

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL060-757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/13/2026
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NAME OF PROVIDER OR SUPPLIER BRITE HORIZON	STREET ADDRESS, CITY, STATE, ZIP CODE 12219 WINDY WOOD COURT CHARLOTTE, NC 28273
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 1/13/26. The complaint was unsubstantiated (intake #NC00234979. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding</p>	V 366	<p style="text-align: center;">RECEIVED FEB 16 2026 DHSR-MH Licensure Sect</p>	

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

[Signature]

TITLE

[Signature] President

(X6) DATE

[Signature] February 6, 2026

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V 366	<p>Continued From page 1</p> <p>Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(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;</p> <p>(B) gather other information needed;</p> <p>(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</p>	V 366	<p><i>My Brothers House Inc understands the significance 2/13/2026</i></p> <p><i>Rate 17306 276.0603</i></p> <p><i>Incident Response Requirements and the 24 hour submission and notifications to all responsible parties.</i></p> <p><i>These incident reporting are the responsibility of designated Quality & Professionals and will continue to be supervised by the Director for Compliance</i></p> <p><i>In addition, Refresher training with designated QPs was complete 2/12/2026 to ensure thoroughness and timelines for completion and closure are done.</i></p>	

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V 366	<p>Continued From page 2</p> <p>located and to the LME where the client resides, if different; and</p> <p>(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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing</p>	V 366	<p><i>Note! My Brothers 2/13/2025 House They understand the significance of Critical Incident Reporting and Notifications to all parties. In our 28 years we have only had (1) incident ever in regards Critical Incident Reporting. However, this incident report time line occurred during a week when we had multiple Critical Incidents occurring as all hands were on deck in dealing with multiple exposures and IV's and fighting with the Hospital to help stabilize another consumer with a higher level of care PRTF was secured. In addition,</i></p>	
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V 366	<p>Continued From page 3</p> <p>their response to level II incidents. The findings are:</p> <p>Review on 1/5/26 of Client #1's record revealed: -Admission date of 7/14/25. -15 years old. -Diagnoses of Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder. -Monthly Staffing Report dated 12/9/25: "On 11/10/25 [Client #1] was involved in another physical altercation ..."</p> <p>Review on 1/13/26 of Client #2's record revealed: -Admission date of 9/9/25. -17 years old. -Diagnoses of Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Post Traumatic Stress Disorder, Insomnia. -Monthly Staffing Report dated 12/9/25: "[Client #2] had 1 physical aggression towards his peers on November 10th (2025) ..."</p> <p>Review on 1/2/26 of the North Carolina Incident Response Improvement System (IRIS) for incidents dated 11/1/25 to 1/2/25 revealed: -No incident reports for the incident on 11/17/25 involving Client #1 and Client #2 fighting, police intervention, and transportation to the hospital.</p> <p>Interview on 1/5/26 with Client #1 revealed: -Was in a fight with Client #2 on 11/17/25. -Was treated for a "busted nose" at the hospital. -Client #2 had a cut on his hand.</p> <p>Interview on 1/5/26 with Client #2 revealed: -Was in a fight with Client #1 on 11/17/25. -Was bit on the wrist/forearm and hand by Client #1.</p>	V 366	<p><i>There were multiple Child and Family Team Meetings daily with Foster & placement Members advocating for safety of all consumers. Therefore we have completed refresher training on TRS with all qualified professionals and Incident reports will continue to be completed in the 92 hour timeframe.</i></p> <p><i>This information was shared w/ the Surveyor on Ms Osborne who could see multiple current Incident reports were submitted during the same time frame, it was clearly and oversight. However all legal guardian and care coordinator from</i></p>	

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V 366	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The police were called. -Was transported to the hospital. <p>Interview on 1/13/25 with Staff #1 revealed:</p> <ul style="list-style-type: none"> -Client #1 and Client #2 were in a fight on 11/17/25. -The police were called and both clients were taken to the local hospital for evaluation and treatment. -Did not complete an incident report. -The Licensee/Qualified Professional (QP) was responsible for completing the incident report. <p>Interview on 1/5/25 with the Licensee/QP revealed:</p> <ul style="list-style-type: none"> -Client #1 and Client #2 were in a fight in November. -Documented the date of the fight in the Monthly Staffing Notes as 11/10/25. -Had a note in his phone that the fight was on 11/17/25. -Was in route to the facility when the fight occurred. -The police were called and both clients were taken to the local hospital for evaluation and treatment. -Was responsible for completing the IRIS reports. -Thought he completed the IRIS report but was unable to locate it. -Had not documented the cause of the incident, implemented corrective measures, or recommendations for minimizing the occurrence of future incidents. 	V 366	<p><i>The Manager Case Organization were notified and reviewed documentation on this incident via Child & Family Team Staffing Report. We will submit to State agency in which we are part of Compliance So. Note.</i></p>	
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p>	V 367		

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V 367	<p>Continued From page 5</p> <p>(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 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:</p> <ol style="list-style-type: none"> (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. <p>(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:</p> <ol style="list-style-type: none"> (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. <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <ol style="list-style-type: none"> (1) hospital records including confidential 	V 367		

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V 367	<p>Continued From page 6</p> <p>information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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 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).</p> <p>(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:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p>	V 367		

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V 367	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit Level II incident reports to the LME/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are:</p> <p>Review on 1/5/26 of Client #1's record revealed: -Admission date of 7/14/25. -15 years old. -Diagnoses of Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder. -Monthly Staffing Report dated 12/9/25: "On 11/10/25 [Client #1] was involved in another physical altercation ..."</p> <p>Review on 1/13/26 of Client #2's record revealed: -Admission date of 9/9/25. -17 years old. -Diagnoses of Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Post Traumatic Stress Disorder, Insomnia. -Monthly Staffing Report dated 12/9/25: "[Client #2] had 1 physical aggression towards his peers on November 10th (2025) ..."</p> <p>Review on 1/2/26 of the North Carolina Incident Response Improvement System (IRIS) for incidents dated 11/1/25 to 1/2/25 revealed: -No incident reports for the incident on 11/17/25 involving Client #1 and Client #2 fighting, police intervention, and transportation to the hospital.</p>	V 367		

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V 367	<p>Continued From page 8</p> <p>Interview on 1/5/26 with Client #1 revealed: -Was in a fight with Client #2 on 11/17/25. -Was treated for a "busted nose" at the hospital. -Client #2 had a cut on his hand.</p> <p>Interview on 1/5/26 with Client #2 revealed: -Was in a fight with Client #1 on 11/17/25. -Was bit on the wrist/forearm and hand by Client #1. -The police were called. -Was transported to the hospital.</p> <p>Interview on 1/13/25 with Staff #1 revealed: -Client #1 and Client #2 were in a fight on 11/17/25. -The police were called and both clients were taken to the local hospital for evaluation and treatment. -Did not complete an incident report. -The Licensee/Qualified Professional (QP) was responsible for completing the incident report.</p> <p>Interview on 1/5/25 with the Licensee/QP revealed: -Client #1 and Client #2 were in a fight in November. -Documented the date of the fight in the Monthly Staffing Notes as 11/10/25. -Had a note in his phone that the fight was on 11/17/25. -Was in route to the facility when the fight occurred. -The police were called and both clients were taken to the local hospital for evaluation and treatment. -Was responsible for completing the IRIS reports. -Thought he completed the IRIS report but was unable to locate it. -Had not notified the LME/MCO of the incident.</p>	V 367		