STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on July 11, 2024. The complaint was substantiated (intake #NC00218874). 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 current client.	V 000		
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	V 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report allegations of abuse and harm to the Health Care Personnel Registry (HCPR) for 1 of 1 audited staff (Staff #1). The findings are: Review on 7/3/24 of the North Carolina Incident Response Improvement System (IRIS) Incident Report dated 6/28/24 revealed: -On 6/26/24 Client #1 displayed physical aggression toward Staff #1. -Staff #1 attempted to put Client #1 in a physical restraint. -Client #1 bit down on Staff #1's right thumb while he (Staff #1) he attempted to physically restrain Client #1. -Staff #1 bit Client #1 on the left shoulder to get	V 132	THERE WERE an OVERSIGHT in regards to Report to HCPR because after Multiple attempts during late hrs of putting the Incident Report the System continue to show error Kicking out Report requiring Director to start over. This was monitored IN EXIT to Survey Checks. 6/28/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 132	Continued From page 2 Client #1 to release his bite on Staff #1's right thumb. -No HCPR report for Staff #1 biting Client #1 on the left shoulder on 6/26/24. Review on 7/3/24 of the facility's Internal Investigation dated 6/28/24 revealed: - On 6/26/24, Client #1 displayed physical aggression toward Staff #1. -Licensee was notified of the incident on 6/27/24. -The local Department of Social Services (DSS) was notified of the incident on 6/27/24 by the local hospital staff. -Staff #2 and Staff #3 wrote statements saying Client #1 was verbally aggressive to Staff #1 . -Client #2 and Client #3 wrote statements saying Client #1 was verbally aggressive to Staff #1. -No one witnessed Client #1 and Staff #1 biting each other because it happened in Client #1's room. -Staff #1 was suspended on 6/27/24 for one day because he admitted to biting Client #1 on the left shoulder because Client #1 was biting his right thumb. -An IRIS report was submitted on 6/28/24. -No documentation of a HCPR report. Interview on 7/3/24 with the Licensee revealed: -DSS completed their investigation of the incident and it was unsubstantiated. -Did not know he still had to report Staff #1 to the HCPR. -"I thought because DSS found no wrong doing, I didn't have to report him (Staff #1) to the healthcare registry." -Would report the incident to HCPR.	V 132	HOWEVER, THIS OVERSIGHT WILL NOT OCCUR AGAIN. 6/28/24 STEPS TO BE IMPLEMENT DIRECTOR OR DESIGNEE QUALIFIED PROFESSION W/ ENSURE SHOULD ALLEGATION OCCUR IN FUTURE, ALL STAFF AFFILIATES WILL BE NOTIFIED W/ THE 72 HOUR TIME FRAME. IN ADDITION SAFETY PRECAUTION INTO THE INVESTIGATION IN WHICH STAFF WILL HAVE NO FURTHER CONTACT W/ CONSUMER DURING THE SCOPE OF THE ALLEGATION. DEPENDING ON THE ALLEGATION MBH INC ADMINISTRATION RESERVE THE RIGHT TO RELOCATE OR PLACE STAFF ON ADMINISTRATIVE LEAVE PER POLICY. => DURING OUR INTERVIEW ON 7/3/24 W/ STATE SURVEYOR IT WAS MENTIONED THAT DSS INVESTIGATED THIS INCIDENT AND ONLY OFFERED RECOMMENDATION FOR SAFETY PRECAUTION AND	
V 514	27E .0102 Client Rights - Prohibited Procedures	V 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 3 10A NCAC 27E .0102 PROHIBITED PROCEDURES In each facility the following types of procedures shall be prohibited: (1) those interventions which have been prohibited by statute or rule which shall include: (a) any intervention which would be considered corporal punishment under G.S. 122C-59; (b) the contingent use of painful body contact; (c) substances administered to induce painful bodily reactions, exclusive of Antabuse; (d) electric shock (excluding medically administered electroconvulsive therapy); (e) insulin shock; (f) unpleasant tasting foodstuffs; (g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and (h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior. (2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility. This Rule is not met as evidenced by: Based on record review and interviews 1 of 3 Staff (#1) used a prohibited procedure contingent use of painful body contact affecting 1 of 3 clients (Client #1). The findings are: Review on 7/3/24 of Client #1's record revealed: -Admission date of 10/25/22. -14 years old. -Diagnoses of Trauma and Stress Related	V 514	steps to keep the Consumers SAFE. Not that incident was unsubstantiated. DSS 6/28/24 just came out on Monday July 29th to bring closure to this case, in which we are currently awaiting final documentation. => My Brothers Implemented refresher Training w/ staff as well meeting with all staff to discuss the importance of least restrictive intervention, team work when Consumer or Co Worker are in stressful and Crisis situation. All staff have signed Administration Signature Sheet. In addition Consumer & Customer Surveys have been Implemented to get Consumer & Customer feedback on the Treatment Plan w/ the Facility as well as staff Professionalism. conti-	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: ______ B. WING ______	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	**12219 WINDY WOOD COURT CHARLOTTE, NC 28273**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 4	V 514	STAFF #1 as well all employees have recieved clinical oversight related to appropriate procedures toward Therapeutic Restraints. STAFF have been informed that biting or causing any bodily harm to consumer(s) are prohibited and will not be tolerated. All STAFF will recieve ongoing clinical training supervision from group/individual setting monthly or as need basis by qualified professionals and Director LCMHC.	6/20/24

