STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
			71. 501251110		
		MHL036-371	B. WING		C 08/08/2025
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	= ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			E, ZIF GODE	
AUBREY'	S SAFE HAVEN		HAVEN DRIVE IIA, NC 28052		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	d (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on 8-8-25. The compl (Intake #NC00232455 This facility is licensed	w up survey was completed aint was substantiated 5). Deficiencies were cited. d for the following service 27G .1700 Residential re For Children Or			
	•	d for 4 and has a current vey sample consisted of nt.			
V 105	27G .0201 (A) (1-7) G	Soverning Body Policies	V 105		
	10A NCAC 27G .0201 POLICIES (a) The governing bod facility or service shal written policies for the (1) delegation of man operation of the facilit (2) criteria for admissi (3) criteria for dischard (4) admission assessi (A) who will perform to (B) time frames for co (5) client record mana (A) persons authorize (B) transporting record (C) safeguard of record defacement or use by (D) assurance of record authorized users at al (E) assurance of conf (6) screenings, which (A) an assessment of problem or need;	dy responsible for each I develop and implement e following: agement authority for the y and services; ion; ge; ments, including: he assessment; and impleting assessment. agement, including: d to document; ds; rds against loss, tampering, r unauthorized persons; ord accessibility to I times; and identiality of records.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BLILLDING:		COMPLET	ΓED
			A. BUILDING:			
					l c	
		MIII 000 074	B. WING			(000 =
		MHL036-371	D: 11110		08/08	/2025
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADD	RESS, CITY, STA	TE ZIR CODE		
NAME OF FI	ROVIDER OR SUFFLIER	STREET ADE	ME33, CITT, 31A	ile, zir code		
AUBREY'S SAFE HAVEN			VEN DRIVE			
AUDRET	S SAFE HAVEN	GASTONIA	, NC 28052			
			1			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NAIE	DAIL
				DEI IGIENGI)		
V 10E	0		V 105			
V 105	Continued From page	? 1	V 105			
	oon provide convices t	to address the individual's				
		to address the individual's				
	needs; and					
	(C) the disposition, in	cluding referrals and				
	recommendations;					
		and quality improvement				
		and quality improvement				
	activities, including:					
	(A) composition and a	• •				
	assurance and quality	/ improvement committee;				
	(B) written quality ass	urance and quality				
	improvement plan;	, ,				
		toring and avaluating the				
		toring and evaluating the				
	quality and appropriat					
	including delineation of	of client outcomes and				
	utilization of services;					
	•	nical supervision, including				
	-	aff who are not qualified				
	·	vide direct client services				
	shall be supervised by	y a qualified professional in				
	that area of service;					
	(E) strategies for impr	oving client care:				
		_				
	(F) review of staff qua					
	determination made to					
	treatment/habilitation	privileges:				
	(G) review of all fatalit	ties of active clients who				
	` '	area-operated or contracted				
	residential programs					
	· ,	ards that assure operational				
	and programmatic pe					
	applicable standards	of practice. For this				
	purpose, "applicable s	•				
		petence established with				
		•				
	reference to the preva					
	methods, and the deg	ree of knowledge, skill and				
	care exercised by oth	er practitioners in the field;				
		•				

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 2 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.2.7.2.1.10.7.00.1.1.1			A. BUILDING: _			
		MHL036-371	B. WING		08/0)8/2025
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
AUBREY'S SAFE	HAVEN		AVEN DRIVE			
			A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 105 Contin	ued From page	e 2	V 105			
Based facility delega operation oper	on record revi- failed to imple- tion of manag- ion of services of on 8-6-25 of faures revealed: EGATION OF MORITY: The Lifers shall design or (ED) for the man, who will sensible for the man, who will sensible for the man" current operator [ED], Executive event that the fable, the Chiesional will assutive Director as a sibilities which of the design of the community of the	MANAGEMENT LC (limited liability company) nate in writing an Executive Aubrey 's Safe Haven LLC rve as the operator and be anagement of this or of Aubrey 's Safe Haven re Director" Executive Director is of Executive Officer, Qualified ume the role as the of well as all job duties and of includes but not limited 7-11-25 of the facility's of no one was at the facility. Of the Licensee/ED at of the She was out of the of the She was available. and 8-6-25 with the				

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 3 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
AUDDEV	CAFE HAVEN	837 LYNH	AVEN DRIVE		
AUBRET	S SAFE HAVEN	GASTONIA	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 105	Continued From page	e 3	V 105		
	professional (QP) is r (QP) in the hospital, semergency. The Ass with me out of the cor-"The staff took the cleven know where the local town 2 hours aw get someone (direct semeet you there (facility access to the recordstare locked up at my hon't have access to -"I don't keep client resoft confidentiality. The numbers in the record and doing something (records) locked up a -Staff does not have a access client records	not available either. She's she had a medical ociate Professional (AP) is untry." ients on an outing. I don't by are. I think they went to [a way] to the water park. I can support professional/DSP) to ty) but they don't have so you need. Those records house. The staff (DSPs) those records." ecords at the facility because by have social security ds and I'm not going to take the getting that information with it so I keep those			
V 112	PLAN (c) The plan shall be assessment, and in p legally responsible per of admission for clien receive services beyond) The plan shall income.	developed based on the sartnership with the client or erson or both, within 30 days ts who are expected to and 30 days. clude:) that are anticipated to be an of the service and a	V 112		

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 4 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	SI SOMMESTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COWIFLE	120
		MHL036-371	B. WING		08/08	3/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'	S SAFE HAVEN		VEN DRIVE			
		GASTONIA	, NC 28052	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 112	(3) staff responsible (4) a schedule for re annually in consultati responsible person o (5) basis for evaluat outcome achievemen (6) written consent or responsible party, or provider stating why s obtained.	; eview of the plan at least on with the client or legally r both; ion or assessment of nt; and or agreement by the client or a written statement by the such consent could not be	V 112			
	facility failed to develorstrategies to meet the former client (FC #4). Review on 7-15-25 of -Date of admission: 4 -Date of discharge: 7 -Age: 15 yea.rs -Diagnoses: Post-Tra Attention Deficit Hype Oppositional Defiant Disorder with Mood a -Person Centered Plaupdated on 6-2-25 ar following: -4-30-25: "During the client went AWOL (abs	ews and interviews, the op and implement goals and e needs of 1 of 1 clients, The findings are: If FC #4's record revealed: 1-1-25. 1-8-25. Inumatic Stress Disorder; Interactive Disorder; Indicate Conduct. In				

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 5 of 81

DIVISION	i Health Service Negu	ialion			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			Ι -		1	
					C	;
		MHL036-371	B. WING		08/0	8/2025
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIDDEVI	CAFE HAVEN	837 LYNHA	VEN DRIVE			
AUDRET	S SAFE HAVEN	GASTONIA	, NC 28052			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 112	Continued From page	e 5	V 112			
	under the influence w	non roturn (facility) "				
	under the influence up					
		as gone AWOL a total of				
		nission, including a recent				
		de. During that incident, she				
	refused to take accou	intability and tends to elope				
	when frustrated"					
	-7-2-25: "The client is	currently struggling with				
		engagement and behavioral				
		avior (AWOL) continues to				
	be a primary concern					
	overstimulating enviro					
	•	or strategies to address FC				
	#4's AWOL behavior.					
	Interview on 7-15-25	and 8-7-25 with the				
	Licensed Professiona	ıl (LP) revealed:				
	-The LP is responsible	e for completing and				
	updating the PCP's.					
	. •	the PCP updates come from				
		Team (CFT) meetings. So				
	-	Todam (Of T) meetings. Go				
		et updates and that's what				
		area (on the PCP). The				
	update is the informat	·				
	-	her team members share				
	during the meeting."					
	-"Any issues the prov	ider reports that need a				
	-	t into a goal, that's the				
	provider's responsibili	•				
		-				
	Interview on 7-15-25	and 8-6-25 with the				
	Licensee/ED revealed					
	-The LP completes th					
		(4-9-25) we immediately				
		or FC #4). I thought it was in				
		e (LP) had added it to the				
	PCP. I know we disc	ussed it (AWOL) in the CFT				
	meeting (4-30-25)."	•				
	J (/-					

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 6 of 81

Division C	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		MHL036-371	B. WING		08/08/2025
NAME ∩E PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
NAME OF T	TOVIDER OR OUT FIER			(IL, ZII GOBL	
AUBREY'S SAFE HAVEN			HAVEN DRIVE		
		GASTO	IIA, NC 28052		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
				DEI IGIENCI)	
V 113	Continued From page	e 6	V 113		
V 113	27G .0206 Client Red	cords	V 113		
	10A NCAC 27G .0206	6 CLIENT RECORDS			
	(a) A client record sha	all be maintained for each			
	individual admitted to	the facility, which shall			
	contain, but need not	be limited to:			
	(1) an identification fa	ice sheet which includes:			
	(A) name (last, first, n				
	(B) client record number	,,,			
	(C) date of birth;	551,			
	(D) race, gender and	marital etatus:			
	(E) admission date;	mantai status,			
	• •				
	(F) discharge date;	mantal illuses			
	(2) documentation of				
	•	lities or substance abuse			
	diagnosis coded acco	•			
	(3) documentation of	the screening and			
	assessment;				
	(4) treatment/habilitat				
	(5) emergency inform	ation for each client which			
	shall include the name	e, address and telephone			
	number of the person	to be contacted in case of			
	sudden illness or acci	ident and the name, address			
	and telephone number	er of the client's preferred			
	physician;	·			
	(6) a signed statemen	nt from the client or legally			
		ranting permission to seek			
		a hospital or physician;			
	(7) documentation of				
		progress toward outcomes;			
	(9) if applicable:	progress to maid outcomics,			
	(A) documentation of	nhysical disorders			
		o International Classification			
	of Diseases (ICD-9-C				
	•	•			
	(B) medication orders				
	(C) orders and copies				
	(D) documentation of				
		and adverse drug reactions.			
	(b) Each facility shall	ensure that information			

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 7 of 81

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL036-371	B. WING		08	C 3 /08/2025
NAME OF D	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE	ZIR CODE		
NAME OF PI	ROVIDER OR SUPPLIER		HAVEN DRIVE	, ZIP CODE		
AUBREY'S	S SAFE HAVEN		NIA, NC 28052			
(X4) ID		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO 1	THE APPROPRIATE	DATE
V 113	Continued From pag	e 7	V 113			
	only in accordance w	lated conditions is disclosed vith the communicable cified in G.S. 130A-143.				
	facility failed to maint	as evidenced by: lews and interviews, the tained a complete record for g 1 of 1 clients (FC #4). The				
	-Date of admission: 4 -Date of discharge: 7 -Age: 15. -Diagnoses: Post-Tra Attention Deficit Hype	r-8-25. aumatic Stress Disorder; eractive Disorder; Disorder; Adjustment				
	from April 1,2025 to Goal #1: "Purpose of Goal: Timeline: [FC #4] will staff weekly to review objectives and discussface in maintaining or responsibilities. Intervention/Activity: 30 minute increments consumers to ensure consumer. Effectiveness/Respo	e safety of facility and				

Division of Health Service Regulation

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Division	of Health Service Regu	lation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
AUBREY'	S SAFE HAVEN		IAVEN DRIVE		
		GASTON	IA, NC 28052		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(710)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIE
				22.10.2.10.1	
V 113	Continued From page	e 8	V 113		
		1 (4 12			
	concerns for safety th				
		in her bed throughout the			
	night."				
		Contact: Participate in Level			
	III program and decre	<u> </u>			
		II meet with her group home			
	-	her progress on these			
		s any challenges she may			
	_	ompliance with the rules and			
	responsibilities.				
		Staff provided regular verbal			
		#4] improve her compliance			
		s. Staff provided ongoing			
	monitoring and suppo	ort to ensure [FC #4] felt safe			
	and encouraged Scot	ut to ask for help when			
	needed. Staff facilitat	ted her ability to follow			
	directions effectively a	and adhere to the			
	executions. Staff iden	ntified positive and negative			
	attributes for consum	er meeting daily goal.			
	Effectiveness/Respor	nse: The consumer did well			
	with interventions. The	ne consumer followed all			
	facility rules and inter	acted with peers positively			
	throughout the shift.	The consumer made			
	positive strides. Cons	sumer interacted with peers			
	positively throughout	shift. Consumer made			
	positive strides through	ghout the shift. [FC #4] will			
	maintained her perso	nal hygiene, copying skill,			
	aggressive behavior t	toward staff and peers,			
	verbal aggression and	d completed her daily			
	grooming. The consu	umer did not have any verbal			
	outburst."	-			
	Each note was typed	and contained the same			
		neline, Intervention and			
		h day from April 1, 2025 to			
	July 8, 2025.	, , , , ,			
	Interview on 8-7-25 w	vith the Licensed			
	Professional (LP) rev	ealed:			
	-She does not review				
		eviews progress notes). I			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		MHL036-371	B. WING		08/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
ALIDDEV	S SAFE HAVEN	837 LYNI	HAVEN DRIVE			
AUBRET	SAFE HAVEN	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 113	Continued From page	9	V 113			
	don't work for Aubrey	's Safe Haven, I contract herapist. Progress notes ential side. I don't do				
	Interview on 8-7-25 with the Licensee/Executive Director (ED) revealed: -When the client is admitted into the facility the Licensee/ED types the progress notes and prints the copies for staff on each shift to document daily notes"There is a 'note' section at the bottom of the					
		ent what happens during the				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	10A NCAC 27G .0209 REQUIREMENTS					
	only be administered	n-prescription drugs shall to a client on the written				
	drugs.	norized by law to prescribe				
	` '	be self-administered by norized in writing by the				
	(3) Medications, inclu administered only by unlicensed persons tr	ding injections, shall be licensed persons, or by ained by a registered nurse,				
	privileged to prepare (4) A Medication Adm	egally qualified person and and administer medications. inistration Record (MAR) of				
	current. Medications	after administration. The				
	(A) client's name;	nd quantity of the drug;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2)			
		MHL036-371	B. WING		0.6	C 3/ 08/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 00	700/2020
			HAVEN DRIVE	., 2.11 0002		
AUBREY'	S SAFE HAVEN		IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	(C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor		V 118			
	facility failed to ensur current affecting 1 of findings are: Review on 7-15-25 of -Date of admission: 4 -Date of discharge: 7- -Age: 15Diagnoses: Post-Tra Attention Deficit Hype Oppositional Defiant I Disorder with Mood at Review on 7-22-25 of 2025 to July 8,2025 r medications were do administered from Ap -Vyvanse (ADHD) 40 -Vitamin D3 (supplem -Vitamin Iron (iron sup	ews and interviews the e the MARs were kept 1 clients (FC #4). The FC #4's record revealed: -1-258-25. umatic Stress Disorder; eractive Disorder (ADHD); Disorder; Adjustment nd Conduct. FC #4's MARs for April 1, evealed the following cumented as being ril 1, 2025 to April 30, 2025.: milligrams (mg). nent) 5,000 units. pplement) Tablets.				
	10mgOmeprazole (acid re	nt) HCL (hydrochloride) flux) 20mg.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-371	B. WING	B. WING		; 8/2025	
NAME OF D					1 06/0	0/2025	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA HAVEN DRIVE	TE, ZIP CODE			
AUBREY'S	S SAFE HAVEN		IIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	-Vyvanse (ADHD) 20i -Olanzapine (mood) 1 -Pataday (allergy relie -Advair (asthma) HFA grams (gm)Fluticasone (allergies -Suckeess (nail biting -The following medica being administered fro 2025: -Vyvanse 50 mgVitamin D3 5,000 uni -Vitamin Iron TabletsCetirizine HCL 10mg -Omeprazole 20mgVyvanse 20mgVyvanse 20mgOlanzapine 10mgPataday 2,500 mlAdvair HFA 12 gm.	mg. 0mg. ef) 2,500 milliliters (ml). (hydrofluoroalkane) 12 s) 50 micrograms (mcg)) 4% ations were documented as om May 1, 2025 to July 7,	V 118				
	Licensed (LP) docum -4-30-25 update: "The medications on occase Interview on 7-16-25 update: "Yeah, I've refused medications on occase Interview on 7-16-25 update: "Yeah, I've refused medications of the like taking them, a wasn't taking them, a update in the like	n revealed completed by the ented the following: e client (FC #4) has refused sions due to anger." with FC #4 revealed: ny meds (medications) (refused meds). I just didn't and I told them (staff) I nd I didn't." I didn't take none of them					

