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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 8-8-25. The complaint was substantiated (Intake #NC00232455). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement their policy on delegation of management authority for the operation of services. The findings are: Review on 8-6-25 of the facility's policy and procedures revealed: -"DELEGATION OF MANAGEMENT AUTHORITY: The LLC (limited liability company) members shall designate in writing an Executive Director (ED) for the Aubrey ' s Safe Haven LLC program, who will serve as the operator and be responsible for the management of this program..." -"The current operator of Aubrey ' s Safe Haven LLC is [ED], Executive Director..." -"In an event that the Executive Director is unavailable, the Chief Executive Officer, Qualified Professional will assume the role as the Executive Director as well as all job duties and responsibilities which includes but not limited to..." Attempted review on 7-11-25 of the facility's records revealed: -At 3:15pm there was no one was at the facility. -A Call was placed to the Licensee/ED at approximately 3:30pm. She was out of the country (7-10-25 to 7-15-25). -No direct care staff was available. Interview on 7-11-25 and 8-6-25 with the Licensee/ED revealed: -"I'm out of the country. The qualified	V 105		

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V 105	Continued From page 3 professional (QP) is not available either. She's (QP) in the hospital, she had a medical emergency. The Associate Professional (AP) is with me out of the country." -"The staff took the clients on an outing. I don't even know where they are. I think they went to [a local town 2 hours away] to the water park. I can get someone (direct support professional/DSP) to meet you there (facility) but they don't have access to the records you need. Those records are locked up at my house. The staff (DSPs) don't have access to those records." -"I don't keep client records at the facility because of confidentiality. They have social security numbers in the records and I'm not going to take a chance on someone getting that information and doing something with it so I keep those (records) locked up at my house." -Staff does not have access to the ED's home to access client records. "No, that's my personal home. I'm not giving anybody access to my house."	V 105		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies;	V 112		

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V 112	Continued From page 4 (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to meet the needs of 1 of 1 clients, former client (FC #4). The findings are: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of discharge: 7-8-25. -Age: 15 yea.rs -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. -Person Centered Plan (PCP) dated 4-30-25, and updated on 6-2-25 and 7-2-25 noted the following: -4-30-25: "During the first week of admission, the client went AWOL (absent without leave) for approximately two hours and appeared to be	V 112		

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V 112	Continued From page 5 under the influence upon return (facility)..." -6-2-25: "The client has gone AWOL a total of three times since admission, including a recent 36-hour AWOL episode. During that incident, she refused to take accountability and tends to elope when frustrated..." -7-2-25: "The client is currently struggling with consistent treatment engagement and behavioral regulation. Flight behavior (AWOL) continues to be a primary concern, especially in overstimulating environments..." -There were no goals or strategies to address FC #4's AWOL behavior. Interview on 7-15-25 and 8-7-25 with the Licensed Professional (LP) revealed: -The LP is responsible for completing and updating the PCP's. -"The information for the PCP updates come from the Child and Family Team (CFT) meetings. So when we have the CFT, we go over medical, school and placemenet updates and that's what is placed in the note area (on the PCP). The update is the information that the staff, [Licensee/ED] and other team members share during the meeting." -"Any issues the provider reports that need a goal, that's what's put into a goal, that's the provider's responsibility. I don't do that." Interview on 7-15-25 and 8-6-25 with the Licensee/ED revealed: -The LP completes the PCPs -"After the first AWOL (4-9-25) we immediately put a plan in place (for FC #4). I thought it was in the PCP, I thought she (LP) had added it to the PCP. I know we discussed it (AWOL) in the CFT meeting (4-30-25)."	V 112		

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V 113	Continued From page 6	V 113		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information	V 113		

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V 113	Continued From page 7 relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintained a complete record for 1 of 1 clients affecting 1 of 1 clients (FC #4). The findings are: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of discharge: 7-8-25. -Age: 15. -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. Review on 7-18-25 of FC #4's progress notes from April 1,2025 to July 8, 2025 revealed: -Goal #1: "Purpose of Contact: Hygiene/Sleep Goal: Timeline: [FC #4] will meet with her group home staff weekly to review her progress on these objectives and discuss any challenges she may face in maintaining compliance with the rules and responsibilities. Intervention/Activity: Staff monitored consumer in 30 minute increments. Staff observed consumers to ensure safety of facility and consumer. Effectiveness/Response: Consumer was monitored throughout shift. She showed no	V 113		

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V 113	Continued From page 8	V 113		

concerns for safety throughout the shift. Consumer remained in her bed throughout the night."
-Goal #2 "Purpose of Contact: Participate in Level III program and decrease anger outburst.
Timeline: [FC #4] will meet with her group home staff weekly to review her progress on these objectives and discuss any challenges she may face in maintaining compliance with the rules and responsibilities.
Intervention/Activity: Staff provided regular verbal feedback to help [FC #4] improve her compliance with group home rules. Staff provided ongoing monitoring and support to ensure [FC #4] felt safe and encouraged Scout to ask for help when needed. Staff facilitated her ability to follow directions effectively and adhere to the executions. Staff identified positive and negative attributes for consumer meeting daily goal.
Effectiveness/Response: The consumer did well with interventions. The consumer followed all facility rules and interacted with peers positively throughout the shift. The consumer made positive strides. Consumer interacted with peers positively throughout shift. Consumer made positive strides throughout the shift. [FC #4] will maintained her personal hygiene, copying skill, aggressive behavior toward staff and peers, verbal aggression and completed her daily grooming. The consumer did not have any verbal outburst."
Each note was typed and contained the same documentation for Timeline, Intervention and Effectiveness for each day from April 1, 2025 to July 8, 2025.

Interview on 8-7-25 with the Licensed Professional (LP) revealed:
-She does not review progress notes.
-"I'm not sure (who reviews progress notes). I

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V 113	Continued From page 9 don't work for Aubrey's Safe Haven, I contract with them to be their therapist. Progress notes would be on the residential side. I don't do anything on the residential side." 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 form that staff document what happens during the shift."	V 113		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug;	V 118		

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V 118	Continued From page 10 (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the MARs were kept current affecting 1 of 1 clients (FC #4). The findings are: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of discharge: 7-8-25. -Age: 15. -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder (ADHD); Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. Review on 7-22-25 of FC #4's MARs for April 1, 2025 to July 8,2025 revealed the following medications were documented as being administered from April 1, 2025 to April 30, 2025.: -Vyvanse (ADHD) 40 milligrams (mg). -Vitamin D3 (supplement) 5,000 units. -Vitamin Iron (iron supplement) Tablets. -Cetirizine (supplement) HCL (hydrochloride) 10mg. -Omeprazole (acid reflux) 20mg.	V 118		

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V 118	Continued From page 11 -Vyvanse (ADHD) 20mg. -Olanzapine (mood) 10mg. -Pataday (allergy relief) 2,500 milliliters (ml). -Advair (asthma) HFA (hydrofluoroalkane) 12 grams (gm). -Fluticasone (allergies) 50 micrograms (mcg) -Suckeess (nail biting) 4% -The following medications were documented as being administered from May 1, 2025 to July 7, 2025: -Vyvanse 50 mg. -Vitamin D3 5,000 units. -Vitamin Iron Tablets. -Cetirizine HCL 10mg. -Omeprazole 20mg. -Vyvanse 20mg. -Olanzapine 10mg. -Pataday 2,500 ml. -Advair HFA 12 gm. -Fluticasone 50 mcg -Suckeess 4% Review on 7-15-25 and 7-22-25 of FC #4's Person Centered Plan revealed completed by the Licensed (LP) documented the following: -4-30-25 update: "The client (FC #4) has refused medications on occasions due to anger." Interview on 7-16-25 with FC #4 revealed: -"Yeah, I've refused my meds (medications) before. I don't know (refused meds). I just didn't feel like taking them, and I told them (staff) I wasn't taking them, and I didn't." -"No, when I refused, I didn't take none of them (meds). I don't know (how many times she refused), a couple of times, twice or maybe 3 times." Interview on 7-16-25 with staff #1 revealed: -Denied FC #4 ever refused medications.	V 118		

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V 118	Continued From page 12 Interview on with staff #2 revealed: -"[FC #4] never refused her meds with me, but I believe she has refused with other staff." -If clients refuse there medications, staff try to get them to take their medications. If clients continue to refuse medications, staff will document on the MAR that the client refused and inform the Licensee /ED of the refusal, then complete an incident report documenting the refusal. Interview on 7-15-25 and 8-7-25 with the LP revealed: -She would get updates regarding FC #4's behavior (medication refusals) when she visited the facility for therapy sessions as well as during monthly Child and Family Team meetings (CFT). -"Her medication refusals would have been discussed during the CFTs." -"The facility staff, would inform her of FC #4 refusing medications." Interview on 7-15-25 with the Licensee/ED revealed: -"The clients always take they meds. We (facility) don't have refusals. That is a part of our program. They (clients) can't refuse (medications). That's grounds for immediate discharge. They have to take their medicine. We explain that (medication protocol) to them when they are admitted, you have to take your meds or you will be discharged. We have that in our admission packet. The only time [FC #4] refused her meds was the day the incident happened (7-8-25). The day before (7-7-25) she was refusing that morning but she eventually took the meds after she got to the day program, so that wasn't a refusal."	V 118		

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V 132	Continued From page 13	V 132		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all	V 132		

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allegations against health care personnel, failed to provide evidence that alleged acts were investigated and failed to report within 5 working days the results of the investigation to the Department. The findings are:

Review on 7-15-25 of the facility's records revealed:
-No documentation of HCPR notification for staff #1 verbally abusing FC #4 on 7-8-25 by cursing at FC #4 and for staff #1 physically abusing FC #4 by hitting FC #4 on her head and shoulders.