Disorder, Conduct Disorder, and Disruptive Mood Dysregulation Disorder.
-History of verbal and physical aggression, elopement, threatening behavior, assaultive behavior and problems with authority.

Review on 7/3/24 of the North Carolina Incident Response Improvement System Incident Report (IRIS) dated 6/28/24 revealed:
-On 6/26/24 Client #1 displayed physical aggression toward Staff #1.
-Staff #1 attempted to put Client #1 in a physical restraint.
-Client #1 bit down on Staff #1's right thumb while he (Staff #1) was attempting to physically restrain Client #1.
-Staff #1 bit Client #1 on the left shoulder to get Client #1 to release his bite on Staff #1's right thumb.

Interview on 7/10/24 with Client #1 revealed:
-Did not want to discuss the incident that occurred on 6/26/24 with Staff #1.

Interview on 7/8/24 with Client #1's Department of Social Service Guardian revealed:
-The Licensee notified her on 6/27/24 that Client #1 attempted to physically attack Staff #1 on 6/26/24.
-"When I spoke to him (Client #1) he said [Staff #1] started it. [Staff #1] had an attitude with him (Client #1) because he wanted to go outside."
-"He (Client #1) said [Staff #1] pulled him by the shirt and threw him on the bed, breaking the bed, then he (Client #1) grabbed a piece of wood from the broken bed and defended himself against [Staff #1]."
-"According to [Client #1], [Staff #1] tried to put him in a chokehold and he (Client #1) bit [Staff #1] in an attempt to get out of the chokehold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 5	V 514		

when [Staff #1] bit his shoulder."
-"I don't believe he (Staff #1) bit [Client #1] maliciously."

Interview on 7/9/24 with Staff #2 revealed:
-Client #1 became upset while being transported from the day program to the facility on 6/26/24.
-"[Client #1] had something in his backpack that he was trying to hide and got upset because I asked to search his bag."
-"He (Client #1) asked [Staff #1] if he and another client could go outside to play ball and [Staff #1] said no, it was time to shower and get ready for dinner."
-"[Client #1] started yelling and cursing. He asked for a bottle of water then threw it back at us (Staff #1 and Staff #2)."
-Staff #1 escorted Client #1 to his room."
-"I went to the kitchen to help [Staff #3] prepare dinner and assist the other clients."
-Did not witness a physical altercation between Staff #1 and Client #1.
-Did not witness Client #1 bite Staff #1.
-Did not witness Staff #1 bite Client #1.