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-Denied FC #4 ever refused medications.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		MHL036-371	B. WING		C 08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'	S SAFE HAVEN		VEN DRIVE , NC 28052			
			1, 140 20032			—
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
V 118	Continued From page	e 12	V 118			
	believe she has refuse -If clients refuse them to take their me to refuse medications MAR that the client re Licensee /ED of the rincident report docum Interview on 7-15-25 revealed: -She would get updat behavior (medication the facility for therapy monthly Child and Fa-"Her medication refudiscussed during the -"The facility staff, we refusing medications. Interview on 7-15-25 revealed: -"The clients always to don't have refusals. They (clients) can't regrounds for immediat take their medicine. Protocol) to them whe have to take your me We have that in our attime [FC #4] refused incident happened (7 (7-7-25) she was refu	ded her meds with me, but I seed with other staff." e medications, staff try to get dications. If clients continue is, staff will document on the efused and inform the efused and inform the efused and inform the efused. and 8-7-25 with the LP des regarding FC #4's refusals) when she visited is sessions as well as during smilly Team meetings (CFT). It is also would have been CFTs." ould inform her of FC #4 with the Licensee/ED dake they meds. We (facility) That is a part of our program. It is a part of our program				

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DIVISION	n Health Service Regu	ialion					
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					_ ا	,	
		MUU 000 074	B. WING		00/0		
		MHL036-371	5:		08/0	8/2025	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		837 LYN	HAVEN DRIVE				
AUBREY'S	S SAFE HAVEN		IIA, NC 28052				
	OLIMANA DV OT		<u> </u>	DROUGERIO DI ANI OF CORRECTIO	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE	
				DEFICIENCY)			
V 132	Continued From page	. 12	V 132				
V 132	Continued From page	9 13	V 132				
V 132	G.S. 131E-256(G) HC	CPR-Notification,	V 132				
	Allegations, & Protect	tion					
	G.S. §131E-256 HEA	LTH CARE PERSONNEL					
	REGISTRY						
	(g) Health care facilities	es shall ensure that the					
	Department is notified	d of all allegations against					
	health care personne	I, including injuries of					
	unknown source, which	ch appear to be related to					
	any act listed in subdi	ivision (a)(1) of this section.					
	(which includes:						
	a. Neglect or abuse	of a resident in a healthcare					
		whom home care services					
		31E-136 or hospice services					
		31E-201 are being provided.					
	-	of the property of a resident					
		y, as defined in subsection					
		uding places where home					
		ned by G.S. 131E-136 or					
		lefined by G.S. 131E-201					
	are being provided.						
	c. Misappropriation	of the property of a					
	healthcare facility.	or the property or a					
	-	s belonging to a health care					
	facility or to a patient						
	,	ealth care facility or against					
	_	whom the employee is					
	providing services).	e are employee to					
		evidence that all alleged					
		and must make every effort					
	to protect residents fro						
		gress. The results of all					
	investigations must be	•					
	•	e reported to the e working days of the initial					
	notification to the Dep						
	nouncation to the Dep	oarunent.					
	This Rule is not met	as evidenced by:					
		ews and interviews, the					
		e that the Health Care					
	racinty range to ensure	c that the Health Cale	1			i	

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Personnel Registry (HCPR) was notified of all

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILBING.		
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
AUBREY'	S SAFE HAVEN	837 LYNH	AVEN DRIVE		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5 67 ti 2 117 ti 211	GASTONI	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETE
V 132	Continued From page	2 14	V 132		
	to provide evidence th	d to report within 5 working e investigation to the			
	#1 verbally abusing F FC #4 and for staff #1	the facility's records HCPR notification for staff C #4 on 7-8-25 by cursing at physically abusing FC #4 er head and shoulders.			
	Carolina Incident Res (IRIS) revealed no do of a report for staff #1 7-8-25 by cursing at F	nd 7-15-25 of the North sponse Improvement System cumentation of submission verbally abusing FC #4 on FC #4 and for staff #1 C #4 by hitting FC #4 on her			
	not allow her to talk to -FC #4 refused to tak and complete her ass evening. -Staff #2 called the Li	s upset because her Services guardian would b her biological sister. e her evening medications signed chores for the censee/ED to return to the			
	medications and com-FC #4 went to her ro began listening to her When the Licensee/E informed FC #4 that s medications and com refused, and the Lice could not refuse to tal-"She (Licensee/ED)	om, closed the door and electronic music device. D returned to the facility she she had to take her plete her chores. FC #4 nsee/ED told FC #4 she			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION	
		A. BUILDING: _		
	MHL036-371	B. WING		C 08/08/2025
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
AUDDEVIO GAEE HAVEN	837 LYN	HAVEN DRIVE		
AUBREY'S SAFE HAVEN	GASTON	IIA, NC 28052		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
V 132 Continued From page	15	V 132		
I had rights. That's whany rights." -"Then she (Licensee/E the meds (medications bed and give you (admarthe Licensee/ED grata arm/wrist and pulled he #4's bedroom and dow area to take her medications." She (Licensee/ED) sayour meds,' and she pure and the factor of the Licensee/ED lead where FC #4 sat in one of the Licensee/ED asked take the meds?' "I said the factor of the Licensee/ED) where factor of the factor of the licensee/ED) where factor of the licensee/ED where factor of the licensee/ED called have the grandmother her medicine and compare factor of the licensee/ED called have the grandmother here factor of the licensee/ED called have the grandmother and the licensee/ED in the licensee/ED called have the grandmother and the licensee/ED in the grandmother and the grandmother	en she said I didn't have ED) said 'either you take c) or I will drag you out of chinister) the meds." Dibed FC #4 by her er out of her bed, out of FC orn the hallway to the dining ations. aid, 'yes you are taking culled me out of my room." FC #4 to the dining room are of the dining room chairs. Id FC #4, 'are you gonna at no, I'm not, I'm not taking as like, 'either I can take it conna put it in your mouth and to the chair trying to falling, we fell to the ground as, she literally sat on me and to take my meds." as like, 'if you don't take being to the hospital.' She mese meds you are going arefuse." and FC #4's grandmother to talk to FC #4 into taking beleting her chores but FC at was cursing and being andmother. C #4's conversation with old her to 'stop being at grandmother). At which astaff #1, 'leave me alone,	V 102		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-371	B. WING		08/0	; 8/2025
	ROVIDER OR SUPPLIER	837 LYNHA	RESS, CITY, STA VEN DRIVE , NC 28052	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	(going to) stab you." -The Licensee/ED graand hung up on the g -The Licensee/ED wa her arms under FC #4 FC #4 from hitting sta with the Licensee/ED Licensee/ED fell back time the Licensee/ED FC #4's legs to preve and staff #1. -Staff #1 replied to FC staff #1 and FC #4 en forth. "Then she's (st stab? I said, You. Sh you need to stay in a disrespectful." -"I told her I was gonr whatever and that's was me go (released the reform - FC #4 left the living her bedroom. -"I went to my room. I door shut. I was looking device] and [Licenseed was asking me what I in (the room), she rand came in the room, agasying, 'you said you Well, whoop my a*s the fighting." -" we were fighting, then she hit me. It was restraint." -FC #4 was hit in the not know how many the state of the s	abbed the phone from FC #4 randmother. s behind FC #4 and looped d's arms to attempt to keep ff #1. As FC #4 struggled s she (FC #4) and the c onto the couch. At which wrapped her legs around int FC #4 from kicking her C #4's threat to stab her and agaged in a verbal back and aff #1) like, 'who you gonna he was like, you just a child, child's place, you being ablow up the place or when she (licensee/ED) let estraint)" room area and retreated to was in my room, I had my ing for my [electronic music e/ED] opened the door and was doing. [Staff #1] came around [Licensee/ED] and gressive like and she was was gonna whoop my a*s? hen.' Then we started It was a fight. I hit her first,	V 132			

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DIVISION	of Health Service Regu	lation				
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING	P WINC)
		MHL036-371	B. WING		08/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			IAVEN DRIVE	,,		
AUBREY'	S SAFE HAVEN					
		GASTON	IA, NC 28052			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG	1,2002,110111 0111		IAG	DEFICIENCY)		
V 132	Continued From page	e 17	V 132			
	Interview on 7 19 25	with client #1 revealed:				
		as in her room listening to				
	her music. She was i	•				
		er chores because she was				
		able to talk to her sister.				
	· -	_icensee/ED] had [FC #4's]				
	hand, like she was ho					
		front (walking in front of FC				
	#4) and [FC #4] was v					
	,	e Licensee/ED went to the				
		#4] did some chores but she				
		en [Licensee/ED] tried to put				
		they fell on the floor and				
	[Licensee/ED] sat on					
	, ,	nave her full weight on her				
	, ,	like she was straddling her.				
		E [Licensee/ED's] legs were				
	straddling [FC #4's] w					
		o call her grandmother but				
	FC #4 was still upset	•				
		g) at her grandmother.				
		ng to her grandma, [Staff #1]				
		old her to stop cussing and				
		her grandma and [FC #4]				
	, ,	staff #1 and FC #4) started				
	_	ut. [FC #4] told [staff #1] to				
		#4] called [staff #1] a b***h,				
	[staff #1] called [FC #					
		m at that point and went to				
		she exited the shower the				
		he hallway in front of FC				
	#4's door talking to F					
		and ran in the room. She				
		ng her (FC #4), telling her				
	, , ,	and beat her a*s like she				
	said she was going to					
		egan to fight. "They were				
	hitting each other."					
		aff #1's hair and hitting her				
	in her head and face	and staff #1 was hitting FC				

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
						С
		MHL036-371	B. WING		08	/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		837 LYNF	IAVEN DRIVE			
AUBREY	S SAFE HAVEN	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 132	Continued From page	<u> </u>	V 132			
V 132	Staff "2 told [staff #1] (FC #4)."' Interview on 7-18-25 -7-8-25, "[FC #4] didr [Licensee/ED] was ta she had to take her m She (FC #4) was cus Another staff (staff #1 talking smack (arguin	nest. nsee/ED] got them apart. 'you shouldn't have hit her with client #2 revealed:	V 132			
	you and [staff #1] was #4] said, I'll drown yo [staff #1] was, like 'we -"[FC #4] didn't want go to her room, she d [staff #1]. [Licensee/E -"[Staff #1] went in he [FC #4] was holding [s like b***h, I'll stab you. [FC ur son, I'll drown you and ell do it then." to fight. She (FC #4) tried to lidn't want to fight. It was ED] was handling it." er room and was hitting her. (staff #1's] head and hitting is hitting [FC #4] in her head				
	-On 7-8-25, FC #4 refor the night and instered or and turned of staff #2 asked her (Fand FC #4 responded thing." -Staff #2 call the Lice when she arrived she grandmother. FC #4 disrespectful to her grandmother). She with me I'll stab you."" -Staff #1 denied she of	with staff #1 revealed: fused to complete her chore ead went to her room, shut on her music "real loud." FC #4) to finish her chores d "I'm not doing any f*****g nsee/ED for assistance and e allowed FC #4 to call her was cursing and being randmother and staff #1 eal disrespectful (cursing at as like 'b***h, if you touch cursed at FC #4. "No, I as trying to process with her				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MIII 026 274	B. WING		C
		MHL036-371	3		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
AUBREY'S	S SAFE HAVEN		IAVEN DRIVE		
		GASTON	IA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 132			V 132		
	to get her to calm do				
	#4's arms to restrict h	oped her hands through FC			
	**	d FC #4 from the hold after			
		'blow up" the group home.			
		er room and staff #1 and the			
		d she was going to retrieve a			
	weapon so they follow	wed FC #4 to her room.			
		gging (looking) in her book			
		something out of the blue			
	_	I tried to grab it and that's			
	_	into an altercation (FC #4)			
	her head and face)."	ir and began hitting her in			
		ig FC #4. "she still had a			
		was hitting me in the head			
	_	e on my hands and stuff."			
		with staff #2 revealed:			
		n't want to do her chores.			
	music playing."	and shut the door with the			
	-Staff #2 called the Li				
		ed to the facility to assist th doing chores and taking			
	her medications.	in doing chores and taking			
		d her (FC #4) she had to			
		. "She (FC #4) was just like			
		nedicine.' She's blessing			
	(cursing) everybody	S S			
	,	using medicine, walking off			
	and she is just being				
		II FC #4's grandmother to			
		ould talk FC #4 into taking			
	-	C #4] was cussing them out,			
	yelling, kicking, being				
	cussing each other of	ng with staff #1. "They were			
	_	stab staff #1 then walked to			
		was like, 'if you gonna stab			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
A. BUILDING.	
MHL036-371 B. WING	08/08/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AUBREY'S SAFE HAVEN 837 LYNHAVEN DRIVE	
GASTONIA, NC 28052	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
we like you just said go get whatever (weapon) you need to." -"[FC #4] ended up walking into the room (her bedroom), I guess to grab a potential weapon or whatever. [Licensee/ED] ended up following behind her to see is she had a weapon or what she was getting out of her book bag." -Staff #1 went to FC #4's bedroom and witnessed staff #1 and FC #4 fighting. "[FC #4] was hitting [staff #1] and [staff #1] was hitting [FC #4]. I don't know who hit who first. I mean they were fighting each other." -The Licensee/ED and staff #2 pulled FC #4 and staff #1 apart but staff #1 and FC #4 continued to verbally argue with each other. "[Staff #1 was saying to [FC #4]you are a child, you're a chap (child), you need to learn how to stay in a chap's place." -"Ok, now I'm telling [staff #1], be quiet, just be quiet. She is still arguing back and forth with [FC #4]. It was inappropriate" Interview on 7-15-25 with the Licensee/ED revealed: -The Licensee/ED had been at the facility earlier on 7-8-25 and processed with FC #4 because FC #4 was upset over not being able to speak with her sister. "I made it, I think 5 minutes from the group home. I get a call (staff #2), 'she's on one (having a behavior)."' -FC #4 refused to complete her chores and take her medications"I get back, go to her room and she is in her room lying on her bed. She has a little [electronic music device]. I just grab the [electronic music device] and say, 'what's the problem?" "She (FC #4) says, 'I don't want to be bothered [Licensee/ED]." -"I said, well come on you got to do your chores	