Review on 7-11-25 and 7-15-25 of the North Carolina Incident Response Improvement System (IRIS) revealed no documentation of submission of a report for staff #1 verbally abusing FC #4 on 7-8-25 by cursing at FC #4 and for staff #1 physically abusing FC #4 by hitting FC #4 on her head and shoulders.

Interview on 7-16-25 with FC #4 revealed:
On 7-8-25 FC #4 was upset because her Department of Social Services guardian would not allow her to talk to her biological sister.
-FC #4 refused to take her evening medications and complete her assigned chores for the evening.
-Staff #2 called the Licensee/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 began 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).

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V 132	Continued From page 15 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 (administer) 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.'" -"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 sat on me and kept telling me I had to take my meds." -"She (Licensee/ED) was like, 'if you don't take these meds you are going to the hospital.' She said 'if you don't take these meds you are going somewhere you can't refuse.'" -The Licensee/ED called FC #4's grandmother to have the grandmother talk to FC #4 into taking her medicine and completing her chores but FC #4 remained upset and was cursing and being 'disrespectful' to the grandmother. -Staff #1 interrupted FC #4's conversation with her grandmother and told her to 'stop being disrespectful' (cursing at grandmother). At which point FC #4 replied to staff #1, 'leave me alone, stop talking to me. I said b***h stop talking to me." -"She (staff #1) ran up on me (Staff #1 walked towards FC #4). She (staff #1) was trying to put	V 132		

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V 132	Continued From page 16 me in a restraint. I said if you touch me, I'm a (going to) stab you." -The Licensee/ED grabbed the phone from FC #4 and hung up on the grandmother. -The Licensee/ED was behind FC #4 and looped her arms under FC #4's arms to attempt to keep FC #4 from hitting staff #1. As FC #4 struggled with the Licensee/ED, she (FC #4) and the Licensee/ED fell back onto the couch. At which time the Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from kicking her and staff #1. -Staff #1 replied to FC #4's threat to stab her and staff #1 and FC #4 engaged in a verbal back and forth. "Then she's (staff #1) like, 'who you gonna stab? I said, You. She was like, you just a child, you need to stay in a child's place, you being disrespectful.'" -"I told her I was gonna blow up the place or whatever and that's when she (licensee/ED) let me go (released the restraint) ..." - FC #4 left the living room area and retreated to her bedroom. -"I went to my room. I was in my room, I had my door shut. I was looking for my [electronic music device] and [Licensee/ED] opened the door and was asking me what I was doing. [Staff #1] came in (the room), she ran around [Licensee/ED] and came in the room, aggressive like and she was saying, 'you said you was gonna whoop my a*s? Well, whoop my a*s then.' Then we started fighting." -" ...we were fighting, It was a fight. I hit her first, then she hit me. It was a fight, it wasn't no restraint." -FC #4 was hit in the head by staff #1 but she did not know how many times staff #1 hit her. "I don't know, we were just swinging (hitting) on each other."	V 132		

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V 132	Continued From page 17 Interview on 7-18-25 with client #1 revealed: -On 7-8-25, FC #4 was in her room listening to her music. She was refusing to take her medications and do her chores because she was upset about not being able to talk to her sister. -"When I saw them, [Licensee/ED] had [FC #4's] hand, like she was holding her hand and [Licensee/ED] was in front (walking in front of FC #4) and [FC #4] was walking behind her." -"They (FC #4 and the Licensee/ED went to the dining room and [FC #4] did some chores but she didn't do them all. Then [Licensee/ED] tried to put [FC #4] in a restraint, they fell on the floor and [Licensee/ED] sat on her (FC #4) ...She (Licensee/ED) didn't have her full weight on her (FC #4). It was more like she was straddling her. Around her waist, like [Licensee/ED's] legs were straddling [FC #4's] waist." -FC #4 was allowed to call her grandmother but FC #4 was still upset and she was being "disrespectful" (cursing) at her grandmother. -"While she was talking to her grandma, [Staff #1] butted in ...[staff #1] told her to stop cussing and being disrespectful to her grandma and [FC #4] didn't like that. They (staff #1 and FC #4) started cussing each other out. [FC #4] told [staff #1] to shut the f**k up, [FC #4] called [staff #1] a b***h, [staff #1] called [FC #4] a b***h." -Client #1 left the room at that point and went to take a shower. When she exited the shower the Licensee/ED was in the hallway in front of FC #4's door talking to FC #4. "[Staff #1] came around [Licensee/ED] and ran in the room. She was kind of like taunting her (FC #4), telling her (FC #4) to go ahead and beat her a*s like she said she was going to do." -Staff #1 and FC #4 began to fight. "They were hitting each other." -FC #4 was pulling staff #1's hair and hitting her in her head and face and staff #1 was hitting FC	V 132		

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#4 in her head and chest.
-"[Staff #2] and [Licensee/ED] got them apart. Staff "2 told [staff #1] 'you shouldn't have hit her (FC #4).'"

Interview on 7-18-25 with client #2 revealed:
-7-8-25, "[FC #4] didn't want to take meds. [Licensee/ED] was talking to her and telling her she had to take her meds. She (FC #4) said no. She (FC #4) was cussing out staff (Licensee/ED). Another staff (staff #1) butted in and started talking smack (arguing with FC #4) and they got into a fight. [FC #4] said 'b***h, I'm gonna stab you and [staff #1] was like b***h, I'll stab you. [FC #4] said, I'll drown your son, I'll drown you and [staff #1] was, like 'well do it then.'"
-"[FC #4] didn't want to fight. She (FC #4) tried to go to her room, she didn't want to fight. It was [staff #1]. [Licensee/ED] was handling it."
-"[Staff #1] went in her room and was hitting her. [FC #4] was holding [staff #1's] head and hitting her and [staff #1] was hitting [FC #4] in her head and on her shoulders."

Interview on 7-16-25 with staff #1 revealed:
-On 7-8-25, FC #4 refused to complete her chore for the night and instead went to her room, shut her door and turned on her music "real loud."
-Staff #2 asked her (FC #4) to finish her chores and FC #4 responded "I'm not doing any f*****g thing."
-Staff #2 call the Licensee/ED for assistance and when she arrived she allowed FC #4 to call her grandmother. FC #4 was cursing and being disrespectful to her grandmother and staff #1 said, "[FC #4] that's real disrespectful (cursing at grandmother). She was like 'b***h, if you touch me I'll stab you.'"
-Staff #1 denied she cursed at FC #4. "No, I never cursed her. I was trying to process with her

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to get her to calm down."
-The Licensee/ED looped her hands through FC #4's arms to restrict her movement. The Licensee/ED released FC #4 from the hold after FC #4 threatened to "blow up" the group home.
-FC #4 ran back to her room and staff #1 and the Licensee/ED believed she was going to retrieve a weapon so they followed FC #4 to her room.
-"She (FC #4) was digging (looking) in her book bag. She had pulled something out of the blue bag or whatever and I tried to grab it and that's when me and her got into an altercation (FC #4) grabbed staff #1's hair and began hitting her in her head and face)."
-Staff #1 denied hitting FC #4. " ...she still had a hold of my hair ...She was hitting me in the head and like scratching me on my hands and stuff."

