DSS LG again to tell her about her thoughts of self-harming. -DSS LG called Mobile Crisis to the facility because staff would not take FC #1 to the	V 132		

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V 132	Continued From page 9	V 132		

hospital.
-Got into an argument with the ED/Licensee when Mobile Crisis arrived.
-Pushed the ED/Licensee twice.
-"[ED/Licensee] said if you want to be disrespectful, you can pack your sh*t and get out."
-"I told her I wasn't packing my things and I wasn't leaving."
-"[ED/Licensee said, get your sh*t out my house!"
-"I told her no, and she [ED/Licensee] said "Well I'll do it for you."
-ED/Licensee packed all of her belongings and set them outside.
-"She (ED/Licensee) was pulling on me because I was trying to leave with Mobile Crisis, so I pushed her."
-The police took her to the local hospital.

Interview on 4/8/25 with the Associate Professional (AP) revealed:
-He was not present on 3/31/25 during the incident involving FC #1 and ED/Licensee.
-The ED/Licensee was responsible for incident reporting and reporting to thr Healthcare Personnel Registry (HCPR).

Interview on 4/10/25 with the Qualified Professional (QP) revealed:
-Did not know if the ED/Licensee was reported to HCPR after the incident with FC #1 on 3/31/25.
-The ED/Licensee was responsible for incident reporting and reporting to HCPR.

Interview on with the ED/Licensee revealed:
-Completed the IRIS report.
-On 3/31/25 FC #1 physically assaulted her by pushing her.
-Did not know she had to report herself to HCPR upon learning about the allegation of abuse.

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V 132	Continued From page 10 -Will have the QP handle all incident reports going forward and when there is an allegation of abuse by any staff they will be suspended pending investigation.	V 132		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set	V 300		

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V 300	Continued From page 11 forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on interview and record review, the facility did not do a proper discharge affecting 1 of 1 former clients (FC#1). The findings are: Review on 4/8/25 of FC #1's record revealed: -Admission date of 1/3/25. -Diagnoses of Posttraumatic Stress Disorder, Oppositional Defiant Disorder and Conduct Disorder. -16 years old. -History of suicidal ideation. -Discharged on 3/31/25. Review on 4/3/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -On 3/31/25 FC #1 physically assaulted ED/Licensee and made suicidal threats. -FC #1 was taken to the hospital and discharged on 3/31/25. -No report of the alleged abuse by the ED/Licensee. Interview on 4/7/25 with FC #1's Department of Social Services (DSS) Legal Guardian (LG) revealed: -On 3/31/25 FC #1 physically assaulted the ED/Licensee by pushing her. -ED/Licensee immediately discharged FC #1. -As of 4/16/25 she had not heard from the ED/Licensee and have not had a service planning meeting.	V 300		

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V 300	Continued From page 12 Interview on 4/16/25 with the ED/Licensee revealed: -On 3/31/25 FC #1 physically assaulted her by pushing her. -Her policy is zero tolerance for assaultive behavior towards staff. -Her policy is assaultive behavior toward staff is grounds for immediate discharge. -Called FC #1's DSS LG and advised her that FC #1 was immediately discharged and as of 4/16/25 she had not had a service planning meeting with FC #1's DSS LG	V 300		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for	V 512		

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	MHL036-418	A. BUILDING: _____ B. WING _____	C 04/22/2025

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AUBREY'S SAFE HAVEN LLC 2	115 ROXIE LANE BELMONT, NC 28012

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V 512	Continued From page 13 dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews 1 of 6 Paraprofessionals abused and neglected 1 of 1 Former Client (FC #1). The findings are: Review on 4/8/25 of FC #1's record revealed: -Admission date of 1/3/25. -Diagnoses of Posttraumatic Stress Disorder, Oppositional Defiant Disorder and Conduct Disorder. -16 years old. -History of suicidal ideation. -Discharged on 3/31/25. -Person Centered Plan (PCP) updated on 3/25/25. -PCP: "3.25.2025 Update: She actively participates in both individual and group therapy and is scheduled to begin family therapy shortly. The therapist will work with the client using dialectical behavior therapy (DBT) techniques to enhance interpersonal effectiveness, build emotional resilience, and address unresolved trauma. The client struggles immensely with self-harm and suicidal ideations." -"As a last resort, to ensure the safety of [FC #1] & others, CPI interventions (Crisis Prevention Institute) and/or therapeutic holds may be used as a planned restrictive intervention. CPI therapeutic holds will be utilized whenever he (she) presents an imminent danger to himself (herself) and/or others and less restrictive behavioral interventions have failed or are not appropriate. Please contact the trained First Responder to assist with emergency response	V 512		