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NAME OF PROVIDER OR SUPPLIER A. BUILDING: B. WING O8/08/2029 STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052	AND PLAN OF CORRECTION
MHL036-371 B. WING	
AUBREY'S SAFE HAVEN 837 LYNHAVEN DRIVE	
AUBREY'S SAFE HAVEN	NAME OF PROVIDER OR SUPPLIE
GASTONIA. NC 28052	AURREV'S SAFE HAVEN
	AUDICET S SAI E HAVEN
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (2) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH DEFI
V 132 Continued From page 21 really want to be bothered." -The Licensee/ED went over to the bed where FC #4 was lying, grabbed her hand and pulled her off her bed. "She gets off the bed, holding my hand and we walk (together) her holding my hand the whole way, up to the front." -FC #4 started doing her chore but she does not complete the chore. FC #4 walks back towards her room before finishing her chore and The Licensee/ED stopped her and tells her she must take her medications which FC #4 refuses. -"I said, [FC #4] come on, "I don't really want to do this today, you know I got somewhere I gotta be. Take your meds. 'Im saying (to FC #4), you know, I got somewhere to go, I need to get where I need to go. I said why we having this problem?" She goes back in her room she lays back on her bed and I said come on let's take it (medications) she gets up again and we come back in here (living room)." -"She sits in this (points to a dining room chair) chair, but how she sits (how she sits in the chair), she throws it (the chair) back and she falls back." -The Licensee/ED calls FC #4's grandmother to see if the grandmother can talk her into taking her medications. -The Licensee/ED calls FC #4's grandmother to see if the grandmother can talk her into taking her medications. -"She gets to cussing at her grandma. I said, 'hey watch your mouth, like chill (stop cursing). She is cussing, cussing, cussing, [Staff #1] was like, [FC #4] stop being disrespectful." She (FC #4) says she was going to stab [staff #1]. Then I hear her say 'I'll blow this b**'n down. I'll have somebody to come in here and do it." -FC #4 walks back towards her room and the Licensee/ED calls ST 4 has a pair of	really want to be -The Licensee/E #4 was lying, gra her bed. "She ge and we walk (too whole way, up to -FC #4 started do complete the cher room before Licensee/ED stotake her medica -"I said, [FC #4] this today, you k Take your meds I got somewhere to go. I said why goes back in her and I said come gets up again ar room)." -"She sits in this chair, but how sishe throws it (the -The Licensee/E force her to take -The Licensee/E see if the grandr medications. -"She gets to cue watch your mour cussing, cussing [FC #4] stop be says she was go her say 'I'll blow somebody to co -FC#4 walks bac Licensee/ED cal -FC #4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some somebody to co -FC#4 goes to her say 'I'll some some some some some some some some

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		MHL036-371	B. WING		08/08/20	25
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIDDEV	S SAFE HAVEN	837 LYNHA	VEN DRIVE			
AUDRET	S SAFE HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) MPLETE DATE
V 132	Continued From page	22	V 132			
	had scissors), I autom back to see her in her -The Licensee/ED got through the door and through her closet in I something. Licensee/asks FC #4 what she to FC #4 staff #1 com grabs staff #1's hair a her face"I grab [FC #4], [staff are trying to pull FC #-The Licensee denied -"Yeah, some of her (inappropriate. I didn't but she was engaging That's why I told her (inappropriate).	natically, immediately go room" es to FC #4's room peeks observes FC #4 going her room looking for ED goes in the room and is doing. As she is talking les in the room. FC #4 nd starts punching her in #2] grabs staff #1 and we led off of [staff #1]." I seeing staff #1 hit FC #4. It is staff #1) language was the her cursing at [FC #4] go with her inappropriately. It is that thought it was just that				
V 293	10A NCAC 27G .170 ^a (a) A residential treat children or adolescen free-standing resident intensive, active there interventions within a shall not be the prima who is not a client of (b) Staff secure meal awake during client shall be continuous at this Section. (c) The population se adolescents who have mental illness, emotic substance-related dis	ment staff secure facility for ts is one that is a tial facility that provides apeutic treatment and system of care approach. It ry residence of an individual the facility. Ins staff are required to be eep hours and supervision is set forth in Rule .1704 of erved shall be children or ee a primary diagnosis of	V 293			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
			B. WING		С	
		MHL036-371	B. WING		08/08	3/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE AVEN DRIVE	, ZIP CODE		
AUBREY'	S SAFE HAVEN		A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 293	not meet criteria for in (d) The children or ac require the following: (1) removal from community-based restacilitate treatment; and (2) treatment in (e) Services shall be (1) include indivistructure of daily living (2) minimize the related to functional did (3) ensure safe control behaviors inclimanagement with or (4) assist the clacquisition of adaptive communication, social (5) support the gaining the skills need intensive treatment set (f) The residential treshall coordinate with or sequence of the conditional co	ildren or adolescents shall apatient psychiatric services. dolescents served shall m home to a idential setting in order to a staff secure setting. designed to: vidualized supervision and g; e occurrence of behaviors eficits; ty and deescalate out of uding frequent crisis without physical restraint; hild or adolescent in the e functioning in self-control, all and recreational skills; and child or adolescent in ded to step-down to a less etting.	V 293			
		as evidenced by: ews and interviews, the e the coordination of care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		I \ /	(X3) DATE SURVEY COMPLETED	
		MUI 026 274	B. WING	B. WING		C
		MHL036-371			08/	08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
AUBREY'	S SAFE HAVEN		IAVEN DRIVE			
		GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 293	Continued From page	24	V 293			
		and agencies within the system of care affecting 1 of e findings are:				
	Review on 7-15-25 of -Date of admission: 4 -Age: 15.	FC #4's record revealed: -1-25.				
	-Diagnoses: Post-Tra Attention Deficit Hype Oppositional Defiant I Disorder with Mood a	Disorder; Adjustment				
	Improvement System revealed the following -IRIS report submitted involving FC #4 on 4-to use her Electronic misplaced the device. the missing device. Sthe back patio to allow	g: d on 4-11-25 for an incident 9-25: FC #4 allowed a peer music device and the peer . FC #4 got upset becaue of Staff allowed FC #4 to sit on v her to calm down. "Client				
	(minutes) while staff of once staff went to tell the home client was reporch. One staff went the other staff stayed client could not be for was contacted an hor returned high. Police	constantly check on client. the client to come back into no longer sitting on the and look for the client while with the other clients. once and in the neighborhood. 911 ar and half later client question the client and ask hospital client decline."				
	4-1-25 to 7-8-25 reve- -4-9-25 note documer arrival (on shift) client relieve some stress. Thave snack at 1pm(nap. Client woke up a	FC #4's progress notes for aled: nted the following: "Upon (FC #4) went on a walk to Then came back inside to Client did chores and took a and helped with dinner. Then				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL036-371	B. WING		08/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIRDEV	S SAFE HAVEN	837 LYNHA	VEN DRIVE			
AUBRET	SAFE HAVEN	GASTONIA	, NC 28052		<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 293	Continued From page	25	V 293			
	then called an began later returned around was high and was act -4-10-25 note docume arrival client was eatin had 1pm snack. Then she wasn't feeling we know what drug she in Interview on 7-15-25 to Director revealed: -On 4-9-25 FC #4 was the facility for approxi Facility staff contacted was returned to the howhich time it was sus "high" (under the influ an unknown drugFacility staff failed to or a drug screen for Fwas under the influen -"I don't know if she we tell us she was high. Said she was high. To wanted to go to the how didn't take her (to right, she has the right I didn't think we could if she refused to go.	to search for client. She 7pm with suspicion client ing very abnormal." ented the following: Upon ng lunch and shortly after n client informed me that III. I believe she doesn't ncantered (encountered)" with the Licensee/Executive is absent without leave from mately 1 and 1/2 to 2 hours. If the police and the client ome by the local police at pected that FC #4 was ence of drugs or alcohol) on follow up with medical care IC #4 to determine if FC #4 ce. It was high. She (FC #4) didn't The police was the one that the police asked her if she pospital and she refused so the hospital. That's her t to refuse to medical care. make her go to the hospital We monitored her the rest was ok. She went to bed and				
V 300	27G .1708 Residential dischg	al Tx. Child/Adol - Trans or	V 300			
		TRANSFER OR is Rule is to address the of a child or adolescent				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' ·	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AIND FLAIN	SI CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			
		MHL036-371	B. WING		08/0	; 8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
AUBREY'	S SAFE HAVEN	837 LYNH	HAVEN DRIVE			
		GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
V 300	Continued From page	e 26	V 300			
	from the facility. (b) A child or adolescon transferred from a emergency, without the notification of the treatlegally responsible per Rule, treatment team existing child and fampersons as set forth in (c) The facility shall refamily teams or other the parent(s) or legal county program representatives involved treatment of the child local Department of Securation Agency and make service planning transfer or discharge from the facility. (d) In case of an emenotify the treatment to the child or adolescer situation is stabilized. (e) In case of an emenoty telephone. A service or transfer or discharge.	cent shall not be discharged facility, except in case of the advance written atment team, including the erson. For purposes of this means the same as the nily team or other involved in Paragraph (c) of this Rule. Meet with existing child and involved persons including guardian, area authority or esentative(s) and other or adolescent, including or adolescent, including decisions prior to the of the child or adolescent ergency, the facility shall eam including the legally of the transfer or discharge of the as soon as the emergency ergency, notification may be ice planning meeting as set of this Rule shall be held ays of an emergency				
	facility failed to ensur was held within 5 bus	as evidenced by: ews and interviews, the e a service planning meeting siness days of an emergency of 1 clients, former client				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		' '	(X3) DATE SURVEY COMPLETED	
			74. BOILBING.			
		MHL036-371	B. WING	B. WING		08/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AUBREY'	S SAFE HAVEN		AVEN DRIVE			
	I		A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 300	00 Continued From page 27		V 300			
	(FC) #4. The findings	s are:				
	-Date of admission: 4 -Date of Discharge: 7 -Age: 15Diagnoses: Post-Tra Attention Deficit Hype Oppositional Defiant I Disorder with Mood a Review on 7-15-25 of Response Improveme -Report submitted on following: "After initia #4] threatened to "blo (facility) along with th member (staff #1) as (Licensee/Executive I emergency services of threaten staff (staff #1) threats. We also cont grandmother to convi importance of taking of continued to threaten After running to her re said was "something with," [FC #4] staff at going into the closet a weapon. Client (FC #1 hospital] to be evaluat Review on 8-6-25 of a 6:31pm from the asso to FC #4's Departmen guardian, her Local M coordinator and her th following: "Hello Everyone,	umatic Stress Disorder; eractive Disorder; Disorder; Adjustment and Conduct. If the North Carolina Incident ent System (IRIS) revealed: 7-9-25 documenting the ally refusing medication, [FC aw up" the entire group home reatening to stab a staff well. We Director/ED) contacted when [FC #4] began to 1) and make other homicidal acted [FC #4's] nce her (FC #4) of the her medicine but she staff and refuse medication. com to retrieve what [FC #4] to stab the staff member tempted to restrain her from and retrieving the potential 4) was sent to [local				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
			IAVEN DRIVE		
AUBREY'	S SAFE HAVEN	GASTON	IA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 300	Continued From page	28	V 300		
	Aubrey's Safe Haven medication, [FC #4] the entire group home (fato stab a staff member emergency services with the entire staff and made where the entire staff and made we also contacted [Figure convince her of the immedicine but she content of the entire staff member with member (staff #1) got once the staff attempting oing into the closet at weapon. CPI measure of others and herself.	ediately discharged from After initially refusing breatened to "blow up" the cility) along with threatening or as well. We contacted when [FC #4] began to ke other homicidal threats. C #4] grandmother to hiportance of taking her tinued to threaten staff and ter running to her room to said was "something to stab ", [FC #4] and the staff into a physical altercation ted to restrain her from and retrieving the potential res was taken due to safety there are any questions or			
	team (legal guardian, therapist) of FC #4's in refusing to take her most to stab staff #1 and bits -"Yes, we (AP and Lice emails after that to vato check on [FC #4] at meeting. I have them can forward them to you -No follow up emails to guardian or LME care by survey exit. Interview on 7-15-25 for revealed: -FC #4 was given an	Il on 7-8-25 notifying FC #4's LME care coordinator, mmediate discharge due to nedications and threatening low up the facility. Densee/ED) sent several rious team members trying nd trying to arrange a n (emails) on my phone. I rou." From the AP to FC #4's DSS re coordinator was received			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		MHL036-371	B. WING		C 08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIBREY'	S SAFE HAVEN	837 LYNHA	VEN DRIVE			
AUDICET	S SAI E HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 300	0 Continued From page 29		V 300			
	-She and the AP atter guardian on 7-8-25 to discharge however thanswer her call nor rethe DSS guardian"We, me and the AP 7-8-25 and 7-9-25 to guardian but no one responded to emails.' -"We, (AP and Licens where we were reach you." -No follow up emails the survey expenses the survey expenses and the AP and Licens where we were reach you."	returned our calls or ree/ED) have the emails ring out. I'll send them to from the Licensee/ED to FC r LME care coordinator was kit.				
	revealed: -On 7-9-25 when she reviewed an email fro of the immediate disc"That morning (7-9-2) a [local hospital] num location) and I called didn't know who the come. But when I got in e-mail from [Licensee [Licensee/ED] text methat they (emergency (FC #4) to [local beharmore a physical alterca (staff #1). When the staff #1). When the staff #1 when the staff #1 when the staff #1 when the staff #1 and her staff physical altercation. I	25) when I got up I had seen ber up there (providers them (local hospital) but I slient was or who had called in (the office) I seen the s/ED] and I seen that e at 9:09pm (7-8-25) stating medical services) took her				

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			A. BOILDING.		С	
		MHL036-371	B. WING		08/08/2	025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'	S SAFE HAVEN		VEN DRIVE			
			, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
V 300	Continued From page	30	V 300			
		hing else from Aubrey's had reached out to me for				
V 318	130 .0102 HCPR - 24	Hour Reporting	V 318			
	The reporting by heal Department of all aller personnel as defined including injuries of ur done within 24 hours becoming aware of the health care facility submitted to the Department of the D	H CARE PERSONNEL th care facilities to the gations against health care in G.S. 131E-256 (a)(1), nknown source, shall be of the health care facility ne allegation. The results of r's investigation shall be artment in accordance with				
	facility failed to notify Registry (HCPR) with allegations of abuse a	ews and interviews, the Health Care Personnel in 24 hours of learning of				
	Review on 7-15-25 of revealed: -Date of hire: 8-9-202 -Job Title: Executive [