Interview on 7-16-25 with staff #2 revealed:
-7-8-25, "[FC #4] didn't want to do her chores. She went in her room and shut the door with the music playing."
-Staff #2 called the Licensee/ED and she (Licensee/ED) returned to the facility to assist with getting FC #4 with doing chores and taking her medications.
-The Licensee/ED told her (FC #4) she had to take her medications. "She (FC #4) was just like 'she's not taking no medicine.' She's blessing (cursing) everybody (staff #1, #2 and the Licensee/ED) out, refusing medicine, walking off and she is just being disrespectful."
-The Licensee/ED call FC #4's grandmother to see if grandmother could talk FC #4 into taking her medications. "[FC #4] was cussing them out, yelling, kicking, being forceful."
-"FC #4 started arguing with staff #1. "They were cussing each other out ..."
-FC #4 threatened to stab staff #1 then walked to her room. "[Staff #1] was like, 'if you gonna stab

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V 132	Continued From page 20 me 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 and take some meds. "Again, she said 'I don't	V 132		

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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. I'm 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 denies sitting on FC #4 to force her to take 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***h down. I'll have somebody to come in here and do it.'"
-FC#4 walks back towards her room and the Licensee/ED calls 911
-FC #4 goes to her bedroom and client #2 tells the Licensee/ED that FC #4 has a pair of scissors. "Once she (client #2) said that (FC #4

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V 132	Continued From page 22 had scissors), I automatically, immediately go back to see her in her room..." -The Licensee/ED goes to FC #4's room peeks through the door and observes FC #4 going through her closet in her room looking for something. Licensee/ED goes in the room and asks FC #4 what she is doing. As she is talking to FC #4 staff #1 comes in the room. FC #4 grabs staff #1's hair and starts punching her in her face. -"I grab [FC #4], [staff #2] grabs staff #1 and we are trying to pull FC #4 off of [staff #1]." -The Licensee denied seeing staff #1 hit FC #4. -"Yeah, some of her (staff #1) language was inappropriate. I didn't hear her cursing at [FC #4] but she was engaging with her inappropriately. That's why I told her (staff #1) to leave, go outside, go home. But I thought it was just that moment, in the heat of the moment."	V 132		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental	V 293		

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V 293	Continued From page 23 disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the coordination of care	V 293		

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with other individuals and agencies within the child or adolescents system of care affecting 1 of 1 clients (FC #4). The findings are:

Review on 7-15-25 of FC #4's record revealed:
-Date of admission: 4-1-25.
-Age: 15.
-Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct.

Review of the North Carolina Incident Response Improvement System for 4-1-25 to 7-8-25 revealed the following:
-IRIS report submitted on 4-11-25 for an incident involving FC #4 on 4-9-25: FC #4 allowed a peer to use her Electronic music device and the peer misplaced the device. FC #4 got upset becaue of the missing device. Staff allowed FC #4 to sit on the back patio to allow her to calm down. "Client FC #4 sat on the back porch for about 20 mins (minutes) while staff constantly check on client. once staff went to tell the client to come back into the home client was no longer sitting on the porch. One staff went and look for the client while the other staff stayed with the other clients. once client could not be found in the neighborhood. 911 was contacted an hour and half later client returned high. Police question the client and ask did she need to go to hospital client decline."

Review on 7-18-25 of FC #4's progress notes for 4-1-25 to 7-8-25 revealed:
-4-9-25 note documented the following: "Upon arrival (on shift) client (FC #4) went on a walk to relieve some stress. Then came back inside to have snack at 1pm...Client did chores and took a nap. Client woke up and helped with dinner. Then shortly after decided she wanted to just facility. I

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V 293	Continued From page 25 then called an began to search for client. She later returned around 7pm with suspicion client was high and was acting very abnormal." -4-10-25 note documented the following: Upon arrival client was eating lunch and shortly after had 1pm snack. Then client informed me that she wasn't feeling well. I believe she doesn't know what drug she incantered (encountered)..." Interview on 7-15-25 with the Licensee/Executive Director revealed: -On 4-9-25 FC #4 was absent without leave from the facility for approximately 1 and 1/2 to 2 hours. Facility staff contacted the police and the client was returned to the home by the local police at which time it was suspected that FC #4 was "high" (under the influence of drugs or alcohol) on an unknown drug. -Facility staff failed to follow up with medical care or a drug screen for FC #4 to determine if FC #4 was under the influence. -"I don't know if she was high. She (FC #4) didn't tell us she was high. The police was the one that said she was high. The police asked her if she wanted to go to the hospital and she refused so we didn't take her (to the hospital. That's her right, she has the right to refuse to medical care. I didn't think we could make her go to the hospital if she refused to go. We monitored her the rest of the night and she was ok. She went to bed and slept for the rest of the night."	V 293		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent	V 300		

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V 300	Continued From page 26 from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a service planning meeting was held within 5 business days of an emergency discharge affecting 1 of 1 clients, former client	V 300		

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V 300	Continued From page 27 (FC) #4. The findings are: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of Discharge: 7-8-25. -Age: 15. -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. Review on 7-15-25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -Report submitted on 7-9-25 documenting the following: "After initially refusing medication, [FC #4] threatened to "blow up" the entire group home (facility) along with threatening to stab a staff member (staff #1) as well. We (Licensee/Executive Director/ED) contacted emergency services when [FC #4] began to threaten staff (staff #1) and make other homicidal threats. We also contacted [FC #4's] grandmother to convince her (FC #4) of the importance of taking her medicine but she continued to threaten staff and refuse medication. After running to her room to retrieve what [FC #4] said was "something to stab the staff member with,' [FC #4] staff attempted to restrain her from going into the closet and retrieving the potential weapon. Client (FC #4) was sent to [local hospital] to be evaluated." Review on 8-6-25 of an email dated 7-8-25 at 6:31pm from the associate professional (AP) sent to FC #4's Department of Social Services (DSS) guardian, her Local Management Entity/LME care coordinator and her therapist documenting the following: " Hello Everyone, Effective 7/8/25, [FC #4] for health and safety	V 300		

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V 300	Continued From page 28	V 300		

reasons is being immediately discharged from Aubrey's Safe Haven. After initially refusing medication, [FC #4] threatened to "blow up" the entire group home (facility) along with threatening to stab a staff member as well. We contacted emergency services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4] grandmother to convince her of the importance of taking her medicine but she continued to threaten staff and refuse medication. After running to her room to retrieve what [FC #4] said was "something to stab the staff member with", [FC #4] and the staff member (staff #1) got into a physical altercation once the staff attempted to restrain her from going into the closet and retrieving the potential weapon. CPI measures was taken due to safety of others and herself.
Please let me know if there are any questions or concerns."

Interview on 8-6-25 with the AP revealed:
-The AP sent an email on 7-8-25 notifying FC #4's team (legal guardian, LME care coordinator, therapist) of FC #4's immediate discharge due to refusing to take her medications and threatening to stab staff #1 and blow up the facility.
-"Yes, we (AP and Licensee/ED) sent several emails after that to various team members trying to check on [FC #4] and trying to arrange a meeting. I have them (emails) on my phone. I can forward them to you."
-No follow up emails from the AP to FC #4's DSS guardian or LME care coordinator was received by survey exit.

Interview on 7-15-25 with the Licensee/ED revealed:
-FC #4 was given an immediate discharge on 7-8-25 due to threatening to stab staff #1 and

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threatening to "blow up the group home (facility)."
-She and the AP attempted to call FC #4's DSS guardian on 7-8-25 to inform her of the immediate discharge however the legal guardian did not answer her call nor return messages she left for the DSS guardian.
-"We, me and the AP tried several times on 7-8-25 and 7-9-25 to reach [FC #4's] DSS guardian but no one returned our calls or responded to emails."
-"We, (AP and Licensee/ED) have the emails where we were reaching out. I'll send them to you."
-No follow up emails from the Licensee/ED to FC #4's DSS guardian or LME care coordinator was received by survey exit.

Interview on 7-16-25 with FC #4's DSS guardian revealed:
-On 7-9-25 when she arrived at her office she reviewed an email from the provider informing her of the immediate discharge (FC #4).
-"That morning (7-9-25) when I got up I had seen a [local hospital] number up there (providers location) and I called them (local hospital) but I didn't know who the client was or who had called me. But when I got in (the office) I seen the e-mail from [Licensee/ED] and I seen that [Licensee/ED] text me at 9:09pm (7-8-25) stating that they (emergency medical services) took her (FC #4) to [local behavioral health unit]..."
-"The e-mail said that [FC #4] ended up getting into a physical altercation with one of the staff (staff #1). When the staff tried to restrain her, they (Licensee/ED) said [FC #4] said she was gonna 'blow up the facility' and that she was gonna 'stab the staff.' She (Licensee/ED) said her (FC #4) and her staff ended up getting into a physical altercation. I think she (FC #4) was trying to go to the closet to get something. That's all I

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V 300	Continued From page 30 got, that's what I got in the e-mail." -"I haven't heard anything else from Aubrey's Safe Haven. No one had reached out to me for anything since I got that email."	V 300		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify Health Care Personnel Registry (HCPR) within 24 hours of learning of allegations of abuse affecting 1 of 1 staff (Licensee/Executive Director (ED). The findings are: Review on 7-15-25 of the Licensee/ED record revealed: -Date of hire: 8-9-2022. -Job Title: Executive Director	V 318		