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V 512	Continued From page 14 and crisis stabilization." Review on 4/8/25 of the ED/Licensee's personnel record revealed: -Date of hire was 8/9/22. -Job title of Executive Director. Review on 4/4/25 of a Call for Service Report dated 3/31/25 from the local police revealed: -Mobile Crisis called the local police for assistance. -FC #1 was threatening self-harm/suicide. -FC #1 was involuntarily admitted to the hospital. Interview on 4/10/25 with FC #1 revealed: -"I had been telling them (she could not remember which staff) that I wanted to harm myself for a couple of weeks, but they (staff) didn't listen." -On 3/31/25 she and Staff #4 got into an argument because Staff #4 told her to, "Shut the f**k up." -"I tried to talk to [ED/Licensee] about the situation with [Staff #4] but [ED/Licensee] started getting loud and taking her shoes off, and saying the incident was my fault." -ED/ Licensee said, "If you want to put your hands on my staff, put your hands on me." -Did not want to fight ED/Licensee. -Told ED/Licensee she felt like harming herself after the verbal exchange but was ignored. -Called her Department of Social Services (DSS) Legal Guardian (LG) and told her DSS LG she felt like self-harming. -DSS LG called the facility and informed staff she (FC #1) wanted to harm herself and to take her to the hospital. -ED/Licensee and Staff #4 said, "No, because there was nothing wrong with me." -Called her DSS LG again to tell her about her	V 512		

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V 512	Continued From page 15	V 512		

thoughts of self-harming.
-DSS LG called Mobile Crisis to the facility because staff would not take her to the hospital.
-Got into an argument with the ED/Licensee when Mobile Crisis arrived because ED/Licensee was trying to "Kick her out."
-"[ED/Licensee] said "if you want to be disrespectful, you can pack your s**t and get out.""
-"I told her I wasn't packing my things and I wasn't leaving."
-"[ED/Licensee] said, "get your s**t out my house!""
-"I told her no, and she (ED/Licensee) said "well I'll do it for you.""
-ED/Licensee packed all of her belongings and set them outside.
-"She (ED/Licensee) was pulling on me because I was trying to leave with Mobile Crisis, so I pushed her."
-The police took her to the hospital and had the ED/Licensee get FC #1's belongings off the porch a place them in a safe place.

Interview on 4/7/25 with FC #1's DSS LG revealed:
-On 3/31/25 FC #1 called her and said she wanted to harm herself.
-Called the facility and asked staff (did not know who the staff was) to take FC #1 to the hospital to be assessed.
-FC #1 called her back and said the staff would not take her to the hospital.
-Called back to the facility and requested for them to take FC #1 to the hospital and the staff said, "[ED/Licensee] said "no.""
-Called the ED/Licensee and asked her to take FC #1 to the hospital and ED/Licensee said, "No, there is nothing wrong with her (FC #1). She's just saying that (she wanted to harm herself)

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V 512	Continued From page 16	V 512		

because she got a talking to earlier."
-ED/Licensee said she would have facility staff monitor FC #1 closely.
-"I asked her (ED/Licensee) to call Mobile Crisis since she refused to take her (FC #1) to the hospital and she said,"you can call them.""
-Called Mobile Crisis and had them go out to the facility to assess FC #1.
-A Mobile Crisis Staff called her and told her (DSS LG) she witnessed ED/Licensee "assault" FC #1 by pushing her, and heard ED/Licensee say "get out of my f**king house."
-Mobile Crisis Staff called the police after witnessing the "physical and verbal exchange" between the ED/ Licensee and FC #1.
-Mobile Crisis Staff told her FC #1 belonging's were outside and the police had the ED/Licensee put FC #1's thing back in the facility until she was able to get them.
-ED/Licensee called and informed her that FC #1 was being immediately discharged and could not come back to the facility.
-FC #1 was discharged via email.
-FC #1 had been saying she was depressed because she could not have any contact with her father.
-"The Therapist had assessed [FC #1] for suicide about a week or two ago and she scored high on the assessment. No one informed me."
-Learned about the suicide assessment from FC #1's Therapist after FC #1 was discharged from the facility.