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MANAGE		С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE	
AUBREY'	S SAFE HAVEN		AVEN DRIVE A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 318	Continued From page	31	V 318		
	allegations that the Li by sitting on FC #4 ar pillow due to FC #4 remedications. Review on 7-11-25 ar Carolina Incident Resrevealed: -No documentation of documenting the alleg	al report documenting censee/ED abused FC #4 and suffocating FC #4 with a efusing to take her and 7-15-25 of the North ponse Improvement System a report submitted gations that the Licensee/ED			
	Interview on 7-22-25 revealed: -She was not aware of until she spoke with the Services investigator -"DSS came before your Service Regulations (didn't know that I was until she showed up as	of the allegation against her ne Department of Social on 7-15-25.			
	[Licensee/ED] sat on suffocate her (FC #4) said something (discu [Licensee/ED]. She (about staff #1. She (I [Licensee/ED]t sat on her and was trying to mouth and that wasn'	ility on 7-10-25. allegations were that her (FC #4) and tried to and she (DSS) just mainly ussed allegations) about DSS) didn't say anything DSS) said that her (FC #4) and suffocated force the medicine in her			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-371	B. WING		C 08/08/2025
	ROVIDER OR SUPPLIER	837 LYNF	DDRESS, CITY, STATHAVEN DRIVE IA, NC 28052	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 318	and told her about the Interview on 8-7-25 w -"Yeah she (DSS) jus (7-10-25), asked som interviewed the staff, Associate Professional Interview on 8-7-25 w revealed: -I went to the group he there but her employed were. I actually spoke the phone. When I tal	e allegations." with staff #3 revealed: st kind of showed up e questions. She the kids (clients) the al (AP), [Licensee/ED]. with DSS investigator ome on 7-10-25 she wasn't ees (staff #2 and staff #3) e to her (Licensee/ED) on ked to her (Licensee/ED) eout the allegations, she	V 318		
V 366	10A NCAC 27G .0603 RESPONSE REQUIR CATEGORY A AND B (a) Category A and B implement written pol response to level I, II shall require the provi (1) attending to of individuals involved (2) determining (3) developing a measures according t timeframes not to exc (4) developing a to prevent similar incid specified timeframes	REMENTS FOR B PROVIDERS Is providers shall develop and icies governing their or III incidents. The policies ider to respond by: Ithe health and safety needs in the incident; Ithe cause of the incide	V 366		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MUI 026 274	B. WING		C	
		MHL036-371	1 2		1 08/0	8/2025
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		837 LYNHA	AVEN DRIVE			
AUBREY'S	S SAFE HAVEN		A, NC 28052			
	OUR MAR DV OT		<u> </u>	DD0//DDD0 D/ AV 05 00DD50T0		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
V/ 266	0	- 00	V 366			
V 366	Continued From page	2 33	V 300			
	(6) adhering to	confidentiality requirements				
	set forth in G.S. 75, A	article 2A, 10A NCAC 26B,				
	42 CFR Parts 2 and 3	3 and 45 CFR Parts 160 and				
	164; and					
		documentation regarding				
		through (a)(6) of this Rule.				
		requirements set forth in				
	` '	Rule, ICF/MR providers				
	shall address incidents as required by the federal					
	regulations in 42 CFR					
	•	requirements set forth in				
	` ,	Rule, Category A and B				
	• ,	CF/MR providers, shall				
		ent written policies governing				
	· · · · · · · · · · · · · · · · · · ·	vel III incident that occurs				
	· ·	delivering a billable service				
		on the provider's premises.				
		uire the provider to respond				
	by:	une the provider to respond				
		securing the client record				
	by:	securing the chefit record				
	-	e client record;				
	(B) making a pl					
	` ,	ногосору, ne copy's completeness; and				
		the copy to an internal				
	review team;	and dopy to an internal				
	·	a meeting of an internal				
		hours of the incident. The				
		shall consist of individuals				
		d in the incident and who				
		for the client's direct care or				
		al oversight of the client's f the incident. The internal				
		nplete all of the activities as				
	follows:	and afthe allegate 11				
		opy of the client record to				
		nd causes of the incident				
		dations for minimizing the				
	occurrence of future in	ncidents;				

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLE	
		MHL036-371	B. WING		08/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE		
TWAINE OF TH	TOVIDER OR OUT FEEL		HAVEN DRIVE	12,211 3002		
AUBREY'S	S SAFE HAVEN		IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	within five working da preliminary findings of LME in whose catchmolocated and to the LM if different; and (D) issue a final owner within three more final report shall be see catchment area the public document area the public document include all public documents include all public documents needed available within three LME may give the protection of the LME may give the protection of the LME may give the protection of the LME result area where the service Rule .0604; (B) the LME who different; (C) the provider for maintaining and uptreatment plan, if different; (D) the Departmore (E) the client's applicable; and	r information needed; n preliminary findings of fact ys of the incident. The f fact shall be sent to the nent area the provider is in where the client resides, written report signed by the onths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The fall address the issues hal review team, shall fuments pertinent to the factor the report are not months of the incident, the for the report are not months of the incident, the for incident and to the resides in the report are not months of the incident, the for the report are not months of the incident, the for the catchment we are provided pursuant to mere the client resides, if or agency with responsibility podating the client's erent from the reporting	V 366			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
			B. WING			С
		MHL036-371	B. WING		08	3/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
AUBREY'	S SAFE HAVEN		HAVEN DRIVE			
	T		NIA, NC 28052			T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED TO TO DEFICIENCED TO TO TO THE PROVIDER OF THE PROVIDER	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 366	Continued From page	35	V 366			
	facility failed to impler governing their responsal incidents as required. Review on 7-15-25 of plan updated on 4-30 following: "The client medication on occasionanger." Review on 8-6-25 a 9 revealed: -5-24-25: FC #4 abserfacility (AWOL). Review on 7-11-25 of no documentation of (unknown dates). No AWOL on 5-25-25. Interview on 7-16-25 - "Yeah, I've refused medication of the taking them, wasn't taking them, a - "No, when I refused, (meds). I don't know (meds). I don't know (meds).	ews and interviews, the ment written policies nse to level I, II and III The findings are: FC #4's person centered -25 documenting the (FC #4) has refused on (unknown dates) due to 11 print out to the facility nt without leave from the the facility records revealed FC #4's medication refusal documentation of FC #4's with FC #4 revealed: ny meds (medications) (refused meds). I just didn't and I told them (staff) I and I didn't." I didn't take none of them				
	-There had been a fer occasions that FC #4 medications.	•				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		MHL036-371	B. WING		08/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
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()(1) ID	SHIMMARY ST	ATEMENT OF DEFICIENCIES	A, NC 28052	PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 366	Continued From page	2 36	V 366			
	But she had refused t staff."	o take her meds for other				
	revealed: -"The clients always to don't have refusals. They (clients) can't regrounds for immediate take their medicine. In protocol) to them when have to take your med. We have that in our a time [FC #4] refused lincident happened (7-(7-7-25) she was refueventually took the magnitude of the program, so that was linterview on 7-16-25 to revealed:	with FC #4's DSS guardian efusals had been discussed nild and Family Team				
∨ 367	10A NCAC 27G .0604 REPORTING REQUIL CATEGORY A AND B (a) Category A and B level II incidents, exce the provision of billabl consumer is on the pr incidents and level II of	REMENTS FOR B PROVIDERS I providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients	V 367			
		rendered any service within cident to the LME tchment area where				

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DIVISION	of Fleatill Service Regu	iation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		837 I YNH.	AVEN DRIVE		
AUBREY'	S SAFE HAVEN		A, NC 28052		
			H, NC 20032	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
IAG		,	IAG	DEFICIENCY)	
V 367	Continued From page	e 37	V 367		
	hecoming aware of th	e incident. The report shall			
	be submitted on a for	•			
		•			
		t may be submitted via mail,			
	in person, facsimile or				
	-	nall include the following			
	information:				
		ovider contact and ·			
	identification informat				
	` '	fication information;			
	(3) type of incid				
	(4) description				
	` '	e effort to determine the			
	cause of the incident;				
	· /	luals or authorities notified			
	or responding.				
		providers shall explain any			
	_	e information. The provider			
		ed report to all required			
		ne end of the next business			
	day whenever:				
		has reason to believe that			
	information provided i	in the report may be			
	erroneous, misleadino	g or otherwise unreliable; or			
	(2) the provider	obtains information			
	required on the incide	ent form that was previously			
	unavailable.				
	(c) Category A and B	providers shall submit,			
	upon request by the L	.ME, other information			
	obtained regarding the	e incident, including:			
	(1) hospital reco	ords including confidential			
	information;				
	(2) reports by o	ther authorities; and			
		's response to the incident.			
		providers shall send a copy			
	, , ,	reports to the Division of			
		opmental Disabilities and			
		rvices within 72 hours of			
		e incident. Category A			
	providers shall send a				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDEN.	A. BUILDING: _		OOM! LETED	
		MHL036-371	B. WING		C 08/08/202	25
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
		837 LYNHA	VEN DRIVE			
AUBREY	S SAFE HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETE DATE
V 367	Health Service Regul becoming aware of the client death within service restraint, the provice immediately, as requiled. 300 and 10A NCAC (e) Category A and Be report quarterly to the catchment area where The report shall be subled to the catchment area where The report shall be subled to the catchment area where The report shall be subled to the secretary via a conclude summary information of a level II (2) restrictive in the definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a concludents that occurre (6) a statement been no reportable in incidents have occurrence any of the criteria.	client death to the Division of ation within 72 hours of the incident. In cases of even days of use of seclusion der shall report the death red by 10A NCAC 26C 27E .0104(e)(18). The providers shall send a set LME responsible for the electronic means and shall report that do not meet the or level III incident; the reventions that do not meet the lill or level III incident; a client or his living area; client property or property in lient; mber of level II and level III and indicating that there have cidents whenever no the during the quarter that it is as set forth in Paragraphs election in the control of the contr	V 367			
	facility failed to report	as evidenced by: ews and interviews, the all level II incidents to the ntity (LME)/Managed Care				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
					c	;
		MHL036-371	B. WING		08/0	8/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'S	S SAFE HAVEN		VEN DRIVE A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	÷ 39	V 367			
		n the catchment area within gaware of the incident. The				
	revealed:	nt without leave from the				
	revealed:	11 print out to the facility				
	make sure all the IRIS to you."	d: or completing the IRIS I'm big on documentation. I S's are submitted. I'll send it f an AWOL incident for FC				
V 500	10A NCAC 27D .0101 RESTRICTIONS AND (a) The governing both assures the implement G.S. 122C-65, and G (b) The governing both implement policy to as	ndy shall develop policy that ntation of G.S. 122C-59, .S. 122C-66. dy shall develop and	V 500			

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	of Health Service Regu				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		MHL036-371	B. WING	08/08/2025	
NAME OF D		OTDEET	ADDDESS OF STATE	7/10 CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIF GODE	
AUBREY'S	S SAFE HAVEN		IHAVEN DRIVE		
	T	GASTO	NIA, NC 28052		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	(- /
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
				DEFICIENCY)	
V 500	Continued From page	0.40	V 500		
V 300	Continued From page	6 40	V 300		
		ploitation of clients are			
	reported to the County Department of Social				
		I in G.S. 108A, Article 6 or			
	G.S. 7A, Article 44; a				
		and safeguards are			
		nce with sound medical			
	·	ication that is known to			
	present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.				
	-	se procedures prohibited in			
	10A NCAC 27E .0102(1), the governing body of				
		elop and implement policy			
	that identifies:	, e.e.p aap.ee pee,			
	(1) any restricti	ive intervention that is			
	prohibited from use w	vithin the facility; and			
	(2) in a 24-hou	r facility, the circumstances			
		prohibited from restricting			
	the rights of a client.				
	, ,	ody allows the use of			
		ns or if, in a 24-hour facility,			
		ent rights specified in G.S.			
	122C-62(b) and (d) a identify:	ire allowed, the policy shall			
	l	ed restrictive interventions or			
	allowed restrictions;	Sa resultance interventions of			
		al responsible for informing			
	the client; and	iai respensible for illienning			
		cess procedures for an			
	involuntary client who				
	restrictive intervention				
	(e) If restrictive interv	ventions are allowed for use			
		governing body shall			
		ent policy that assures			
		chapter 27E, Section .0100,			
	which includes:				
		ation of an individual, who			
		I who has demonstrated			
	Lompetence to use re	estrictive interventions, to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		MUU 000 074	B. WING			C
		MHL036-371	B. WING		08	3/08/2025
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AUBREY'	S SAFE HAVEN		HAVEN DRIVE			
	T	GASTON	IIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 500	renewed for up to a to accordance with the to NCAC 27E .0104(e)(1) the designaresponsible for review interventions; and 1) the establis appeal for the resolutions.	rization for the use of ns when the original order is otal of 24 hours in ime limits specified in 10A	V 500			
	facility failed to ensurabuse were reported Social Services (DSS Review on 7-15-25 of -No documentation of Licensee/ED abused and suffocating her way -No documentation of Licensee/ED wrapped legs to prevent FC #4-No documentation of verbally abused FC #4 and threatening to 'be-No documentation of the legs to prevent FC #4-No documentation of	ews and interviews, the e all incidents of alleged to the county Department of c). The findings are: If facility records revealed: If the allegation that the FC #4 by sitting on FC #4, In the allegation that the Id her legs around FC #4's If from moving. If the allegation that staff #1				
	Social Services guard talk to her biological s	with FC #4 revealed. cause her Department of dian would not allow her to sister. When asked by staff ed to take her evening				