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V 318	Continued From page 31 Review on 7-22-25 of the facility records revealed: -A HCPR 24 hour initial report documenting allegations that the Licensee/ED abused FC #4 by sitting on FC #4 and suffocating FC #4 with a pillow due to FC #4 refusing to take her medications. Review on 7-11-25 and 7-15-25 of the North Carolina Incident Response Improvement System revealed: -No documentation of a report submitted documenting the allegations that the Licensee/ED abused FC #4 by against the Licensee/ED. Interview on 7-22-25 with the Licensee/ED revealed: -She was not aware of the allegation against her until she spoke with the Department of Social Services investigator on 7-15-25. -"DSS came before you (Division of Health Service Regulations (DHSR) got here (facility). I didn't know that I was named in the allegation until she showed up and told me. I did the 24 hour report after she told me I was named in the allegation." Interview on 8-7-25 with staff #2 revealed: -DSS came to the facility on 7-10-25. -"She (DSS) said the allegations were that [Licensee/ED] sat on her (FC #4) and tried to suffocate her (FC #4) and she (DSS) just mainly said something (discussed allegations) about [Licensee/ED]. She (DSS) didn't say anything about staff #1. She (DSS) said that [Licensee/ED]t sat on her (FC #4) and suffocated her and was trying to force the medicine in her mouth and that wasn't true." -"Yeah she spoke to all of us (staff and clients)	V 318		

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V 318	Continued From page 32 that day. I think she (DSS) called [Licensee/ED] and told her about the allegations." Interview on 8-7-25 with staff #3 revealed: -"Yeah she (DSS) just kind of showed up (7-10-25), asked some questions. She interviewed the staff, the kids (clients) the Associate Professional (AP), [Licensee/ED]. Interview on 8-7-25 with DSS investigator revealed: -I went to the group home on 7-10-25 she wasn't there but her employees (staff #2 and staff #3) were. I actually spoke to her (Licensee/ED) on the phone. When I talked to her (Licensee/ED) she was telling me about the allegations, she already knew why I was out there."	V 318		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	V 366		

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V 366	Continued From page 33 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;	V 366		

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V 366	Continued From page 34 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II and III incidents as required. The findings are:

Review on 7-15-25 of FC #4's person centered plan updated on 4-30-25 documenting the following: "The client (FC #4) has refused medication on occasion (unknown dates) due to anger."

Review on 8-6-25 a 911 print out to the facility revealed:
-5-24-25: FC #4 absent without leave from the facility (AWOL).

Review on 7-11-25 of the facility records revealed no documentation of FC #4's medication refusal (unknown dates). No documentation of FC #4's AWOL on 5-25-25.

Interview on 7-16-25 with FC #4 revealed:
-"Yeah, I've refused my meds (medications) before. I don't know (refused meds). I just didn't feel like taking them, and I told them (staff) I wasn't taking them, and I didn't."
-"No, when I refused, I didn't take none of them (meds). I don't know (how many times she refused), a couple of times, twice or maybe 3 times."

Interview on 7-16-25 with staff #2 revealed:
-There had been a few (unknown number) occasions that FC #4 had refused her medications.
-"She (FC #4) has never refused meds for me.

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V 366	Continued From page 36 But she had refused to take her meds for other staff." -Interview on 7-15-25 with the Licensee/ED revealed: -"The clients always take they meds. We (facility) don't have refusals. That is a part of our program. They (clients) can't refuse (medications). That's grounds for immediate discharge. They have to take their medicine. We explain that (medication protocol) to them when they are admitted, you have to take your meds or you will be discharged. We have that in our admission packet. The only time [FC #4] refused her meds was the day the incident happened (7-8-25). The day before (7-7-25) she was refusing that morning but she eventually took the meds after she got to the day program, so that wasn't a refusal." Interview on 7-16-25 with FC #4's DSS guardian revealed: -FC #4's medication refusals had been discussed during her monthly Child and Family Team Meetings by the LP and the Licensee/ED.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of	V 367		

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becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III

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V 367	Continued From page 38 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents to the Local Management Entity (LME)/Managed Care	V 367		

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V 367	Continued From page 39 Organization (MCO) in the catchment area within 72 hours of becoming aware of the incident. The findings are: Review on 8-6-25 a 911 print out to the facility revealed: -5-24-25: FC #4 absent without leave from the facility (AWOL). Review on 8-6-25 a 911 print out to the facility revealed: -5-24-25: FC #4 absent without leave from the facility (AWOL). Review on 7-15-25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation of three restraints the Licensee/ED placed FC #4 in on 7-8-25. Interview on 7-15-25 and 8-6-25 with the Licensee/ED revealed: -She is responsible for completing the IRIS reports. -"I have all the IRIS. I'm big on documentation. I make sure all the IRIS's are submitted. I'll send it to you." -No documentation of an AWOL incident for FC #4 was received by survey exit.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected	V 500		

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abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and
(2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.
(c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:
(1) any restrictive intervention that is prohibited from use within the facility; and
(2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.
(d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:
(1) the permitted restrictive interventions or allowed restrictions;
(2) the individual responsible for informing the client; and
(3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.
(e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:
(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to

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V 500	Continued From page 41 provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse were reported to the county Department of Social Services (DSS). The findings are: Review on 7-15-25 of facility records revealed: -No documentation of the allegation that the Licensee/ED abused FC #4 by sitting on FC #4, and suffocating her with a pillow. -No documentation of the allegation that the Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from moving. -No documentation of the allegation that staff #1 verbally abused FC #4 by calling FC #4 a b***h and threatening to 'beat' FC #4's 'a*s.' -No documentation of the allegation that staff #1 physically abused FC #4 by hitting FC #4 in her head, shoulders and chest. Interview on 7-16-25 with FC #4 revealed. -FC #4 was upset because her Department of Social Services guardian would not allow her to talk to her biological sister. When asked by staff #1 and #2, she refused to take her evening	V 500		

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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). 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 sat on me and kept telling me I had to take my meds."

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V 500	Continued From page 43 -"She was like, 'if you don't take these meds you are going to the hospital. She said 'if you don't take these meds you are going somewhere you can't refuse.'" -The Licensee/ED called FC #4's grandmother to have the grandmother talk to FC #4 into taking her medicine and completing her chores but FC #4 remained upset and was cursing and being "disrespectful" to the grandmother. -Staff #1 interrupted FC #4's conversation with her grandmother and told her to 'stop being disrespectful' (cursing at grandmother). At which point FC #4 replied to staff #1, "leave me alone, stop talking to me. I said b***h stop talking to me." -Staff #1 walked towards FC #4 to restrain her. "She ran up on me. She (staff #1) was trying to put me in a restraint. I said if you touch me, I'm a (going to) stab you." -The Licensee/ED grabbed the phone from FC #4 and hung up on the grandmother and put FC #4 in a restraint. -The Licensee/ED was behind FC #4 and looped her arms under FC #4's arms to attempt to keep FC #4 from hitting staff #1. As FC #4 struggled to get out of the restraint to fight staff #1 she and the Licensee/ED fell back onto the couch. At which time the Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from kicking her and staff #1. -Staff #1 replied to FC #4's threat to stab her and staff #1 and FC #4 engaged in a verbal back and forth. "Then she's (staff #1) like, 'who you gonna stab? I said, You. She was like, you just a child, you need to stay in a child's place, you being disrespectful.'" -"I told her I was gonna blow up the place or whatever and that's when she (licensee/ED) let me go (released the restraint) ..." -The Licensee/ED released FC #4 from the	V 500		

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restraint at that point in order to call the police due to FC #4 threatening to "blow up the place." FC #4 left the living room area and retreated to her bedroom.
-"I went to my room. I was in my room, I had my door shut. I was looking for my [electronic music device] and [Licensee/ED] opened the door and was asking me what I was doing. [Staff #1] came in (the room), she ran around [Licensee/ED] and came in the room, aggressive like and she was saying, 'you said you was gonna whoop my a*s? Well, whoop my a*s then.' Then we started fighting."
-" ...we were fighting, It was a fight. I hit her first, then she hit me. It was a fight, it wasn't no restraint."
-FC #4 was hit in the head by staff #1 but she did not know how many times staff #1 hit her. "I don't know, we were just swinging (hitting) on each other."

Interview on with client #1 revealed:
-FC #4 was upset because she couldn't talk to her sister.
-"[FC #4] and [staff #1] got into it (fight)."
-"[FC #4] was being disrespectful to her grandma on the phone and [staff #1] told her to stop being S
-"Yeah, they both were swinging on each other. Yeah, [staff #1] was hitting her in her head and chest."
-[Staff #2] and [ED] got them apart. [staff #2] told [staff #1] 'you shouldn't have hit her.'"