Interview on 4/4/25 with the local Police Officer revealed:
-On 3/31/25 Mobile Crisis called the Police in reference to an assault at the facility.
-When he arrived there was a "verbal exchange" between FC #1 and ED/Licensee.
-"They were yelling and cursing at each other, but

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V 512	Continued From page 17	V 512		

I did not witness an assault."
-The ED/Licensee was trying to kick FC #1 out of the facility.
-Spoke to ED/Licensee and FC #1 about the assault and they both gave different stories.
-There were other people present at the facility but he could not determine who were staff and who were clients.
-ED/Licensee had put all of FC #1's belongings outside.
-"I advised [ED/Licensee] she had to store [FC #1's] belongings inside the house. The social worker (DSS LG) informed me it was neglect to throw the client's things out and relayed that to [ED/Licensee]. She (ED/Licensee) put [FC #1's] belongings in the trunk of a van in the driveway."
-Took FC #1 to the hospital for an assessment.

Attempted to interview Mobile Crisis on 4/4/25, 4/7/25 and 4/11/25 but never received a return call prior to survey exit.

Interview on 4/9/25 with FC #1's Therapist revealed:
-FC #1 had a suicide assessment on 3/25/25 and 3/27/25.
-"The first assessment was standard due to her history of SI (suicidal ideation). The assessment on 3/27/25 was because [FC #1] said she wanted to kill herself."
-"At the time of the assessments she did not have a plan. I told [ED/Licensee] to remove all potential weapons from her (FC #1) room and monitor her closely, and if she (FC #1) says she wants to harm herself again to call the hospital and have her IVC'd (involuntary committed)."
-"[FC #1] had been suspended from school for fighting, had been threatening staff and had lost visitation with her father all in the same week, and that is when she started expressing feeling

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V 512	Continued From page 18	V 512		

suicidal."
-The ED/Licensee was notified of FC #1's thoughts of self-harm on 3/27/25.

Interview on 4/10/25 with Staff #4 revealed:
-A "few" days (did not know the exact date) before FC #1 left (discharged), she was antagonizing other clients during group therapy and she asked FC #1 to be quiet.
-FC #1 got upset.
-FC #1 got up and tried to hit her but another staff (couldn't remember staff's name) stepped in and stopped her.
-On 3/31/25 FC #1 came to her and apologized and asked to talk to her.
-"She said somebody told her she was getting kicked out (of the facility). She was upset and worked up."
-Denied telling FC #1's DSS LG the ED/Licensee said she wasn't taking the FC #1 to the hospital.
-Denied she refused to take FC #1 to the hospital.
-Told FC #1's DSS LG that local police would not take FC #1 to the hospital just because she wanted to go.
-Didn't notice a difference in FC #1's behavior.
-Denied hearing the ED/Licensee curse at FC #1 while Mobile Crisis was present.
-The ED/Licensee placed FC #1's belongings in the trunk of the facility's van "because no one was going to be home (facility) when her social worker (DSS LG) came to pick them (belongings) up."

Interview on 4/8/25 with the Associate Professional (AP) revealed:
-He was not present on 3/31/25 during the incident involving FC #1 and the ED/Licensee.
-Heard from other staff that there was a "yelling back and forth" between FC #1 and the ED/Licensee.

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V 512	Continued From page 19	V 512		

-No knowledge of what was exactly said during the verbal exchange between FC #1 and the ED/Licensee.
-He had interacted with FC #1 earlier in the day on 3/31/25 and she was upset about family and school.
-The Therapist completed the suicide assessment because FC #1 "Vocalized something about wanting to harm herself."