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NAME OF PROVIDER OR SUPPLIER **STREET ADDRESS, CITY, STATE, ZIP CODE** **AUBREY'S SAFE HAVEN** **STREET ADDRESS, CITY, STATE, ZIP CODE** **AUBREY'S SAFE HAVEN** **STLYNHAVEN DRIVE** GASTONIA, NC 28052** **CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG** **REGULATORY OR LSC IDENTIFYING INFORMATION** **V 500** **CONTINUED From page 42** **medications and complete her assigned chores for the evening.** Staff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her chores.** FC #4 went to her room, closed the door and was listening to her [electronic music device].** When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications.** -"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).**	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER AUBREY'S SAFE HAVEN SITEST ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (IX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 W 500 Continued From page 42 Medications and complete her assigned chores for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) sold I couldn't refuse and I told her yes I could (refuse to take medications).				A. BUILDING: _			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 reducations and complete her assigned chores for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device], When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).				D MANAGO		1	
AUBREY'S SAFE HAVEN (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 V 500 Continued From page 42 medications and complete her assigned chores for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).			MHL036-371	B. WING		08/0	8/2025
AUBREY'S SAFE HAVEN (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 medications and complete her assigned chores for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 W 500 Continued From page 42 Medications and complete her assigned chores for the evening. -Staff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her chores. -FC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications. -"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).	AUBREY'S	S SAFE HAVEN	837 LYNH	AVEN DRIVE			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 500 Continued From page 42 medications and complete her assigned chores for the evening. -Staff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her chores. -FC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications. -"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).	AODILLI	O OAI E HAVEIV	GASTON	A, NC 28052			
medications and complete her assigned chores for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
for the eveningStaff #2 called the Licensee/Executive Director/ED to return to the facility to assist with getting FC #4 to take her medications and complete her choresFC #4 went to her room, closed the door and was listening to her [electronic music device]. When the Licensee/ED returned to the facility she informed FC #4 that she had to take her medications and complete her chores. FC #4 refused, and the Licensee/ED told FC #4 she could not refuse to take her medications"She (Licensee/ED) said I couldn't refuse and I told her yes I could (refuse to take medications).	V 500	Continued From page	÷ 42	V 500			
I had rights. That's when she said I didn't have any rights." -"Then she (Licensee/ED) said 'either you take the meds (medications) or I will drag you out of bed and give you the meds." -The Licensee/ED grabbed FC #4 by her arm/wrist and pulled her out of her bed, out of FC #4's bedroom and down the hallway to the dining area to take her medications. -"She (Licensee/ED) said, 'yes you are taking your meds and she pulled me out of my room." -The licensee/ED lead FC #4 to the dining room where FC #4 sat in one of the dining room chairs. The Licensee/ED asked FC #4, 'are you gonna take the meds?' "I said no, I'm not, I'm not taking the f*****g meds." -"She (Licensee/ED) was like, 'either I can take it (medications), or I'm gonna put it in your mouth and I'm gonna drown you with the water." -At that point the Licensee/ED put FC #4 in a restraint. "She literally got me out of the chair trying to restrain me. We were falling, we fell to the ground and she sat on me. Yes, she literally	V 300	medications and comfor the eveningStaff #2 called the Li Director/ED to return getting FC #4 to take complete her choresFC #4 went to her rowas listening to her [6] When the Licensee/E informed FC #4 that smedications and comrefused, and the Licenseed, and the Licenseed, and the Licenseed (Licensee/ED) told her yes I could (Indications) your meds and give you the -The Licensee/ED gram/wrist and pulled Indications and she put to take her medications and she put to take her medications and she put to the Licensee/ED ask take the meds?' "I sate the f******g meds." -"She (Licensee/ED) (medications), or I'm gand I'm gonna drown -At that point the Licensetraint. "She literall trying to restrain me.	censee/Executive to the facility to assist with her medications and om, closed the door and electronic music device]. D returned to the facility she she had to take her plete her chores. FC #4 nsee/ED told FC #4 she ke her medications. said I couldn't refuse and I efuse to take medications). hen she said I didn't have /ED) said 'either you take is) or I will drag you out of meds." abbed FC #4 by her her out of her bed, out of FC with the hallway to the dining cations. said, 'yes you are taking ulled me out of my room." d FC #4 to the dining room he of the dining room chairs. hed FC #4, 'are you gonna hid no, I'm not, I'm not taking was like, 'either I can take it gonna put it in your mouth you with the water." nsee/ED put FC #4 in a y got me out of the chair We were falling, we fell to	V 300			

meds."

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 43 of 81

DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						:
		MHL036-371	B. WING		1	8/2025
		2000 0. 1	1		1 00/0	072020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AUBREY'S	S SAFE HAVEN		AVEN DRIVE			
, to bit i	5 67 ti 2 117 ti 211	GASTONI	A, NC 28052			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT ORT	100 IDENTIFY TING IN GRANATION)	TAG	DEFICIENCY)	WAIL	
1/500			1,500			
V 500	Continued From page	e 43	V 500			
	-"She was like, 'if you	don't take these meds you				
	are going to the hosp	ital. She said 'if you don't				
		are going somewhere you				
	can't refuse."					
		lled FC #4's grandmother to				
	<u> </u>	r talk to FC #4 into taking				
		npleting her chores but FC				
	"disrespectful" to the	nd was cursing and being				
		Grandmother. FC #4's conversation with				
		told her to 'stop being				
	•	g at grandmother). At which				
	, , ,	staff #1, "leave me alone,				
	•	said b***h stop talking to				
	me."					
	-Staff #1 walked towa	ords FC #4 to restrain her.				
	"She ran up on me. S	She (staff #1) was trying to				
		I said if you touch me, I'm a				
	(going to) stab you."					
		abbed the phone from FC #4				
	• .	randmother and put FC #4				
	in a restraint.	a babind FO #4 and lagged				
		s behind FC #4 and looped 4's arms to attempt to keep				
		iff #1. As FC #4 struggled to				
	•	t to fight staff #1 she and the				
		onto the couch. At which				
		wrapped her legs around				
		nt FC #4 from kicking her				
	and staff #1.	-			l	
		C #4's threat to stab her and				
		ngaged in a verbal back and				
		aff #1) like, 'who you gonna			l	
	•	child's place, you being				
		blancom 4b - ml				
	you need to stay in a disrespectful."" -"I told her I was gonr whatever and that's was go (released the response to the respon	ne was like, you just a child, child's place, you being na blow up the place or when she (licensee/ED) let restraint)"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
			A. BUILDING			С	
		MHL036-371	B. WING			08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	E, ZIP CODE			
AUBREY'S	S SAFE HAVEN		HAVEN DRIVE				
	 I	GASTON	IIA, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 500	Continued From page	e 44	V 500				
	due to FC #4 threater FC #4 left the living roher bedroom"I went to my room. I door shut. I was lookidevice] and [Licensee was asking me what in (the room), she rarcame in the room, ag saying, 'you said you Well, whoop my a*s tfighting." -"we were fighting, then she hit me. It was restraint." -FC #4 was hit in the not know how many to	in order to call the police ning to "blow up the place." from area and retreated to I was in my room, I had my ng for my [electronic music e/ED] opened the door and I was doing. [Staff #1] came in around [Licensee/ED] and gressive like and she was was gonna whoop my a*s? hen.' Then we started It was a fight. I hit her first, is a fight, it wasn't no head by staff #1 but she did imes staff #1 hit her. "I don't winging (hitting) on each					
	her sister. -"[FC #4] and [staff # -"[FC #4] was being of on the phone and [staff # S -"Yeah, they both were Yeah, [staff #1] was hechest." -[Staff #2] and [ED] g [staff #1] 'you should want to be a simple of the staff want to be a simple of the staff (ED) was sing out staff (ED) on the staff (ED) on the staff (ED) on the staff (ED) on the staff (ED)	cause she couldn't talk to 1] got into it (fight)." disrespectful to her grandma aff #1] told her to stop being re swinging on each other. ditting her in her head and ot them apart. [staff #2] told n't have hit her.""					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
			B. WING		C
		MHL036-371	B. W		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
AUBREY'	S SAFE HAVEN	837 LYNHA	VEN DRIVE		
AODILLI	O OAI E HAVEN	GASTONIA	, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 500	Continued From page		V 500		
	'b***h, I'm gonna stab b***h, I'll stab you. [Fo son, I'll drown you and it then."' -"[FC #4] didn't want t -[Staff #1] went in her [FC #4] was holding [her and [staff #1] was and on her shoulders Interview on 7-16-25 -FC #4 refused to con	room and was hitting her. staff #1's] head and hitting hitting [FC #4] in her head " with staff #1 revealed: nplete her chore for the ht to her room, shut her door			
	-Staff #2 asked her to #4 responded "I'm no -Staff #2 call the Lice when she arrived she grandmother . FC #4 disrespectful to her gr said, "[FC #4] that's re grandmother). She w me I'll stab you."'	finish her chores and FC t doing any f*****g thing." nsee/ED for assistance and allowed FC #4 to call her was cursing and being randmother and staff #1 eal disrespectful (cursing at ras like 'b***h, if you touch cursed at FC #4. "No, I has trying to process with her			
	to get her to calm dov -The Licensee/ED pur released the restraint "blow up" the group h -FC #4 ran back to he Licensee/ED believed weapon so they follow -"She (FC #4) was dig bag. She had pulled s bag or whatever and when me and her got grabbed staff #1's hai her head and face)."	vn." t FC #4 in a restraint but after FC #4 threatened to			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
AUBREY'S	S SAFE HAVEN	837 LYNHA	AVEN DRIVE		
AODILLI	JOAN E HAVEN	GASTONIA	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 500	Continued From page	e 46	V 500		
V 500	hold of my hairShe and like scratching m Interview on 7-16-25 "[FC #4] didn't want tin her room and shut playing." -Staff #2 called the Lireturned to the facility with doing chores and -The Licensee/ED tolemedications. "She (Fnot taking no medicin) everybody (staff #1, out, refusing medicine being disrespectful." -The Licensee/ED calsee if grandmother content medications. "[FC yelling, kicking, being -FC #4 started arguin cussing each other or all they were saying to -FC #4 threatened to	was hitting me in the head e on my hands and stuff." with staff #2 revealed: o do her chores. She went the door with the music censee/ED and she to assist with getting FC #4 d taking her medications. d her she had to take her C #4) was just like 'she's e.' She's blessing (cursing #2 and the Licensee/ED) e, walking off and she is just II FC #4's grandmother to buld talk FC #4 into taking C #4] was cussing them out, forceful." g with staff #1." They were ut" I can't remember what	V 500		
	me like you just said g you need to."	go get whatever (weapon)			
	bedroom), I guess to	grab a potential weapon or ED] ended up following			
		he had a weapon or what			
	she was getting out o				
	-Staff #1 went to FC #	#4's bedroom and witnessed			
		hting. "[FC #4] was hitting			
] was hitting [FC #4]. I don't t. I mean they were fighting			
	staff #1 apart but staf	d staff #2 pulled FC #4 and f #1 and FC #4 continued to ach other. [FC #4] was			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_			;	
		MHL036-371	B. WING		1	8/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
AUBREY'S	S SAFE HAVEN		VEN DRIVE				
			, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 500	Continued From page	: 47	V 500				
	chap (child), you need chaps' place." -"Ok, now I'm telling [squiet. She is still argu#4]. It was inappropri Interview on 8-6-25 w Professional revealed -"Me, the QP (Qualifie [Licensee/ED] we har team. No one person [Licensee/ED] will del she might say, you (A do this or that and she since she is the owne	with the Associate de Professional) and adle investigations like a is assigned to any task. egate responsibilities. Like P) do the interviews, [QP] e will do her part. I guess					
	the local DSS becaus reporting rule to DSS. -"They (DSS) knew all how I found out about showed up." -She (DSS) told me a she showed up on the only told me about the	d: I not complete a report to e she was not aware of the cout the allegation. That's the allegation is when DSS bout the allegation when e 15th (7-15-25). But she e allegations against me. anything about [staff #1]. It					
V 512	10A NCAC 27D .0304 HARM, ABUSE, NEG (a) Employees shall I	PROTECTION FROM LECT OR EXPLOITATION protect clients from harm, politation in accordance	V 512				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
AUBREY'S	S SAFE HAVEN		IAVEN DRIVE		
	Г		IA, NC 28052		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 512	V 512 Continued From page 48		V 512		
	with G.S. 122C-66.	not subject a client to any			
		ect, as defined in 10A NCAC			
		s shall not be sold to or			
	purchased from a clie established governing				
		use only that degree of force			
	necessary to repel or aggressive client and	which is permitted by			
	governing body policy	/. The degree of force that			
	is necessary depends	s upon the individual client (such as age, size			
		ntal health) and the degree			
		splayed by the client. Use of			
		es shall be compliance with C 27E of this Chapter.			
	(e) Any violation by a	n employee of Paragraphs			
	(a) through (d) of this dismissal of the emplo	Rule shall be grounds for oyee.			
	This Rule is not met	as evidenced by: ews and interviews, 2 of 2			
	audited staff (License	e/Executive Director (ED)			
		1 of 1 clients (former client udited staff (Licensee/ED)			
	,	ts (FC #4). The findings			
	are:	•			
	Review on 7-15-25 of	FC #4's record revealed:			
	-Date of admission: 4				
	-Date of discharge: 7-	-8-25.			
	-Age: 15 years. -Diagnoses: Post-Tra	umatic Stress Disorder			
	(PTSD); Attention De	ficit Hyperactive Disorder			
		l Defiant Disorder (ODD); with Mood and Conduct.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NUMBER.	A. BUILDING: _		COMI LETED
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE	
AUBREY'S	S SAFE HAVEN		AVEN DRIVE A, NC 28052		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 512	Continued From page	e 49	V 512		
	Review on 7-15-25 or -Date of hire: 3-25-25 -Job title: Direct Supp				
	Review on 7-15-25 of revealed: -Date of hire: 8-9-22Job Title: Executive	f the Licensee/ED's record Director.			
	Response Improvement period of 4-1-25 to 7-1-25 to 7-1-25. "After initially #4] threatened to 'blo along with threatening (staff #1) as well. We (emergency) services threaten staff and may We also contacted [From the convince her (FC #4) her medicine but she and refuse medication #4) room to retrieve well staff attempted to the closet and retrieve well staff attempted to the closet and retrieve well as the clos	refusing medication, [FC w up' the entire group home g to stab a staff member contacted emercy when [FC #4] began to ke other homicidal threats. C #4] grandmother to of the importance of taking continued to threaten staff in. After running to her (FC what [FC #4] said was e staff member with,' [FC restrain her from going into ing the potential weapon.			
	not allow her to talk to -FC #4 refused to tak and complete her ass evening. -Staff #2 called the Li	s upset because her Services guardian would o her biological sister. e her evening medications			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	EIED
					С	
		MHL036-371	B. WING		08/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
AUDDEW	O O A E E LIAVEN	837 LYNH.	AVEN DRIVE			
AUBREY	S SAFE HAVEN	GASTONI	A, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				,		
V 512	Continued From page	e 50	V 512			
	medications and com	plete her chores				
		om, closed the door and				
		r electronic music device.				
		D returned to the facility she				
	informed FC #4 that s	she had to take her				
	medications and com	plete her chores. FC #4				
	refused, and the Lice	nsee/ED told FC #4 she				
	could not refuse to ta					
		said I couldn't refuse and I				
		efuse to take medications).				
		hen she said I didn't have				
	any rights."	(ED) : 11 : 11				
		/ED) said 'either you take				
	bed and give you (ad	ns) or I will drag you out of				
	-The Licensee/ED gra	•				
		her out of her bed, out of FC				
		wn the hallway to the dining				
	area to take her medi	-				
	-"She (Licensee/ED)	said, 'yes you are taking				
	,	pulled me out of my room."				
		d FC #4 to the dining room				
	where FC #4 sat in or	ne of the dining room chairs.				
	The Licensee/ED ask	ted FC #4, 'are you gonna				
	take the meds?' "I sa	aid no, I'm not, I'm not taking				
	the f*****g meds."					
	,	was like, 'either I can take it				
		gonna put it in your mouth				
	and I'm gonna drown					
		out of the chair trying to				
		falling, we fell to the ground				
		Yes, she literally sat on me had to take my meds."				
		was like, 'if you don't take				
		going to the hospital.' She				
	,	these meds you are going				
	somewhere you can't					
	_	lled FC #4's grandmother to				
		r talk to FC #4 into taking				
		npleting her chores but FC				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
					С	
		MHL036-371 B. WING			08/08	/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
		837 LYNHA	AVEN DRIVE			
AUBREY'S SAFE HAVEN GASTONI			A, NC 28052			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
V 512	Continued From page	e 51	V 512			
V 512	#4 remained upset an 'disrespectful' to the g-Staff #1 interrupted Fher grandmother and disrespectful' (cursing point FC #4 replied to stop talking to me. I sme." -"She (staff #1) ran up towards FC #4). She me in a restraint. I sai (going to) stab you." -The Licensee/ED grand hung up on the g-The Licensee/ED was her arms under FC #4 FC #4 from hitting sta with the Licensee/ED fell back time the Licensee/ED FC #4's legs to preve and staff #1Staff #1 replied to FC staff #1 and FC #4 en forth. "Then she's (st stab? I said, You. She you need to stay in a disrespectful." -"I told her I was gonr whatever and that's was go (released the reference FC #4 left the living her bedroom"I went to my room. I	and was cursing and being grandmother. FC #4's conversation with told her to 'stop being g at grandmother). At which to staff #1, 'leave me alone, said b***h stop talking to to on me (Staff #1 walked (staff #1) was trying to put id if you touch me, I'm a subbed the phone from FC #4 randmother. It is behind FC #4 and looped the arms to attempt to keep iff #1. As FC #4 struggled to the conto the couch. At which wrapped her legs around int FC #4 from kicking her C #4's threat to stab her and an and an arms was like, you just a child, child's place, you being the state of the core when she (licensee/ED) let	V 512			
	device] and [Licensee was asking me what I in (the room), she ran came in the room, age	e/ED] opened the door and was doing. [Staff #1] came around [Licensee/ED] and gressive like and she was				
	saying, 'you said you	was gonna whoop my a*s?				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			- I			0
		MHL036-371 B. WING		08	C 3/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		837 LYNF	IAVEN DRIVE			
AUBREY'	S SAFE HAVEN	GASTON	IA, NC 28052			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
V 512	Continued From page	÷ 52	V 512			
	Well, whoop my a*s the fighting."	hen.' Then we started It was a fight. I hit her first,				
	then she hit me. It wa restraint."	s a fight, it wasn't no				
		head by staff #1 but she did imes staff #1 hit her. "I don't				
	-	winging (hitting) on each				
	other."	winging (muing) on edon				
	Interview on 7-18-25	with client #1 revealed:				
	-On 7-8-25, FC #4 wa	as in her room listening to				
	her music. She was r	refusing to take her				
	medications and do h	er chores because she was				
	upset about not being	able to talk to her sister.				
		_icensee/ED] had [FC #4's]				
	hand, like she was ho	_				
	l -	front (walking in front of FC				
	#4) and [FC #4] was \	•				
		e Licensee/ED went to the				
		#4] did some chores but she				
		en [Licensee/ED] tried to put				
		they fell on the floor and				
	[Licensee/ED] sat on	• •				
	, ,	nave her full weight on her				
		like she was straddling her.				
	straddling [FC #4's] w	[Licensee/ED's] legs were				
		o call her grandmother but				
	FC #4 was still upset					
		ig) at her grandmother.				
		ng to her grandma, [Staff #1]				
		old her to stop cussing and				
		her grandma and [FC #4]				
		staff #1 and FC #4) started				
		ut. [FC #4] told [staff #1] to				
		#4] called [staff #1] a b***h,				
	[staff #1] called [FC #					
		m at that point and went to				
		she exited the shower the				