Interview on with client #2 revealed:
-"[FC #4] didn't want to take meds. [ED] was talking to her and telling her she had to take her meds. She (FC #4) said no. She (FC #4) was cussing out staff (ED). Another staff (staff #1) butted in and started talking smack (arguing with

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V 500	Continued From page 45 FC #4) and they got into a fight. [FC #4] said 'b***h, I'm gonna stab you and [staff #1] was like b***h, I'll stab you. [FC #4] said, I'll drown your son, I'll drown you and [staff #1] was, like 'well do it then.'" -"[FC #4] didn't want to fight." -[Staff #1] went in her room and was hitting her. [FC #4] was holding [staff #1's] head and hitting her and [staff #1] was hitting [FC #4] in her head and on her shoulders." Interview on 7-16-25 with staff #1 revealed: -FC #4 refused to complete her chore for the night and instead went to her room, shut her door and turned on her music "real loud." -Staff #2 asked her to finish her chores and FC #4 responded "I'm not doing any f*****g thing." -Staff #2 call the Licensee/ED for assistance and when she arrived she allowed FC #4 to call her grandmother . FC #4 was cursing and being disrespectful to her grandmother and staff #1 said, "[FC #4] that's real disrespectful (cursing at grandmother). She was like 'b***h, if you touch me I'll stab you.'" -Staff #1 denied she cursed at FC #4. "No, I never cursed her. I was trying to process with her to get her to calm down." -The Licensee/ED put FC #4 in a restraint but released the restraint after FC #4 threatened to "blow up" the group home (facility). -FC #4 ran back to her room and staff #1 and the Licensee/ED believed she was going to retrieve a weapon so they followed FC #4 to her room. -"She (FC #4) was digging (looking) in her book bag. She had pulled something out of the blue bag or whatever and I tried to grab it and that's when me and her got into an altercation (FC #4 grabbed staff #1's hair and began hitting her in her head and face)." -Staff #1 denied hitting FC #4. " ...she still had a	V 500		

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V 500	Continued From page 46 hold of my hair ...She was hitting me in the head and like scratching me on my hands and stuff." Interview on 7-16-25 with staff #2 revealed: "[FC #4] didn't want to do her chores. She went in her room and shut the door with the music playing." -Staff #2 called the Licensee/ED and she returned to the facility to assist with getting FC #4 with doing chores and taking her medications. -The Licensee/ED told her she had to take her medications. "She (FC #4) was just like 'she's not taking no medicine.' She's blessing (cursing) everybody (staff #1, #2 and the Licensee/ED) out, refusing medicine, walking off and she is just being disrespectful." -The Licensee/ED call FC #4's grandmother to see if grandmother could talk FC #4 into taking her medications. "[FC #4] was cussing them out, yelling, kicking, being forceful." -FC #4 started arguing with staff #1." They were cussing each other out ..." I can't remember what all they were saying to each other." -FC #4 threatened to stab staff #1 then walked to her room. "Staff #1 was like, 'if you gonna stab me 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. [FC #4] was	V 500		

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V 500	Continued From page 47 saying to [staff #1] ...you are a child, you're a chap (child), you need to learn how to stay in a chaps' 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 8-6-25 with the Associate Professional revealed: -"Me, the QP (Qualified Professional) and [Licensee/ED] we handle investigations like a team. No one person is assigned to any task. [Licensee/ED] will delegate responsibilities. Like she might say, you (AP) do the interviews, [QP] do this or that and she will do her part. I guess since she is the owner/ED she is ultimately responsible but generally we handle things as a team." Interview on 7-15-25 and 8-6-25 with the Licensee/ED revealed: -The Licensee/ED did not complete a report to the local DSS because she was not aware of the reporting rule to DSS. -"They (DSS) knew about the allegation. That's how I found out about the allegation is when DSS showed up." -She (DSS) told me about the allegation when she showed up on the 15th (7-15-25). But she only told me about the allegations against me. She never mentioned anything about [staff #1]. It was all about me (Licensee/ED)."	V 500		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance	V 512		

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V 512	Continued From page 48 with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record reviews and interviews, 2 of 2 audited staff (Licensee/Executive Director (ED) and staff #1) abused 1 of 1 clients (former client (FC #4) and 1 of 2 audited staff (Licensee/ED) neglected 1 of 1 clients (FC #4). The findings are: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of discharge: 7-8-25. -Age: 15 years. -Diagnoses: Post-Traumatic Stress Disorder (PTSD); Attention Deficit Hyperactive Disorder (ADHD); Oppositional Defiant Disorder (ODD); Adjustment Disorder with Mood and Conduct.	V 512		

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V 512	Continued From page 49 Review on 7-15-25 of staff #1's record revealed: -Date of hire: 3-25-25. -Job title: Direct Support Professional, Review on 7-15-25 of the Licensee/ED's record revealed: -Date of hire: 8-9-22. -Job Title: Executive Director. Review on 7-15-25 of the North Carolina Incident Response Improvement System (IRIS) for the period of 4-1-25 to 7-8-25 revealed: -Documentation of an incident that occurred on 7-8-25: "After initially refusing medication, [FC #4] threatened to 'blow up' the entire group home along with threatening to stab a staff member (staff #1) as well. We contacted emercy (emergency) services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4] grandmother to convince her (FC #4) of the importance of taking her medicine but she continued to threaten staff and refuse medication. After running to her (FC #4) room to retrieve what [FC #4] said was 'something to stab the staff member with,' [FC #4] staff attempted to restrain her from going into the closet and retrieving the potential weapon. Client (FC #4) was sent to [neighboring town] hospital to be evaluated." Interview on 7-16-25 with FC #4 revealed: -On 7-8-25 FC #4 was upset because her Department of Social Services guardian would not allow her to talk to her biological sister. -FC #4 refused to take her evening medications and complete her assigned chores for the evening. -Staff #2 called the Licensee/ED to return to the facility to assist with getting FC #4 to take her	V 512		

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medications and complete her chores.
-FC #4 went to her room, closed the door and began 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). 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 (administer) 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.'"
-"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 sat on me and kept telling me I had to take my meds."
-"She (Licensee/ED) was like, 'if you don't take these meds you are going to the hospital.' She said 'if you don't take these meds you are going somewhere you can't refuse.'"
-The Licensee/ED called FC #4's grandmother to have the grandmother talk to FC #4 into taking her medicine and completing her chores but FC

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V 512	Continued From page 51 #4 remained upset and was cursing and being 'disrespectful' to the grandmother. -Staff #1 interrupted FC #4's conversation with her grandmother and told her to 'stop being disrespectful' (cursing at grandmother). At which point FC #4 replied to staff #1, 'leave me alone, stop talking to me. I said b***h stop talking to me." -"She (staff #1) ran up on me (Staff #1 walked towards FC #4). She (staff #1) was trying to put me in a restraint. I said if you touch me, I'm a (going to) stab you." -The Licensee/ED grabbed the phone from FC #4 and hung up on the grandmother. -The Licensee/ED was behind FC #4 and looped her arms under FC #4's arms to attempt to keep FC #4 from hitting staff #1. As FC #4 struggled with the Licensee/ED, she (FC #4) and the Licensee/ED fell back onto the couch. At which time the Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from kicking her and staff #1. -Staff #1 replied to FC #4's threat to stab her and staff #1 and FC #4 engaged in a verbal back and forth. "Then she's (staff #1) like, 'who you gonna stab? I said, You. She was like, you just a child, you need to stay in a child's place, you being disrespectful.'" -"I told her I was gonna blow up the place or whatever and that's when she (licensee/ED) let me go (released the restraint) ..." - FC #4 left the living room area and retreated to her bedroom. -"I went to my room. I was in my room, I had my door shut. I was looking for my [electronic music device] and [Licensee/ED] opened the door and was asking me what I was doing. [Staff #1] came in (the room), she ran around [Licensee/ED] and came in the room, aggressive like and she was saying, 'you said you was gonna whoop my a*s?	V 512		

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Well, whoop my a*s then.' Then we started fighting."
-" ...we were fighting, It was a fight. I hit her first, then she hit me. It was a fight, it wasn't no restraint."
-FC #4 was hit in the head by staff #1 but she did not know how many times staff #1 hit her. "I don't know, we were just swinging (hitting) on each other."