Interview on 4/10/25 with the Qualified Professional (QP) revealed:
-On 3/31/25 she was on the phone with the ED/ Licensee when the incident with FC #1 started.
-"[FC #1] was already upset about school and the situation with her father. She was threatening staff that's why [ED/Licensee] went over to the house (facility)."
-It was mentioned during one of FC #1 Child and Family Team meetings that FC #1 had mentioned wanting to harm herself.
-"She would fake seizures and say that when things weren't going her way."
-FC #1's DSS LG had talked to her about FC #1's mental health.
-Did not witness what happen on 3/31/25, just heard what was happening over the phone.
-Did not remember hearing ED/Licensee curse at FC #1.
-FC #1 was immediately discharged due to pushing the ED/Licensee.
-FC #1's clothes were placed in the trunk of the facility's van for her (FC #1) DSS LG to pick up.

Interview on 4/16/25 with the ED/Licensee revealed:
-Had no knowledge FC #1 had made suicidal threats before 3/31/25.
-On 3/31/25 FC #1 was upset because she was suspended from school and was court ordered to

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V 512	Continued From page 20	V 512		

have no contact with her father.
-FC #1's Therapist advised her on 3/27/25 that FC #1 was making suicidal threats and FC #1 was put on a crisis plan.
-FC #1 wanted to speak to her about the incident between her (FC #1) and Staff #4 but she was busy assisting another client experiencing a crisis on 3/31/25.
-FC #1 was upset that she would not talk to her and called her DSS LG and expressed to her she was feeling suicidal.
-FC #1 did not tell her (ED/Licensee) she was feeling suicidal on 3/31/25 but FC #1 would make suicidal threats for attention or when she was not getting her way.
-FC #1's DSS LG called her and asked if FC #1 could be IVC'd on 3/31/25.
-"I explained to her (DSS LG) that [FC #1] was upset over the events that happened that week (March 24th -28th) with [Staff #4], school and her father, and if she wanted [FC #1] to go to the hospital she would take her but she would miss her neurology appointment for her seizures."
-"Her (FC #1) social worker (DSS LG) said, "What about Mobile Crisis?" I told her that was fine and I asked her to call because I was still trying to assist the other client."
-"I never refused to take her to the hospital. I just said if she goes, she will miss her neurology appointment."
-"When Mobile Crisis got there (facility) she tried to runaway. I was trying to block her so she couldn't leave and she pushed me three times, hard. After that I packed her things and immediately discharged her. That is our policy. No assault on staff will be tolerated."
-FC #1 took some of her belongings with her to the hospital and she put the rest in the trunk of the facility's van.
-"Maybe I did, maybe I didn't say, "Get your s**t

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V 512	Continued From page 21 and get out of my house. You're not going to f*****g disrespect me" because I was upset she (FC #1) pushed me." -Admitted to getting into a verbal exchange with FC #1 and the Police Officer. -Denied pushing FC #1. Review on 4/21/25 of the facility's Plan of Protection dated 4/21/25 and written by the QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? To immediately address the identified violations and ensure the ongoing safety and well-being of all consumers in our care, Aubrey Safe Haven (Licensee) has taken the following actions: 10A NCAC 27D .0324 Protection from Harm, Abuse, Neglect or Exploitation/512/ Administrative Action is to conduct an internal investigation on staff member of the alleged abuse. Immediate removal of implicated staff from direct consumer contact pending internal investigation and reporting to the Health Care Personnel Registry, as required under 131E-256. Continued reassessment of current consumers' risk status and needs through emergency interdisciplinary treatment team (IDT) (CFT) meetings to revise and reinforce each consumer ' s Habilitation or Service Plan (per 10A NCAC 27D .0205). Immediate retraining and reinforcement of abuse/neglect prevention policies with all staff, with signed acknowledgement of updated protocols. Describe your plans to make sure the above happens.	V 512		