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		MHL036-371	B. WING		08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AUBREY'S	S SAFE HAVEN		AVEN DRIVE A, NC 28052			
	OLIMAN DV OT		1	DROWNERIO DI AMI OF CORRECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
V 512	Continued From page	e 53	V 512			
	Licensee/ED was in t #4's door talking to Formaround [Licensee/ED] was kind of like taunti (FC #4) to go ahead a said she was going to -Staff #1 and FC #4 to hitting each other." -FC #4 was pulling st in her head and face #4 in her head and ch -"[Staff #2] and [Licensee]	the hallway in front of FC C #4. "[Staff #1] came and ran in the room. She ing her (FC #4), telling her and beat her a*s like she o do." hegan to fight. "They were aff #1's hair and hitting her and staff #1 was hitting FC				
	-7-8-25, "[FC #4] didr [Licensee/ED] was ta she had to take her m She (FC #4) was cus Another staff (staff #1 talking smack (arguin into a fight. [FC #4] sa you and [staff #1] was #4] said, I'll drown yo [staff #1] was, like 'we -"[FC #4] didn't want in go to her room, she d [staff #1]. [Licensee/E -"[Staff #1] went in he [FC #4] was holding [Iking to her and telling her neds. She (FC #4) said no. sing out staff (Licensee/ED).) butted in and started g with FC #4) and they got aid 'b***h, I'm gonna stab is like b***h, I'll stab you. [FC ur son, I'll drown you and lell do it then." to fight. She (FC #4) tried to idn't want to fight. It was in it is in it is in it. To room and was hitting her. staff #1's] head and hitting is hitting [FC #4] in her head				
	-On 7-8-25, FC #4 ref for the night and inste her door and turned c -Staff #2 asked her (F	with staff #1 revealed: fused to complete her chore ead went to her room, shut on her music "real loud." FC #4) to finish her chores				

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Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1			
			B. WING		C	
		MHL036-371	D. WING		08/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	-		HAVEN DRIVE			
AUBREY'S	S SAFE HAVEN					
		GASTON	IIA, NC 28052			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
IAG	REGOLATORT ORT	EGO IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	WATE	
V 512	Continued From page	e 54	V 512			
	Aladia ar II					
	thing."					
		nsee/ED for assistance and				
		allowed FC #4 to call her				
	•	was cursing and being				
	, ,	randmother and staff #1				
		eal disrespectful (cursing at				
	,	as like 'b***h, if you touch				
	me I'll stab you.'"					
		cursed at FC #4. "No, I				
	never cursed her. I w	as trying to process with her				
	to get her to calm dov					
	-The Licensee/ED loc	pped her hands through FC				
	#4's arms to restrict h	er movement. The				
	Licensee/ED release	d FC #4 from the hold after				
	FC #4 threatened to '	'blow up" the group home.				
	-FC #4 ran back to he	er room and staff #1 and the				
	Licensee/ED believed	d she was going to retrieve a				
		wed FC #4 to her room.				
		gging (looking) in her book				
		something out of the blue				
		I tried to grab it and that's				
	•	into an altercation (FC #4)				
		ir and began hitting her in				
	her head and face)."	3				
	,	g FC #4. "she still had a				
		was hitting me in the head				
		e on my hands and stuff."				
	mis coratorning in	and and otali.				
	Interview on 7-16-25	with staff #2 revealed:				
		n't want to do her chores.				
	• •	and shut the door with the				
	music playing."	and shat the door with the				
	-Staff #2 called the Li	censee/FD and she				
		ed to the facility to assist				
		<u>-</u>				
		th doing chores and taking				
	her medications.	d b a				
		d her (FC #4) she had to				
		"She (FC #4) was just like				
	'she's not taking no m	nedicine.' She's blessing				

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(cursing) everybody (staff #1, #2 and the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
711012111	or contraction	ibertii io, itiori io iiberti	A. BUILDING:			
		MHL036-371	B. WING		08/08/2	2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIBBEV	S SAFE HAVEN	837 LYNHA	VEN DRIVE			
AUDRET	S SAFE HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
V 512	Continued From page Licensee/ED) out, refi and she is just being	using medicine, walking off	V 512			
	-The Licensee/ED cal see if grandmother co	ll FC #4's grandmother to ould talk FC #4 into taking				
	yelling, kicking, being	C #4] was cussing them out, forceful." ng with staff #1. "They were				
		stab staff #1 then walked to				
		was like, 'if you gonna stab go get whatever (weapon)				
	bedroom), I guess to	alking into the room (her grab a potential weapon or				
	_	ED] ended up following he had a weapon or what f her book bag."				
	-Staff #1 went to FC # staff #1 and FC #4 fig	#4's bedroom and witnessed hting. "[FC #4] was hitting				
		I] was hitting [FC #4]. I don't tt. I mean they were fighting				
	staff #1 apart but staff verbally argue with ea	d staff #2 pulled FC #4 and f #1 and FC #4 continued to ach other. "[Staff #1 was ou are a child, you're a chap				
	place."	earn how to stay in a chap's				
	9 -	staff #1], be quiet, just be uing back and forth with [FC iate"				
	Interview on 7-15-25 revealed:					
	on 7-8-25 and proces #4 was upset over no	d been at the facility earlier sed with FC #4 because FC t being able to speak with				
	-	I think 5 minutes from the all (staff #2), 'she's on one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ALIDDEV	S SAFE HAVEN	837 LYNI			
AUDICET	3 SAI E HAVEN	GASTON	IIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
V 512	Continued From page	e 56	V 512		
V 512	-FC #4 refused to conher medications. -"I get back, go to her room lying on her bed music device]. I just get device] and say, 'what #4) says, 'I don't wan [Licensee/ED]." -"I said, well come on and take some meds really want to be both -The Licensee/ED we #4 was lying, grabbed her bed. "She gets of and we walk (togethe whole way, up to the -FC #4 started doing complete the chore. her room before finist Licensee/ED stopped take her medications -"I said, [FC #4] come this today, you know Take your meds. I'm stoday, you know Take your hed come on legets up again and we goes back in her roor and I said come on legets up again and we room)." -"She sits in this (poir chair, but how she sit she throws it (the charman the c	r room and she is in her d. She has a little [electronic grab the [electronic music at's the problem?' "She (FC to be bothered") "She (FC to be bothered") "She (FC to be bothered") "Again, she said "I don't altered." ent over to the bed where FC do her hand and pulled her off of the bed, holding my hand the front." her chore but she does not FC #4 walks back towards aning her chore and The I her and tells her she must which FC #4 refuses. e on, "I don't really want to do I got somewhere I gotta be. saying (to FC #4), you know, o, I need to get where I need thaving this problem?' She in she lays back on her bed et's take it (medications) she is come back in here (living ants to a dining room chair) is (how she sits in the chair), air) back and she falls back." nies sitting on FC #4 to	V 512		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ALIRDEV	S SAFE HAVEN	837 LYNHA	AVEN DRIVE		
AUDICLI	S SAI E HAVEN	GASTONIA	A, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 512	'[FC #4] stop being di says she was going to her say 'I'll blow this somebody to come in -FC#4 walks back tov Licensee/ED calls 91 -FC #4 goes to her be the Licensee/ED that scissors. "Once she (had scissors), I auton back to see her in herough the door and through her closet in something. Licensee/asks FC #4 what she to FC #4 staff #1 com grabs staff #1's hair a her face. -"I grab [FC #4], [staff are trying to pull FC #-The Licensee denied -"Yeah, some of her (inappropriate. I didn' but she was engaging That's why I told her (in the says to some thing to the says the say	sing. [Staff #1] was like, srespectful.' She (FC #4) to stab [staff #1]. Then I hear b***h down. I'll have here and do it."' wards her room and the 1 edroom and client #2 tells FC #4 has a pair of client #2) said that (FC #4 hatically, immediately go room" The stage of the stalking her room looking for ED goes in the room and is doing. As she is talking her in the room. FC #4 and starts punching her in f #2] grabs staff #1 and we have fully for the staff #1 language was the hear her cursing at [FC #4] go with her inappropriately. (staff #1) to leave, go at I thought it was just that of the moment."	V 512		
	Protection dated 8-8- Licensee/ED revealed "What immediate acti ensure the safety of t -Aubrey's Safe Haver from location, then di incident at hand, spol the home at the time	25 and written by the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
						С
		MHL036-371	B. WING		08	/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE		
			IAVEN DRIVE			
AUBREY'	S SAFE HAVEN		IA, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 512	Continued From page	e 58	V 512			
		or having a verbal nt that became physical. ry de-escalation training and				
	happens: "Aubrey's Safe Haver work with the staff for staff is utilizing the me 8-13-25. After the 30	o make sure the above n house manager and AP will 30 days to make sure the ethods that was taught on days the staff will be o make sure the incident				
	and 15 with diagnose PTSD, ODD and Adju FC #4 was upset becher sister and refused and complete her ever FC #4 got into a verbally abused FC # calling FC #4 a child a needed to stay in a cl FC #4 into a physical ahead, whoop my a*s grab staff #1 by the h face. Staff #1 and FC and staff #1 physically her in her head, shou Licensee/ED attempte the fight however duri FC #4 fell on the floor her legs to straddled to force FC #4 to take second and third rest	fight by telling her to 'go s which caused FC #4 to air and punch her in her C #4 got into a physical fight y abused FC #4 by hitting lder and chest area. The ed an intervention to stop ing the struggle of the fight, and the Licensee/ED used FC #4's waist in an attempt e medications. During a raint the Licensee/ED				
	Licensee/ED attempted the fight however during FC #4 fell on the floor her legs to straddled to force FC #4 to take second and third rest wrapped her legs aro prevented FC #4 from	ed an intervention to stop ing the struggle of the fight, and the Licensee/ED used FC #4's waist in an attempt medications. During a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		MHL036-371	B. WING		C 08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		837 LYNHA	VEN DRIVE		
AUBREY'	S SAFE HAVEN	GASTONIA	, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 512	Continued From page	2.50	V 512		
V 012	and stop the verbal al #4 before the verbal al physical fight between This deficiency consti	buse of staff #1 towards FC abuse elevated into a n staff #1 and FC #4. tutes a Type A1 rule buse and neglect and must	V 012		
V 521	V 521 27E .0104(e9) Client Rights - Sec. Rest. & ITO		V 521		
	TIME-OUT AND PROFOR BEHAVIORAL Co. (e) Within a facility we may be used, the politin accordance with the (9) Whenever a restrict documentation shall be to include, at a minime (A) notation of the clie psychological well-bee (B) notation of the free duration of the behave intervention, and any contributing to the one (C) the rationale for the positive or less reconsidered and used restrictive intervention (D) a description of the time and duration of in (E) a description of the with the client and the if applicable, for the ephysical restraint or is	INT AND ISOLATION ITECTIVE DEVICES USED CONTROL here restrictive interventions cy and procedures shall be e following provisions: ctive intervention is utilized, be made in the client record um: ent's physical and ing; quency, intensity and for which led to the precipitating circumstance set of the behavior; he use of the intervention, strictive interventions and the inadequacy of less in techniques that were used; he intervention and the date, its use; ccompanying positive			