Interview on 7-18-25 with client #1 revealed:
-On 7-8-25, FC #4 was in her room listening to her music. She was refusing to take her medications and do her chores because she was upset about not being able to talk to her sister.
-"When I saw them, [Licensee/ED] had [FC #4's] hand, like she was holding her hand and [Licensee/ED] was in front (walking in front of FC #4) and [FC #4] was walking behind her."
-"They (FC #4 and the Licensee/ED went to the dining room and [FC #4] did some chores but she didn't do them all. Then [Licensee/ED] tried to put [FC #4] in a restraint, they fell on the floor and [Licensee/ED] sat on her (FC #4) ...She (Licensee/ED) didn't have her full weight on her (FC #4). It was more like she was straddling her. Around her waist, like [Licensee/ED's] legs were straddling [FC #4's] waist."
-FC #4 was allowed to call her grandmother but FC #4 was still upset and she was being "disrespectful" (cursing) at her grandmother.
-"While she was talking to her grandma, [Staff #1] butted in ...[staff #1] told her to stop cussing and being disrespectful to her grandma and [FC #4] didn't like that. They (staff #1 and FC #4) started cussing each other out. [FC #4] told [staff #1] to shut the f**k up, [FC #4] called [staff #1] a b***h, [staff #1] called [FC #4] a b***h."
-Client #1 left the room at that point and went to take a shower. When she exited the shower the

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V 512	Continued From page 53 Licensee/ED was in the hallway in front of FC #4's door talking to FC #4. "[Staff #1] came around [Licensee/ED] and ran in the room. She was kind of like taunting her (FC #4), telling her (FC #4) to go ahead and beat her a*s like she said she was going to do." -Staff #1 and FC #4 began to fight. "They were hitting each other." -FC #4 was pulling staff #1's hair and hitting her in her head and face and staff #1 was hitting FC #4 in her head and chest. -"[Staff #2] and [Licensee/ED] got them apart. Staff "2 told [staff #1] 'you shouldn't have hit her (FC #4).'" Interview on 7-18-25 with client #2 revealed: -7-8-25, "[FC #4] didn't want to take meds. [Licensee/ED] was talking to her and telling her she had to take her meds. She (FC #4) said no. She (FC #4) was cussing out staff (Licensee/ED). Another staff (staff #1) butted in and started talking smack (arguing with FC #4) and they got into a fight. [FC #4] said 'b***h, I'm gonna stab you and [staff #1] was like b***h, I'll stab you. [FC #4] said, I'll drown your son, I'll drown you and [staff #1] was, like 'well do it then.'" -"[FC #4] didn't want to fight. She (FC #4) tried to go to her room, she didn't want to fight. It was [staff #1]. [Licensee/ED] was handling it." -"[Staff #1] went in her room and was hitting her. [FC #4] was holding [staff #1's] head and hitting her and [staff #1] was hitting [FC #4] in her head and on her shoulders." Interview on 7-16-25 with staff #1 revealed: -On 7-8-25, FC #4 refused to complete her chore for the night and instead went to her room, shut her door and turned on her music "real loud." -Staff #2 asked her (FC #4) to finish her chores and FC #4 responded "I'm not doing any f*****g	V 512		

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thing."
-Staff #2 call the Licensee/ED for assistance and when she arrived she allowed FC #4 to call her grandmother. FC #4 was cursing and being disrespectful to her grandmother and staff #1 said, "[FC #4] that's real disrespectful (cursing at grandmother). She was like 'b***h, if you touch me I'll stab you.'"
-Staff #1 denied she cursed at FC #4. "No, I never cursed her. I was trying to process with her to get her to calm down."
-The Licensee/ED looped her hands through FC #4's arms to restrict her movement. The Licensee/ED released FC #4 from the hold after FC #4 threatened to "blow up" the group home.
-FC #4 ran back to her room and staff #1 and the Licensee/ED believed she was going to retrieve a weapon so they followed FC #4 to her room.
-"She (FC #4) was digging (looking) in her book bag. She had pulled something out of the blue bag or whatever and I tried to grab it and that's when me and her got into an altercation (FC #4) grabbed staff #1's hair and began hitting her in her head and face)."
-Staff #1 denied hitting FC #4. " ...she still had a hold of my hair ...She was hitting me in the head and like scratching me on my hands and stuff."

Interview on 7-16-25 with staff #2 revealed:
-7-8-25, "[FC #4] didn't want to do her chores. She went in her room and shut the door with the music playing."
-Staff #2 called the Licensee/ED and she (Licensee/ED) returned to the facility to assist with getting FC #4 with doing chores and taking her medications.
-The Licensee/ED told her (FC #4) she had to take her medications. "She (FC #4) was just like 'she's not taking no medicine.' She's blessing (cursing) everybody (staff #1, #2 and the

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V 512	Continued From page 55 Licensee/ED) out, refusing medicine, walking off and she is just being disrespectful." -The Licensee/ED call FC #4's grandmother to see if grandmother could talk FC #4 into taking her medications. "[FC #4] was cussing them out, yelling, kicking, being forceful." -"FC #4 started arguing with staff #1. "They were cussing each other out ..." -FC #4 threatened to stab staff #1 then walked to her room. "[Staff #1] was like, 'if you gonna stab me 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).'"	V 512		

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V 512	Continued From page 56 -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 and take some meds. "Again, she said 'I don't 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. I'm 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 denies sitting on FC #4 to force her to take 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	V 512		

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V 512	Continued From page 57 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***h down. I'll have somebody to come in here and do it.'" -FC#4 walks back towards her room and the Licensee/ED calls 911 -FC #4 goes to her bedroom and client #2 tells the Licensee/ED that FC #4 has a pair of scissors. "Once she (client #2) said that (FC #4 had scissors), I automatically, immediately go back to see her in her room..." -The Licensee/ED goes to FC #4's room peeks through the door and observes FC #4 going through her closet in her room looking for something. Licensee/ED goes in the room and asks FC #4 what she is doing. As she is talking to FC #4 staff #1 comes in the room. FC #4 grabs staff #1's hair and starts punching her in her face. -"I grab [FC #4], [staff #2] grabs staff #1 and we are trying to pull FC #4 off of [staff #1]." -The Licensee denied seeing staff #1 hit FC #4. -"Yeah, some of her (staff #1) language was inappropriate. I didn't hear her cursing at [FC #4] but she was engaging with her inappropriately. That's why I told her (staff #1) to leave, go outside, go home. But I thought it was just that moment, in the heat of the moment." Review on 8-8-25 of the facility's Plan of Protection dated 8-8-25 and written by the Licensee/ED revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Aubrey's Safe Haven immediately removed staff from location, then did an investigation on the incident at hand, spoke with clients that were in the home at the time of the incident for safety concerns. De-escalation policy was reviewed per	V 512		

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staff and the AP (associate professional) suspended the staff for having a verbal altercation with a client that became physical. Staff have a mandatory de-escalation training and CPI intervention on 8-13-25.

Describe your plans to make sure the above happens:
"Aubrey's Safe Haven house manager and AP will work with the staff for 30 days to make sure the staff is utilizing the methods that was taught on 8-13-25. After the 30 days the staff will be monitored over time to make sure the incident doesn't occur again.

The facility served clients between the ages of 13 and 15 with diagnoses that included ADHD, PTSD, ODD and Adjustment Disorder. On 7-8-25 FC #4 was upset because she could not talk to her sister and refused to take her medications and complete her evening chores. Staff #1 and FC #4 got into a verbal argument and staff #1 verbally abused FC #4 by cursing at FC #4, calling FC #4 a child and telling FC #4 she needed to stay in a child's place. Staff #1 taunted FC #4 into a physical fight by telling her to 'go ahead, whoop my a*s which caused FC #4 to grab staff #1 by the hair and punch her in her face. Staff #1 and FC #4 got into a physical fight and staff #1 physically abused FC #4 by hitting her in her head, shoulder and chest area. The Licensee/ED attempted an intervention to stop the fight however during the struggle of the fight, FC #4 fell on the floor and the Licensee/ED used her legs to straddled FC #4's waist in an attempt to force FC #4 to take medications. During a second and third restraint the Licensee/ED wrapped her legs around FC #4's legs which prevented FC #4 from moving. The Licensee/ED neglected FC #4 by her failure to intervene and

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V 512	Continued From page 59 and stop the verbal abuse of staff #1 towards FC #4 before the verbal abuse elevated into a physical fight between staff #1 and FC #4. This deficiency constitutes a Type A1 rule violation for serious abuse and neglect and must be corrected within 23 days.	V 512		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of	V 521		

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V 521	Continued From page 60 restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the necessary documentation was in the client record when a restrictive intervention was utilized affecting 1 of 1 audited client former client #4 (FC #4). The findings are: Review on 7-15-25 of FC #4 record revealed: -Date of admission: 4-1-25. -Date of Discharge: 7-8-25. -Age: 15. -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. Review on 7/15/25 of the facility's Incident Reports dated 4-1-25 to 7-8-25 revealed: -Documentation of an incident that occurred on 7-8-25: "After initially refusing medication, [FC #4] threatened to "blow up" the entire group home (facility) along with threatening to stab a staff member (staff #1) as well. We contacted emergency services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4] grandmother to convince her of the importance of taking her medicine but she continued to threaten staff and	V 521		