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V 512	Continued From page 22 To ensure the success and sustainability of these safety measures, Aubrey Safe Haven will implement the following plan: -Aubrey 's Safe Haven LLC (Licensee) fax over the 24-hour initial report of the alleged abuse, Interview staff who may have seen the interaction. Corrective measure to address the issue at hand, Monitoring and outgoing compliance and Associate Professional will make sure there's mandatory staff re-training within 72 hours, led by the Quality Assurance and Compliance Officer, focusing on: Protection from harm, abuse, neglect, or exploitation (10A NCAC 27D .0324) -Proper assessment, documentation, and execution of habilitation/service plans (10A NCAC 27D .0205) -Discharge and transfer protocols (10A NCAC 27G .1708) Document and audit all training sessions and safety practices weekly for the next 90 days, with findings reported to the Executive Director and Board of Oversight. Notify and coordinate with guardians, DSS, and external case managers to provide transparency, update on protective measures, and maintain trust and collaboration regarding consumer care was done on 3/31/2025 -Evaluate discharge or transfer of any consumer whose safety needs cannot be met under current circumstances, with full documentation instead of having only verbal communication and consent and a plan aligning with V300 and 10A NCAC 27G .1708. -All documentation will be maintained in accordance with HIPAA (Health Insurance Portability and Accountability Act) and state	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 512	Continued From page 23	V 512		

regulatory standards, and a full internal review will be completed within 30 days to ensure the facility's compliance and readiness for future audits.

Review on 4/22/25 of amended Plan of Protection dated 4/22/25 revealed:
-"Continued reassessment of current consumers' risk status and needs through emergency interdisciplinary treatment team (IDT) (CFT) meetings to revise and reinforce each consumer 's Habilitation or Service Plan (per 10A NCAC 27D .0205).

Immediate retraining and reinforcement of abuse/neglect prevention policies with all staff, with signed acknowledgement of updated protocols.

-To ensure the success and sustainability of these safety measures, Aubrey Safe Haven (Licensee) will implement the following plan on 4/21/2025.

-Aubrey's Safe Haven LLC Qualified Professional will fax over the 24-hour initial report of the alleged abuse, Qualified professional Interviewed the staff who may have seen the interaction on 4/9/2025 and 4/18/2025.

-Corrective measure to address the issue at hand, Monitoring and outgoing compliance and Associate will be monitored by Associate Professional. There is mandatory staff re-training within 72 hours, led by the Quality Assurance and Compliance Officer, focusing on: Protection from harm, abuse, neglect, or exploitation (10A NCAC 27D .0324) The entire staff was retrained on 3/22/2025. Only the executive director (ED/Licensee) will retrain within the next 72 hours due to the allegations on 4/22/2025. There will be

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V 512	Continued From page 24	V 512		

a staff meeting on Thursday April 24, 2025, to make sure that all staff understand there should be no profanity towards client or around clients. This will address verbal abuse allegation and the protection from harm.

-Proper assessment, documentation, and execution of habilitation/service plans (10A NCAC 27D .0205)

-Discharge and transfer protocols (10A NCAC 27G .1708) Document and audit all training sessions and safety practices weekly for the next 90 days, with findings reported to the Executive Director and Board of Oversight. Notify and coordinate with guardians, DSS, and external case managers to provide transparency, update on protective measures, and maintain trust and collaboration regarding consumer care was done on 3/31/2025. Care team was notified about the discharge the time of the incident on 3/31/2025.

-For any future cases where a client indicates suicidal ideation (either verbally or through actions), Aubrey's Safe Haven (Licensee)will utilize Mobile Crisis as an initial point of contact to conduct an assessment with the client. This new plan will go into effect 4/22/25 and will cover any interaction the client may have with staff, peers, or their care team. In the event that a client expresses suicidal ideation Mobile Crisis will be engaged to assist with transportation for the client to the hospital by contacting first responders. This will ensure the proper steps are taken by Aubrey's Safe Haven (Licensee) on behalf of the client to ensure client safety."

Former Client #1 was a16 year old client with diagnoses of Oppositional Defiant Disorder, Conduct Disorder, Suicidal Ideation and

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	MHL036-418	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBREY'S SAFE HAVEN LLC 2	115 ROXIE LANE BELMONT, NC 28012

(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 512	Continued From page 25 Post-Traumatic Stress Disorder. On 3/31/25 FC #1, who has a history of suicidal ideation, expressed to her Therapist and her DSS LG that she felt like harming herself and wanted to kill herself. FC #1 requested to be taken to the local hospital. The ED/Licensee refused to take FC #1 to the hospital or call Mobile Crisis. FC #1's DSS LG called Mobile Crisis. Mobile Crisis showed up at the facility and witnessed a verbal altercation between the ED/Licensee and FC #1. The ED/Licensee demanded FC #1 leave the facility. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		