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	AND BLAN OF CORRECTION INTEREST.		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		MHL036-371	B. WING		08	/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE			
		837 LYNI	HAVEN DRIVE				
AUBREY'	S SAFE HAVEN	GASTON	IA, NC 28052				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE	
V 521	Continued From page	e 60	V 521				
	restrictive interventior	ne.					
		ne debriefing and planning					
		e legally responsible person,					
		lanned use of seclusion,					
	physical restraint or is						
	determined to be clini						
	(H) signature and title	of the facility employee					
		he employee who further					
	authorized, the use of	f the intervention.					
	This Date is makened	an and days and have					
	This Rule is not met	as evidenced by: ew and interview, the facility					
		ecessary documentation					
	was in the client reco	-					
		ed affecting 1 of 1 audited					
		(FC #4). The findings are:					
		(. c ,, .)cagc a.c.					
	Review on 7-15-25 of	FC #4 record revealed:					
	-Date of admission: 4	-1-25.					
	-Date of Discharge: 7	-8-25.					
	-Age: 15.						
	_	umatic Stress Disorder;					
	Attention Deficit Hype						
		Disorder; Adjustment					
	Disorder with Mood a	nd Conduct.					
	Review on 7/15/25 of	the facility's Incident					
	Reports dated 4-1-25						
		incident that occurred on					
		refusing medication, [FC					
	_	w up" the entire group home					
		reatening to stab a staff					
	member (staff #1) as	-					
	, , , , , , , , , , , , , , , , , , , ,	when [FC #4] began to					
		ke other homicidal threats.					
	We also contacted [F	C #4] grandmother to					
	_	nportance of taking her					
		tinued to threaten staff and					

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STATE FORM 6899 6N2M11 If continuation sheet 61 of 81

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			7 80.28.140.				
		MHL036-371	B. WING		08/08/	2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		837 LYNH	AVEN DRIVE				
AUBREY'	S SAFE HAVEN	GASTONI	A, NC 28052				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 521	Continued From page	: 61	V 521				
	retrieve what [FC #4] the staff member with restrain her from goin retrieving the potentia	l ent to [neighboring town]					
	revealed: -No notation of the clipsychological well being -No notation of the free duration of the behavior intervention, and any contributing to the onserties -No notion of the description of the descri	ang. Equency, intensity, and for which led to the precipitating circumstance set of the behavior. use of the use of the ive or less restrictive red and used and the strictive intervention used. cription of the restrictive ite, time, and duration of its ption of accompanying itervention. ing and planning with the responsible person, if					
	physical restraint or is or reduce the probabi restrictive interventior -No description of the with the clients and th person for the plannerestraint or isolation ticlinically necessary at -No documentation of	debriefing and planning eir legally responsible d use of seclusion, physical me out if determined to be nd i the signature and title of who initiated the use of the					

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
AUDDEM	0.0455 !!4\/5\!	837 LYN	HAVEN DRIVE		
AUBREY	S SAFE HAVEN	GASTO	NIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
V 521	Continued From page	e 62	V 521		
	needed to be docume	at the above information ented. and make sure that all that			
V 524	27E .0104(e12-16) C ITO	lient Rights - Sec. Rest. &	V 524		
	TIME-OUT AND PROFOR BEHAVIORAL COMES (e) Within a facility was be used, the polin accordance with the (12) The use of a residiscontinued immediate to the client gains behaviorable to gain behaviorame specified in the intervention, a new arobtained. (13) The written approposering body shall original order for a residence with the I Subparagraph (e)(10) (14) Standing orders used to authorize the restraint or isolation to (15) The use of a residence in G.S. 1220.	AINT AND ISOLATION DTECTIVE DEVICES USED CONTROL There restrictive interventions icy and procedures shall be be following provisions: trictive intervention shall be ately at any indication of risk or safety or immediately after vioral control. If the client is ioral control within the time authorization of the uthorization must be oval of the designee of the be required when the strictive intervention is otal of 24 hours in limits specified in Item (E) of) of this Rule. or PRN orders shall not be use of seclusion, physical imeout. trictive intervention shall be on of the client's rights as			

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` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		C
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
AURREY'S	S SAFE HAVEN	837 LYNHA	VEN DRIVE		
AODILLI	O GAI E HAVER	GASTONIA	, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE COMPLETE
V 524	Continued From page		V 524		
	for a client, notification follows: (A) those to be notified within 24 hours of the include: (i) the treatment or has designee, after each (ii) a designee of the (B) the legally responsible to an incompeter of the include:	restrictions. ctive intervention is utilized in of others shall occur as in a soon as possible but in next working day, to its in the intervention; and			
	This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to to notify the guardian within 24 hours following a restrictive intervention or members of the treatment team affecting 1 of 1 audited clients (former client #4/FC #4). The findings are:				
	-Date of admission: 4 -Date of Discharge: 7 -Age: 15.	-8-25. umatic Stress Disorder; eractive Disorder; Disorder; Adjustment			
	7-8-25: "After initially #4] threatened to "blo	•			

Division of Health Service Regulation

STATE FORM 6899 6N2M11 If continuation sheet 64 of 81

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		MHL036-371	B. WING		08/	08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		837 LYNH.	AVEN DRIVE			
AUBREY'	S SAFE HAVEN		A, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE DATE
V 524	Continued From page	e 64	V 524			
	member (staff #1) as					
	emergency services \	when [FC #4] began to				
	threaten staff and ma	ke other homicidal threats.				
	We also contacted [F	C #4] grandmother to				
	convince her of the in	nportance of taking her				
	medicine but she con	tinued to threaten staff and				
	refuse medication. Af	ter running to her room to				
	retrieve what [FC #4]	said was "something to stab				
	the staff member with	n", [FC #4]I staff attempted to				
	restrain her from goin	ng into the closet and				
	retrieving the potentia	al				
		ent to [neighboring town]				
	hospital to be evaluat					
	Daview en 0.005 ef					
		an email dated 7-8-25 at				
		ociate Professional (AP)				
	sent to FC #4's DSS	_				
		LME) care coordinator and				
	her therapist docume	inting the following:				
	" Hello Everyone,					
		#4] for health and safety				
		ediately discharged from				
		. After initially refusing				
		hreatened to "blow up" the				
	l	acility) along with threatening				
		er as well. We contacted				
		when [FC #4] began to				
		ke other homicidal threats.				
	_	C #4] grandmother to				
		nportance of taking her				
		tinued to threaten staff and				
		ter running to her room to				
		said was "something to stab				
		n", [FC #4] and the staff				
	, , , , , ,	t into a physical altercation				
		ted to restrain her from				
		and retrieving the potential				
		res was taken due to safety				
	of others and herself.					
	Please let me know if	f there are any questions or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLET	ED
			D WING		С	
		MHL036-371	B. WING		08/08/	/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
AUBREY'S	S SAFE HAVEN		AVEN DRIVE			
		GASTONIA	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 524	Continued From page	e 65	V 524			
	concerns."					
	concerns.					
	by the Licensee/ED "I meds and she said I comeds. She told me the meds if she had to make put me in the rest-"Then the other one #1] was trying to talk away and she (Licensme in a restraint." Interview on 8-6-25 a Licensee/ED revealed Other than the email guardian, LME care of there was no verbal correstraint on 7-8-25 wing Family Team members and the restraint on the companion of the companio	chysical restraints on 7-8-25 because refused to take my couldn't refuse to take my nat I was going to take my ake me take my meds. Then traint." (restraint) was when [staff to me and I was walking see/ED] grabbed me and put and 8-8-25 with the d: sent to FC #4's team (DSS coordinator, and therapist) communication regarding the th any team (Child and				
	Interview on 7-16-25 revealed:	with FC #4's DSS Guardian				
	reviewed an email fro of the immediate disc -"That morning (7-9-2 a [local hospital] num location) and I called didn't know who the c me. But when I got in	om the provider informing her harge (FC #4). 25) when I got up I had seen ber up there (providers them (local hospital) but I slient was or who had called in (the office) I seen the				
	e-mail from [Licensee [Licensee/ED] text me	e/ED] and I seen that e at 9:09pm (7-8-25) stating				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		MHL036-371	B. WING		30	C 3/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AUBREY'	S SAFE HAVEN	837 LYN	HAVEN DRIVE			
		GASTON	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 524	that they (emergency (FC #4) to [local beharinto a physical alterca (staff #1). When the sthey (Licensee/ED) sigonna 'blow up the fagonna 'stab the staff. (FC #4) and her staff physical altercation. It ogo to the closet to got, that's what I got i-"I haven't heard anyt Safe Haven. No one anything since I got the	medical services) took her avioral health unit]" [FC #4] ended up getting attion with one of the staff staff tried to restrain her, aid [FC #4] said she was cility' and that she was She (Licensee/ED) said her ended up getting into a think she (FC #4) was trying get something. That's all I in the e-mail." hing else from Aubrey's had reached out to me for	V 524			
V 525	10A NCAC 27E .0104 PHYSICAL RESTRA	t Rights - Sec. Rest. & ITO SECLUSION, INT AND ISOLATION TECTIVE DEVICES USED	V 525			
	may be used, the polin accordance with the (17) The facility shall on any and all use of including: (A) a regular review be governing body, and Committee, in complications as specified in 18) an investigation of unwarranted patterns.	here restrictive interventions cy and procedures shall be e following provisions: conduct reviews and reports restrictive interventions, by a designee of the review by the Client Rights ance with confidentiality OA NCAC 28A; of any unusual or possibly of utilization; and f the following shall be				

Division of Health Service Regulation

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	or riealin Service Regu		<u> </u>		1
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		C
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
				,	
AUBREY'S	S SAFE HAVEN		HAVEN DRIVE		
		GASTON	IIA, NC 28052		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				BEI IOIENOT)	
V 525	Continued From page	e 67	V 525		
	oonanaoa i rom page				
	(ii) name of the resp	onsible professional;			
	(iii) date of each inte	rvention;			
	(iv) time of each inte	rvention;			
	(v) type of intervention	on;			
	(vi) duration of each				
	(vii) reason for use of				
	` '	less restrictive alternatives			
	. , .	t were considered but not			
		alternatives were not used;			
		anning conducted with the			
		sible person, if applicable,			
		d in Parts (e)(9)(F) and (G)			
		ate or reduce the probability			
		strictive interventions; and			
	(x) negative effects	of the restrictive intervention,			
	if any, on the physica	l and psychological			
	well-being of the clier	nt.			
	-				
	This Rule is not met	as evidenced bv:			
		ew and interview, the facility			
	failed to maintain a lo	· · · · · · · · · · · · · · · · · · ·			
		t reviews and reports on any			
		ve interventions including a			
		esignee of the governing			
	-				
		ne Client Rights Committee.			
	The findings are:				
		facility records revealed a			
	document titled "Aubr	ey's Sate Haven			
	Intervention Log."				
	-Only one intervention	n was documented and			
	included FC #4's nam	ne, Date (7-8-25), address			
	of the facility, "reporte				
	"Witness: [staff #2]."				
		nentation of the following:			
	-Name of the respons				
	-Type of intervention.				
	-Type of interventionDuration of interventi				
	-Reason for use of the	e mierveniion.	- 1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL036-371	B. WING		C 08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
AUDDEN	0.0455 !!4\/5\!	837 LYNHA	VEN DRIVE			
AUBREY	S SAFE HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	
V 525	were used or that well and why those alternation -Debriefing and plann client, legally response eliminate or reduce the use of restrictive interestrictive interestrictive effects of the second of th	trictive alternatives that re considered but not used atives were not used. ing conducted with the tible person, and staff to the probability of the future ventions. The restrictive interventions. With the Associate ealed: If Professional (QP) and the director/ED meet weekly to that have going on. Wonday morning on where we talk about any bough them and discuss what id right, what we did wrong, lone better, you if we need the anything. " idents and things in our staff tot so sometimes I will just the at is documented the consideration of the consid	V 525			
	Interview on 8-6-25 a Licensee/ED revealed -She was unaware th needed to be docume	d: at the above information				
	-"I will update the log information is docume -"Yes, we (Licensee/E have staff meetings a incidents, clients with documented in the stathose for you."	and make sure that all that ented in the future." ED, AP, QP and staff) we nd go over behaviors,				

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL036-371	B. WING			C / 08/2025
NAME C	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
			AVEN DRIVE			
AUBRI	Y'S SAFE HAVEN		A, NC 28052			
(X4) II PREFI TAG	((EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V	10A NCAC 27E .0103 SECLUSION, PHYSI ISOLATION TIME-OU (a) Seclusion, physic time-out may be emp been trained and hav competence in the pr to these procedures. staff authorized to en procedures are retrai competence at least (b) Prior to providing disabilities whose tre includes restrictive in service providers, en volunteers shall comp seclusion, physical re and shall not use the training is completed demonstrated. (c) A pre-requisite fo demonstrating competraining in preventing the need for restrictiv (d) The training shall include measurable le measurable testing (v behavior) on those of methods to determine course. (e) Formal refresher by each service provi annually). (f) Content of the tra	CAL RESTRAINT AND JT cal restraint and isolation bloyed only by staff who have re demonstrated roper use of and alternatives Facilities shall ensure that inploy and terminate these ned and have demonstrated annually. direct care to people with atment/habilitation plan terventions, staff including inployees, students or plete training in the use of estraint and isolation time-out se interventions until the and competence is In taking this training is etence by completion of in, reducing and eliminating re interventions. The competency-based, earning objectives, written and by observation of beigetives and measurable the passing or failing the training must be completed dider periodically (minimum ining that the service bloy must be approved by	V 537	DEFICIENCY)		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		MHL036-371	B. WING		08/08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ALIRDEV'	S SAFE HAVEN	837 LYNF	IAVEN DRIVE		
AUDICET	S SAI E HAVEIV	GASTON	IA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 537	Continued From page	e 70	V 537		
	(g) Acceptable training but are not limited to, (1) refresher in the use of restrictive in (2) guidelines of (3) emphasis of rights and dignity of a concepts of least rest incremental steps in a (4) strategies for of restrictive intervent (5) the use of einterventions which in assessment and mon psychological well-be use of restraint through restrictive intervention (6) prohibited proposition (7) debriefing simportance and purpor (8) documentation of initiat least three years. (1) Documental (A) who particip outcomes (pass/fail); (B) when and work (C) instructor's (2) The Division review/request this documents: (1) Trainers shaby scoring 100% on the control of the contr	ng programs shall include, presentation of: formation on alternatives to interventions; on when to intervene ment danger to self and in safety and respect for the all persons involved (using rictive interventions and an intervention); or the safe implementation clions; imergency safety include continuous intoring of the physical and ing of the client and the safe ghout the duration of the in; incocedures; trategies, including their incocedures; shall maintain all and refresher training for the total include: ated in the training and the where they attended; and name. In of MH/DD/SAS may ocumentation at any time, ation and Training and eliminating the including and eliminating the			

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DIVISION	n Health Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
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			D WING		C	
		MHL036-371	B. WING		08/0	8/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OIL OIL OIL I EIER					
AUBREY'S	S SAFE HAVEN		AVEN DRIVE			
		GASTONI	A, NC 28052			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				22.16.2.16.1		
V 537	Continued From page	2 71	V 537			
	(a) T :					
	` '	all demonstrate competence				
	-	esting in a training program				
		eclusion, physical restraint				
	and isolation time-out	i.				
	(3) Trainers sha	all demonstrate competence				
	by scoring a passing	grade on testing in an				
	instructor training pro	gram.				
	(4) The training	ı shall be				
	competency-based, ir	nclude measurable learning				
	objectives, measurab	le testing (written and by				
	-	ior) on those objectives and				
		to determine passing or				
	failing the course.					
	•	t of the instructor training the				
	service provider plans					
		sion of MH/DD/SAS pursuant				
	to Subparagraph (j)(6					
		instructor training programs				
	• •	3 . 3				
		be limited to, presentation				
	of:					
		ng the adult learner;				
	, ,	r teaching content of the				
	course;					
	• •	of trainee performance; and				
	\ /	ion procedures.				
	` '	all be retrained at least				
		trate competence in the use				
		restraint and isolation				
	time-out, as specified	in Paragraph (a) of this				
	Rule.					
	(8) Trainers sha	all be currently trained in				
	CPR.					
	(9) Trainers sha	all have coached experience				
		restrictive interventions at				
	•	positive review by the				
	coach.	,				
		all teach a program on the				
	• •	ventions at least once				
	annually.	VOITEOUS AT ICAST OFFICE				
	amuany.					