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V 521	Continued From page 61 refuse medication. After running to her room to retrieve what [FC #4] said was "something to stab the staff member with", [FC #4]l staff attempted to restrain her from going into the closet and retrieving the potential weapon. Client was sent to [neighboring town] hospital to be evaluated." Review on 7/15/25 and 8-6-25 of facility records revealed: -No notation of the clients physical and psychological well being. -No notation of the frequency, intensity, and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior. -The rationale for the use of the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used. -No notion of the description of the restrictive intervention, or the date, time, and duration of its use. -No notion of a description of accompanying positive methods of intervention. -No notion of debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions. -No description of the debriefing and planning with the clients and their legally responsible person for the planned use of seclusion, physical restraint or isolation time out if determined to be clinically necessary and -No documentation of the signature and title of the facility employee who initiated the use of the restrictive interventions.	V 521		

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V 521	Continued From page 62 Interview on 8-6-25 with the Licensee/ED revealed: -She was unaware that the above information needed to be documented. -"I will update the log and make sure that all that information is documented in the future."	V 521		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall	V 524		

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V 524	Continued From page 63 satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. 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: Review on 7-15-25 of FC #4's record revealed: -Date of admission: 4-1-25. -Date of Discharge: 7-8-25. -Age: 15. -Diagnoses: Post-Traumatic Stress Disorder; Attention Deficit Hyperactive Disorder; Oppositional Defiant Disorder; Adjustment Disorder with Mood and Conduct. Review on 7/15/25 of the facility's Incident Reports dated 4-1-25 to 7-8-25 revealed: -Documentation of an incident that occurred on 7-8-25: "After initially refusing medication, [FC #4] threatened to "blow up" the entire group home (facility) along with threatening to stab a staff	V 524		

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V 524	Continued From page 64	V 524		

member (staff #1) as well. We contacted emergency services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4] grandmother to convince her of the importance of taking her medicine but she continued to threaten staff and refuse medication. After running to her room to retrieve what [FC #4] said was "something to stab the staff member with", [FC #4]l staff attempted to restrain her from going into the closet and retrieving the potential
weapon. Client was sent to [neighboring town] hospital to be evaluated."

Review on 8-6-25 of an email dated 7-8-25 at 6:31pm from the Associate Professional (AP) sent to FC #4's DSS guardian, her Local Management Entity (LME) care coordinator and her therapist documenting the following:
" Hello Everyone,
Effective 7/8/25, [FC #4] for health and safety reasons is being immediately discharged from Aubrey's Safe Haven. After initially refusing medication, [FC #4] threatened to "blow up" the entire group home (facility) along with threatening to stab a staff member as well. We contacted emergency services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4] grandmother to convince her of the importance of taking her medicine but she continued to threaten staff and refuse medication. After running to her room to retrieve what [FC #4] said was "something to stab the staff member with", [FC #4] and the staff member (staff #1) got into a physical altercation once the staff attempted to restrain her from going into the closet and retrieving the potential weapon. CPI measures was taken due to safety of others and herself.
Please let me know if there are any questions or

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V 524	Continued From page 65 concerns." Interview on 7-16-25 with FC #4 revealed: -FC #4 was put in 2 physical restraints on 7-8-25 by the Licensee/ED "because refused to take my meds and she said I couldn't refuse to take my meds. She told me that I was going to take my meds if she had to make me take my meds. Then she put me in the restraint." -"Then the other one (restraint) was when [staff #1] was trying to talk to me and I was walking away and she (Licensee/ED] grabbed me and put me in a restraint." Interview on 8-6-25 and 8-8-25 with the Licensee/ED revealed: -Other than the email sent to FC #4's team (DSS guardian, LME care coordinator, and therapist) there was no verbal communication regarding the restraint on 7-8-25 with any team (Child and Family Team members) member. -"I understand, I should have explained that she (FC #4) was put in a restraint instead of saying "attempted restraint" and (I should have) stated what we (staff) did instead of just saying CPI (Crisis Prevention Intervention) measures were taken." Interview on 7-16-25 with FC #4's DSS Guardian revealed: On 7-9-25 when she arrived at her office she reviewed an email from the provider informing her of the immediate discharge (FC #4). -"That morning (7-9-25) when I got up I had seen a [local hospital] number up there (providers location) and I called them (local hospital) but I didn't know who the client was or who had called me. But when I got in (the office) I seen the e-mail from [Licensee/ED] and I seen that [Licensee/ED] text me at 9:09pm (7-8-25) stating	V 524		

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V 524	Continued From page 66 that they (emergency medical services) took her (FC #4) to [local behavioral health unit]..." -"The e-mail said that [FC #4] ended up getting into a physical altercation with one of the staff (staff #1). When the staff tried to restrain her, they (Licensee/ED) said [FC #4] said she was gonna 'blow up the facility' and that she was gonna 'stab the staff.' She (Licensee/ED) said her (FC #4) and her staff ended up getting into a physical altercation. I think she (FC #4) was trying to go to the closet to get something. That's all I got, that's what I got in the e-mail." -"I haven't heard anything else from Aubrey's Safe Haven. No one had reached out to me for anything since I got that email." She was unaware of any incident of FC #4 being restrained.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client;	V 525		

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V 525	Continued From page 67 (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a log of all restrictive interventions, conduct reviews and reports on any and all use of restrictive interventions including a regular review by a designee of the governing body and review by the Client Rights Committee. The findings are: Review on 8-6-25 of facility records revealed a document titled "Aubrey's Safe Haven Intervention Log." -Only one intervention was documented and included FC #4's name, Date (7-8-25), address of the facility, "reported by: [Licensee/ED], "Witness: [staff #2]." -There was no documentation of the following: -Name of the responsible professional. -Type of intervention. -Duration of intervention. -Reason for use of the intervention.	V 525		

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V 525	Continued From page 68 -Positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used. -Debriefing and planning conducted with the client, legally responsible person, and staff to eliminate or reduce the probability of the future use of restrictive interventions. -Negative effects of the restrictive interventions. Interview on 8-6-25 with the Associate Professional (AP) revealed: -The AP, the Qualified Professional (QP) and the Licensee/Executive Director/ED meet weekly to discuss any incidents that have going on. -"We usually do that Monday morning quarterbacking session where we talk about any incidents. We go through them and discuss what happened, what we did right, what we did wrong, what we could have done better, you if we need to switch up or change anything. " -"We also go over incidents and things in our staff meetings. I'm here a lot so sometimes I will just do like impromptu meetings with the staff that is working." -"Yeah, I'm sure all that is documented somewhere. [Licensee/ED], should have it documented somewhere." Interview on 8-6-25 and 8-8-25 with the Licensee/ED revealed: -She was unaware that the above information needed to be documented. -"I will update the log and make sure that all that information is documented in the future." -"Yes, we (Licensee/ED, AP, QP and staff) we have staff meetings and go over behaviors, incidents, clients with the staff. All that is documented in the staff meeting notes. I can get those for you." -Documentation was not received by survey exit.	V 525		

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V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.	V 537		

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V 537	Continued From page 70 (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.	V 537		

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V 537	Continued From page 71 (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually.	V 537		

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V 537	Continued From page 72 (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews, interviews and observation, 1 of 2 audited staff (Licensee/ED) failed to demonstrate competency during the implementation of restrictive intervention. The findings are: Review on 7-15-25 of the Licensee/ED record revealed: -Date of hire: 8-9-22. -Job Title: Executive Director. -Crisis Prevention Intervention (CPI) training:	V 537		

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V 537	Continued From page 73 3-22-25. Review on 7-15-25 of the North Carolina Incident Response Improvement System (IRIS) for the period of 4-1-25 to 7-8-25 revealed: -Documentation of an incident that occurred on 7-8-25: "After initially refusing medication, [FC #4] threatened to 'blow up' the entire group home along with threatening to stab a staff member (staff #1) as well. We contacted emercy (emergency) services when [FC #4] began to threaten staff and make other homicidal threats. We also contacted [FC #4's] grandmother to convince her (FC #4) of the importance of taking her medicine but she (FC #4)continued to threaten staff and refuse medication. After running to her (FC #4) room to retrieve what [FC #4] said was 'something to stab the staff member with,' [FC #4] staff attempted to restrain her from going into the closet and retrieving the potential weapon. Client (FC #4) was sent to [neighboring town] hospital to be evaluated." Interview on 7-16-25 with FC #4 revealed: On 7-8-25 FC #4 was upset because her Department of Social Services guardian would not allow her to talk to her biological sister. -FC #4 refused to take her evening medications and complete her assigned chores for the evening. -Staff #2 called the Licensee/ED to return to the facility to assist with getting FC #4 to take her medications and complete her chores. -On 7-8-25 FC #4 was in her bedroom with her door closed listening to her electronic music device. The Licensee/ED entered FC #4's room and informed FC #4 that she had to take her medications and complete her chores. FC #4 refused to take her medications. -The Licensee/ED lead FC #4 to the dining room	V 537		

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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) 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 sat on me and kept telling me I had to take my meds."
-FC #4 continued to refuse to take her medications. The Licensee/ED called FC #4's grandmother to have the grandmother talk to FC #4 into taking her medicine and completing her chores but FC #4 remained upset and was cursing and being "disrespectful" to the grandmother.
-Staff #1 walked towards FC #4. "She ran up on me. She (staff #1) was trying to put me in a restraint. I said if you touch me, I'm a (going to) stab you."
-The License/ED got behind FC #4 and looped her arms under FC #4's arms to attempt to keep FC #4 from hitting staff #1. As FC #4 and the Licensee/ED struggled, FC #4 and the Licensee/ED fell back onto the couch, at which time the Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from moving.