Interview on 7/11/24 with Staff #3:
-On 6/26/24 she was preparing dinner for the clients when she heard Client #1 yelling and cursing at Staff #1.
-"He (Client #1) was upset about something, but I don't know what. I heard him (Client #1) cursing."
-Heard Staff #1 tell Client #1 to shower and get ready for dinner.
-"[Staff #2] came in and helped me cook dinner. Then a few minutes later we (Staff #2 and Staff #3) heard commotion (yelling and thumps)."
-Had Client #1 and Client #3 continue with their showers and evening hygiene.
-Did not witness a physical altercation between Staff #1 and Client #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 6 -Did not witness Client #1 bite Staff #1. -Did not witness Staff #1 bite Client #1. Interview on 7/10/24 with Staff #1 revealed: -Was at the facility to assist Staff #2 and Staff #3 with the Clients on 6/26/24. -"I noticed they (Client #1 and Client #3) were trying to hide something, probably a vape. I stood in the hallway to monitor them (Clients), that made [Client #1] upset." -"Then he (Client #1) asked to go outside and I said no, it was time to shower. He (Client #1) got mad and asked to call [Licensee]. I told him he could call after he took a shower and he said he wasn't taking a shower." -Client #1 asked for a bottle of water then threw the bottle of water at him and Staff #2. -Staff #2 went to the kitchen to help Staff #3 with dinner. -Client #1 "charged" at him and he put Client #1 in a physical restraint. -"He (Client #1) charged at me and we fell on the bed. He (Client #1) picked up a piece of wood off the floor and hit me in the head. I had him [Client #1] in a restraint and lost my grip, when I tried to do the restraint again he bit down on my hand. He (Client #1) was biting harder and harder and I bit down on his shoulder to get him to let go. When he let go, I let go." -Called the police and Client #1 was transported to a local hospital for a mental health evaluation for his aggressive behavior. -Reported the incident to the Licensee on 6/27/24. -Admitted to biting Client #1 on the left shoulder because Client #1 was biting his hand. -Did not put Client #1 in a chokehold. -Did not bite Client #1 maliciously or for punishment.	V 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 7 Interview on 7/3/24 with the Licensee revealed: -Staff #1 called him on 6/26/24 to inform him Client #1 was going to the local hospital for his aggressive behavior. -Went to the hospital with Client #1 and stayed until he (Client #1) was admitted. -Staff #1 notified him of the incident with Client #1 on 6/27/24. -Completed an IRIS report on 6/27/24. Review of the Plan of Protection dated 7/11/24 completed by the Licensee on 7/11/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in you care? Immediate action implemented as of 6/27/24. Staff have received refresher training in NCI (Nonviolent Crisis Intervention) Restrictive Intervention i.e the bite technique. Facility will ensure all staff will support and intervene during violent situations to deescalate using the least restrictive intervention as outlined in consumers Person Centered Plan (crisis plan). Also staff will utilized on-call immediately prior to situations escalating. Facility will maintain appropriate staffing. Administrative will continue to support and protect all of the consumers in care. Describe your plan to ensure the above happens. My Brothers House administrative staff i.e (Director/Supervisor) will provided ongoing supervision as outlined in the staff individual supervision plan on a monthly or as need basis and document (date, topic of discussion, feedback and ongoing training). In addition Director and Supervisor will meet w/ consumers and have consumers to complete consumers surveys regarding their level of care/treatment with the facility. This information will be collected	V 514	6/28/2024 My Brothers House Inc in No way shape or form feel as though this situation should be justified w/ a Type A Rule violation. We all have oversight which occur from time to time. We have been in business for over 20 years. As indicated to surveyor the IRIS System Crash (2) times on our Personnel when trying to enter Appropriate restraint Technique used. required us to start over. System indicated Survey Error.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-757	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITE HORIZON	12219 WINDY WOOD COURT CHARLOTTE, NC 28273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 514	Continued From page 8 by the Director only and used for enhancing the level of care, improve consumer outcomes to ensure they have a say in their treatment as well as concerns are addressed." Client #1 had an admission date of 10/25/22, and had diagnoses of Trauma and Stress Related Disorder, Conduct Disorder, and Disruptive Mood Dysregulation Disorder. On 6/26/24 Client #1 was upset about not being allowed to go outside and tried to attack Staff #1. While Staff #1 was trying to complete a restraint on Client #1, Client #1 bit down on Staff #1's right thumb. In an attempt to get Client #1 to release his bite, Staff #1 bit Client #1 on the left shoulder. According to the hospital report, the bite to Client #1's left shoulder did not break the skin, but did leave a full bite mark. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 514	I would like to ask at anytime during DHSR investigation and prior to Consitution a Type A2 rule violation in Communication were address with Consumer #1 / #2 or #3 DSS legal guardian as to the level of care Consumers recieve at My Brothers House Inc. I know this question may not be of any direct collation to the case at hand; but I do feel that it could have been taken in consideration with a lesser infraction along with continue on your training. * I would like to set a Meeting in Raleigh or via Zoom with DHSR Administration to discuss Regarding a potential lesser Infraction.	