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	
		MHL036-371	B. WING		08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AURREV	S SAFE HAVEN	837 LYN	HAVEN DRIVE			
AODILLI	O GAI E HAVEN	GASTON	NIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETI	E
V 537	instructor training at III (k) Service providers documentation of inition training for at least the (1) Documenta (A) who particip outcome (pass/fail); (B) when and vice) (C) instructor's (2) The Division review/request this document (I) Qualifications of (I) Coaches sharequirements as a training (2) Coaches shares, the course whi	all complete a refresher east every two years. shall maintain fal and refresher instructor free years. tion shall include: fated in the training and the where they attended; and frame. In of MH/DD/SAS may focumentation at any time. Coaches: fall meet all preparation finer. fall teach at least three for is being coached. fall demonstrate foletion of coaching or faction. finell be the same	V 537			
	failed to demonstrate	•				
	Review on 7-15-25 of the Licensee/ED record revealed: -Date of hire: 8-9-22Job Title: Executive DirectorCrisis Prevention Intervention (CPI) training:					

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	5. GGTLGTGT.	.52	A. BUILDING: _		00 22.25	
			D WING		С	
		MHL036-371	B. WING		08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ALIRDEV	S SAFE HAVEN	837 LYNF	IAVEN DRIVE			
AUDILLI	O OAI E HAVEIV	GASTON	IA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLE HE APPROPRIATE DATE	
V 537	Continued From page	e 73	V 537			
	3-22-25.					
	Response Improvement period of 4-1-25 to 7-1-25 to 7-1-25. "After initially #4] threatened to 'blo along with threatening (staff #1) as well. We (emergency) services threaten staff and mad We also contacted [For convince her (FC #4) her medicine but she threaten staff and refuruning to her (FC #4 #4] said was 'someth with,' [FC #4] staff at going into the closet as	incident that occurred on refusing medication, [FC w up' the entire group home g to stab a staff member contacted emercy when [FC #4] began to ke other homicidal threats. C #4's] grandmother to of the importance of taking (FC #4)continued to use medication. After b) room to retrieve what [FC ing to stab the staff member tempted to restrain her from and retrieving the potential 4) was sent to [neighboring				
	Interview on 7-16-25					
	On 7-8-25 FC #4 was	•				
	not allow her to talk to	Services guardian would her biological sister.				
		e her evening medications				
	and complete her ass					
	evening.	aanaaa/FD ta ratii iira ta tha				
		censee/ED to return to the jetting FC #4 to take her				
	medications and com					
		s in her bedroom with her				
	_	to her electronic music				
		e/ED entered FC #4's room				
		that she had to take her				
	medications and com refused to take her m	plete her chores. FC #4				
		ad FC #4 to the dining room				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL036-371	B. WING		08/08/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'S	S SAFE HAVEN		VEN DRIVE			
			A, NC 28052		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 74	V 537			
V 537	where FC #4 sat in or The Licensee/ED ask take the meds?' "I sai the f*****g meds." -"She (Licensee/ED) chair trying to restrain fell to the ground and literally sat on me and take my meds." -FC #4 continued to medications. The Licensee/ED and being "disgrandmother to have #4 into taking her medications and being "disgrandmotherStaff #1 walked toware. She (staff #1) warestraint. I said if you stab you." -The License/ED got her arms under FC #4 FC #4 from hitting staticensee/ED struggle Licensee/ED fell back time the Licensee/ED FC #4's legs to preverse Interview on with clier-On 7-8-25 the[License FC #4 take her meds "They (FC #4 and the dining room and [FC south in the dining room and [FC #4] in floor and [Licensee/E -"No, she didn't have more like she was strucked."	ne of the dining room chairs. led FC #4, 'are you gonna id no, I'm not, I'm not taking literally got me out of the in me. We were falling, we she sat on me. Yes, she id kept telling me I had to lefuse to take her lensee/ED called FC #4's the grandmother talk to FC dicine and completing her linained upset and was serespectful" to the literally got me out of the literally got me out of the literally got me out of the literally got me out of the literally got me I had to lefuse to take her lensee/ED called FC #4's the grandmother talk to FC dicine and completing her linained upset and was literally got me in a literally got me in a literally got me in a literally got me I had to literally got me I had to lefuse to take her lensee/ED #4 and looped literally got me in a literally got me I had to literally got me I had to literally got me out of the literally got me of the literally got me out of the literally got me	V 537			
	more like she was str	•				

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AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE		
		7 20.25			•
	MHL036-371	B. WING		08	C 8/ 08/2025
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	·	
	837 I YNI	AVEN DRIVE			
AUBREY'S SAFE HAVEN		IA, NC 28052			
(V4) ID SUMMARY STATEME	NT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST		PREFIX TAG	(EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
V 537 Continued From page 75		V 537			
Interview on 7-16-25 with s -7-8-25, FC #4 was upset a her medications and do he #4) blessing (cursing) ever medicine, walking off and s disrespectful." -"[Licensee/ED] ended up of see if she could get her grataking her medicine. [FC #0 out, yelling kicking being liker and the Licer floor in the dining room, be and dining room and [Licer #4) like between her (Licer legs wrapped around [FC #0 (FC #4) from kicking." -"She (Licensee/ED) just h She (Licensee/ED) used he around FC #4's legs) so st kick her. [FC #4] was fight was trying to fight [Licensee Staff #2 denied the Licensee "No, I didn't see her (Licen #\$3." -FC #4 continued to curse a dining room chair"She (FC #4) was just sw didn't sling it like hard but s out the way. She (FC #4) v [Licensee/ED]. She (FC #4 around her (Licensee/ED) [Licensee/ED] was blocking (Licensee/ED) was standin #4). She was trying to like, front of her, telling her, 'hey medicine, you're not about from me being disrespectfu	and refusing to take r chores. "She's (FC ybody out, refusing she is just being calling her grandma to andma to talk he into 4] was cussing them ke, forceful." Insee/ED) were on the tween the living room hasee/ED] had her (FC hasee/ED) legs, with her the she was like slinging it was trying to get around the she was like slinging it was trying to get around the she was just trying to get to go to her room. In the she was like slinging it was trying to get around the she was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL036-371	B. WING		C 08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUBREY'	S SAFE HAVEN		VEN DRIVE			
		GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	e 76	V 537			
	ensued between staff -"They (FC #4 and Lic in the living room. [Lic the couch, and she had (Licensee/ED's legs was #4's legs) and she was	om where a physical fight f #1 and FC #4. censee/ED) ended up back censee/ED] was sitting on ad [FC #4] between her legs were wrapped around FC as just holding her arms r arms looped under FC#4's				
	and take her medicat -"I get back (to the far she is in her room lyir little [electronic music [electronic music dev problem?' -"She (FC: bothered [Licensee/E -"I said, well come on and take some meds really want to be both -The Licensee/ED too room/dining area in a take her medications"She sits in this," C approximately 12:15p to a dining room chair sits in the chair), she and she falls back." -The Licensee/ED de restraint and sitting or medicationsThe Licensee/ED ca see if the grandmother medications.	d to complete her chores ions. cility), go to her room and and on her bed. She has a device]. I just grab the ice] and say, 'what's the #4) says, 'I don't want to be D]." you got to do your chores "Again, she said 'I don't lered."				
		sing. [staff #1] was like,				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		152.111.16/11.16.11.16.11.1	A. BUILDING: _		00 22.25
			5 14/110		С
		MHL036-371	B. WING		08/08/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ITE, ZIP CODE	
ALIDDEV	S SAFE HAVEN	837 LYNF	IAVEN DRIVE		
AUDRET	S SAFE HAVEN	GASTON	IA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
V 537	Continued From page	e 77	V 537		
V 537	-FC #4 goes to her be Licensee/ED follow F physical fight occurs in physical fight occurs in FC #4 grabs staff #1 her in her face. The Licensee/ED grather arms through FC away from staff #1. -During the struggle of and FC #4 fell to the folion of the Licensee/ED does not and FC #4 fall to the folion of the Licensee/ED again. While Licensee/ED again with the Hallway. I still have because she is still transport of the hallway. I still have because she is still transport of the Licensee/ED and I use living room and I just the living room where again. We are on the and she is right here, wrap my legs around trying to get her to ca go, let me up and I'm you calm down." -Observation on 7-15. The Licensee/ED der back on the couch an Licensee/ED's legs. -"I didn't know that the interventions. I was justing to go the staff of the couch an Licensee/ED's legs. -"I didn't know that the interventions. I was justing to get her to say the couch an Licensee/ED is legs. -"I didn't know that the interventions. I was justing to get her to get her to get here. - "I didn't know that the interventions. I was justing to get here."	edroom and staff #1 and the C #4 to her room where a between staff #1 and FC #4. I's hair and starts punching bs FC #4 by again looping #4's arms and pulled FC #4 of the fight, the Licensee/ED floor in the hallway. The trelease the hold when she floor. I ght and attempts to go after still on the floor, the arps her legs around FC IC #4 from moving. If FC #4 get up from the don't know how we efloor. We are standing in we my arms under hers ying to get to [staff #1]. So through her arms, I'm my body to walk her to the walk her through the hall to we end up on the couch couch, I'm like lying back like between my legs and I her legs. I'm talking to her Im down. She's like let me no, I can't let you up until -25 at approximately 1pm. nonstrated how She laid d FC #4 was between the	V 537		
	you calm down." -Observation on 7-15 The Licensee/ED der back on the couch an Licensee/ED's legs.	-25 at approximately 1pm. nonstrated how She laid d FC #4 was between the			
	interventions. I was judown and to stop fightal- -The Licensee/ED was	ist trying to get her calmed			

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				DATE SURVEY COMPLETED		
			A. BOILDING			
		MHL036-371	B. WING		08	C / 08/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
			AVEN DRIVE			
AUBREY'	S SAFE HAVEN	GASTONI	A, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 537	#4 while she was rest approved intervention -The Licensee/ED was and FC #4 fell to the fishould have released Interview on 7-16-25 frevealed: -CPI training focuses de-escalation. Physicas a last resortA client should be all de-escalate on their crestraint is used"It is never appropriate ground/floor and the rimmediately and re-ast the ground due to the injury." -"Generally, we (CPI) client while the client client is being moved danger." Review on 8-8-25 of the Protection dated 8-8-2 Licensee/ED revealed "What immediate activensure the safety of the Aubrey's Safe Haver	s not aware that moving FC rained was not a CPI s not aware that once she floor, she (Licensee/ED) her hold on FC #4. with a CPI instructor on prevention and cal restraints should be used owed to dis-engage and twn before a physical te to restrain a client on the estraint should be released seessed if a client goes to increased possibility of do not teach to move a is in a restraint unless the away from some type of the facility's Plan of 25 and written by the disconsumers in your care? In immediate action will be PI restraints allowed until	V 537			
	happens. Enroll staff into CPI tr	o make sure the above aining for 8-13-25. The				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		MHL036-371	B. WING		08/08/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALIDDEV	S SAFE HAVEN	837 LYNHA	VEN DRIVE			
AUDRET	S SAFE HAVEN	GASTONIA	, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
V 537	Continued From page	2 79	V 537			
V 537	and make sure that the measures. Quarterly discuss the CPI meast throughout the meeting. The facility served clie and 15 with diagnose Deficit Hyperactivity Estress Disorder, Opposed and Adjustment Disorupset due to not being FC #4 refused to take complete her evening verbally aggressive a #1), which lead to the CPI interventions on lintervention, the Licenthe floor and the Licenthrough FC #4's arms #4 from fighting staffs the Licensee/ED and couch. The Licensee/around FC #4's legs to moving. During the the Licensee/ED fell coutside of FC #4's be the Licensee/ED again FC #4's legs to prevent getting up from the flower arms through FC FC #4 through the haroom where the Licenfell onto the couch. The legs around FC #held FC #4 in that positions.	ne staff is understanding the meeting will be held to sures and a small refreshering." ents between the ages of 13 is that included Attention Disorder, Post-Traumatic positional Defiant Disorder der. On 7-8-25 FC #4 was grable to talk to her sister. The her medications and grachers. FC #4 became and combative with staff (staff a Licensee/ED attempting 3 FC #4. During the first ansee/ED and FC #4 fell to ansee/ED placed her arms in an attempt to prevent FC #1. During the intervention FC #4 fell back onto the ED wrapped her legs to prevent FC #4 from ird intervention, FC #4 and for the floor in the hallway droom. While on the floor, an wrapped her legs around ant FC #4 from moving. After foor, the Licensee/ED looped #4's arms and force walked allway back into the living asee/ED and FC #4 again the Licensee/ED wrapped 4 to prevent movement and sition with the Licensee/ED's	V 537			
	legs wrapped around					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28092 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FILL) TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FILL) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 537 Continued From page 80 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.				(X3) DATE S COMPL			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 80 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected STREET ADDRESS, CITY, STATE, ZIP CODE 837 LYNHAVEN DRIVE GASTONIA, NC 28052 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETE DATE			MHL036-371	B. WING		1	
AUBREY'S SAFE HAVEN (X4) ID PREFIX TAG V 537 Continued From page 80 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected GASTONIA, NC 28052 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE V 537 V 537 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected	NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	·	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 537 Continued From page 80 This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE V 537 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE V 537	AUBREY'S	S SAFE HAVEN					
This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
	V 537	This deficiency consti which is detrimental to welfare of the clients	tutes a Type B rule violation o the health, safety and	V 537			

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