Interview on with client #1 revealed:
-On 7-8-25 the[Licensee/ED] was trying to make FC #4 take her meds and FC #4 was refusing. "They (FC #4 and the Licensee/ED) went to the dining room and [FC #4] did some of her chores but she didn't do them all. Then [Licensee/ED] tried to put [FC #4] in a restraint, they fell on the floor and [Licensee/ED] sat on her (FC #4)."
-"No, she didn't have her full weight on her. It was more like she was straddling her, around her waist, like [Licensee/ED's] legs were straddling [FC #4's] waist."

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V 537	Continued From page 75 Interview on 7-16-25 with staff #2 revealed: -7-8-25, FC #4 was upset and refusing to take her medications and do her chores. "She's (FC #4) blessing (cursing) everybody out, refusing medicine, walking off and she is just being disrespectful." -"[Licensee/ED] ended up calling her grandma to see if she could get her grandma to talk he into taking her medicine. [FC #4] was cussing them out, yelling kicking being like, forceful." -"They (FC #4 and the Licensee/ED) were on the floor in the dining room, between the living room and dining room and [Licensee/ED] had her (FC #4) like between her (Licensee/ED) legs, with her legs wrapped around [FC #4's] legs to keep her (FC #4) from kicking." -"She (Licensee/ED) just had her (FC #4's) legs,. She (Licensee/ED) used her whole legs (to wrap around FC #4's legs) so she (FC #4) would not kick her. [FC #4] was fighting at that point. She was trying to fight [Licensee/ED]." Staff #2 denied the Licensee/ED sat on FC #4. "No, I didn't see her (Licensee/ED) sit on her (FC #$3." -FC #4 continued to curse at staff, and she threw a dining room chair. -"She (FC #4) was just swinging it (the chair) she didn't sling it like hard but she was like slinging it out the way. She (FC #4) was trying to get around [Licensee/ED]. She (FC #4) was just trying to get around her (Licensee/ED) to go to her room. [Licensee/ED] was blocking her. She (Licensee/ED) was standing in front of her (FC #4). She was trying to like, you know stand in front of her, telling her, 'hey you have to take your medicine, you're not about to keep walking off from me being disrespectful." -FC #4 went back to her room and shut her bedroom door. Staff #1 and the Licensee/ED	V 537		

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V 537	Continued From page 76 followed her to her room where a physical fight ensued between staff #1 and FC #4. -"They (FC #4 and Licensee/ED) ended up back in the living room. [Licensee/ED] was sitting on the couch, and she had [FC #4] between her legs (Licensee/ED's legs were wrapped around FC #4's legs) and she was just holding her arms (Licensee/ED had her arms looped under FC#4's arms.." Interview on 7-15-25 with the Licensee/ED revealed: -7-8-25,FC #4 refused to complete her chores and take her medications. -"I get back (to the facility), 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 and take some meds." Again, she said 'I don't really want to be bothered.'" -The Licensee/ED took FC #4 to the living room/dining area in an attempt to get FC #4 to take her medications and complete her chores. . -"She sits in this," Observation on 7-1-25 at approximately 12:15pm. The Licensee/ED points to a dining room chair) but how she sits (how she sits in the chair), she throws it (the chair) back and she falls back." -The Licensee/ED denies placing FC #4 in a restraint and sitting on her to force her to take 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... .She is cussing, cussing, cussing. [staff #1] was like, ["FC #4] stop being disrespectful.'	V 537		

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V 537	Continued From page 77 -FC #4 goes to her bedroom and staff #1 and the Licensee/ED follow FC #4 to her room where a physical fight occurs between staff #1 and FC #4. -"FC #4 grabs staff #1's hair and starts punching her in her face. The Licensee/ED grabs FC #4 by again looping her arms through FC #4's arms and pulled FC #4 away from staff #1. -During the struggle of the fight, the Licensee/ED and FC #4 fell to the floor in the hallway. The Licensee/ED does not release the hold when she and FC #4 fall to the floor. FC #4 continues to fight and attempts to go after staff #1 again. While still on the floor, the Licensee/ED again warps her legs around FC #4's legs to prevent FC #4 from moving. -The Licensee/ED and FC #4 get up from the floor. "To be honest, I don't know how we managed to get off the floor. We are standing in the hallway. I still have my arms under hers because she is still trying to get to [staff #1]. So laying have my arms through her arms, I'm behind her and I use my body to walk her to the living room and I just walk her through the hall to the living room where we end up on the couch again. We are on the couch, I'm like lying back and she is right here, like between my legs and I wrap my legs around her legs. I'm talking to her trying to get her to calm down. She's like let me go, let me up and I'm no, I can't let you up until you calm down." -Observation on 7-15-25 at approximately 1pm. The Licensee/ED demonstrated how She laid back on the couch and FC #4 was between the Licensee/ED's legs. -"I didn't know that those were a CPI interventions. I was just trying to get her calmed down and to stop fighting." -The Licensee/ED was not aware that wrapping her legs around FC #4 was not an approved CPI	V 537		

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intervention.
-The Licensee/ED was not aware that moving FC #4 while she was restrained was not a CPI approved intervention.
-The Licensee/ED was not aware that once she and FC #4 fell to the floor, she (Licensee/ED) should have released her hold on FC #4.

Interview on 7-16-25 with a CPI instructor revealed:
-CPI training focuses on prevention and de-escalation. Physical restraints should be used as a last resort.
-A client should be allowed to dis-engage and de-escalate on their own before a physical restraint is used.
-"It is never appropriate to restrain a client on the ground/floor and the restraint should be released immediately and re-assessed if a client goes to the ground due to the increased possibility of injury."
-"Generally, we (CPI) do not teach to move a client while the client is in a restraint unless the client is being moved away from some type of danger."

Review on 8-8-25 of the facility's Plan of Protection dated 8-8-25 and written by the Licensee/ED revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Aubrey's Safe Haven immediate action will be there is no physical CPI restraints allowed until staff has been retrained on CPI measures 8-13-25.

Describe your plans to make sure the above happens.
Enroll staff into CPI training for 8-13-25. The Qualified professional will supervise the training

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V 537	Continued From page 79 and make sure that the staff is understanding the measures. Quarterly meeting will be held to discuss the CPI measures and a small refresher throughout the meeting." The facility served clients between the ages of 13 and 15 with diagnoses that included Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Oppositional Defiant Disorder and Adjustment Disorder. On 7-8-25 FC #4 was upset due to not being able to talk to her sister. FC #4 refused to take her medications and complete her evening chores. FC #4 became verbally aggressive and combative with staff (staff #1), which lead to the Licensee/ED attempting 3 CPI interventions on FC #4. During the first intervention, the Licensee/ED and FC #4 fell to the floor and the Licensee/ED sat/straddled FC #4 around her waist. During the second intervention the Licensee/ED placed her arms through FC #4's arms in an attempt to prevent FC #4 from fighting staff #1. During the intervention the Licensee/ED and FC #4 fell back onto the couch. The Licensee/ED wrapped her legs around FC #4's legs to prevent FC #4 from moving. During the third intervention, FC #4 and the Licensee/ED fell on the floor in the hallway outside of FC #4's bedroom. While on the floor, the Licensee/ED again wrapped her legs around FC #4's legs to prevent FC #4 from moving. After getting up from the floor, the Licensee/ED looped her arms through FC #4's arms and force walked FC #4 through the hallway back into the living room where the Licensee/ED and FC #4 again fell onto the couch. The Licensee/ED wrapped her legs around FC #4 to prevent movement and held FC #4 in that position with the Licensee/ED's legs wrapped around FC #4's legs until emergency personnel arrived at the facility.	V 537		

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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.	V 537		