STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

July 19, 2023

SENT VIA ELECTRONIC MAIL

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 620, Legislative Office Building
Raleigh, NC 27603

The Honorable Jim Burgin, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 308, Legislative Office Building
Raleigh, NC 27603

The Honorable Larry Potts, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B1, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

North Carolina General Statutes 122C-5, 131D-2.13(e) and 131D-10.6(10) require the Department of Health and Human Services to report annually to the Joint Legislative Oversight Committee on Health and Human Services on the Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraints and Seclusion. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions regarding this report, please contact Karen Wade, Director of Policy, at Karen.Wade@dhhs.nc.gov.

Sincerely,

DocuSigned by:
Mark T. Benton
65A1EE320AD6419...
on behalf of Kody H. Kinsley

Kody H. Kinsley
Secretary

cc:

Mark Collins	Joyce Jones	Lisa Wilks	Jessica Meed
Theresa Matula	Katherine Restrepo	Amy Jo Johnson	Luke MacDonald
Nathan Babcock	Francisco Celis Villagrana	Fred Aikens	Todd Barlow
Darryl Childers	Melissa Roark	Marissa Doctrove	Tai Rochelle

Annual Report on Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraints and Seclusion

N.C.G.S. §§ 122C-5, 131D-2.13(e) and 131D-10.6(10)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By
North Carolina Department of Health and Human Services

July 19, 2023

Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraint and Seclusion

Executive Summary

G.S. § 122C-31, *Report Required Upon Death of a Client*, requires a facility to notify the Secretary, Department of Health and Human Services (DHHS), upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and to notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. In turn, the Secretary is required to provide an annual report by October 1 on the following to the Joint Legislative Oversight Committee on Health and Human Services for the immediately preceding fiscal year:

1. the level of compliance of each adult care home with applicable State law and rules which govern the use of physical restraint and physical hold of residents which indicates the areas of highest and lowest levels of compliance; and the total number of adult care homes that reported client deaths pursuant to G.S. § 131D-34.1 reflecting the number of deaths reported by each facility, the number of deaths investigated, and the number of deaths found upon investigation to be related to the adult care home's use of physical restraint or physical hold. (G.S. § 131D-2.13)
2. the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities including the total number of facilities that reported deaths per this statute, the number of deaths reported by each facility, the number of deaths investigated, and the number found by investigation to be related to the use of physical restraint or time-out. (G.S. § 131D-10.6)
3. the level of facility compliance with applicable State law and federal laws, rules, and regulations governing the use of restraints and seclusion indicating the areas of highest and lowest levels of compliance; and the total number of facilities that reported deaths pursuant to G.S. § 122C-31, as well as the number found by investigation to be related to the use of restraint or seclusion. (G.S. § 122C-5)

The following DHHS Divisions contributed to the compilation of this report: Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Health Service Regulation (DHSR), and State-Operated Healthcare Facilities (DSOHF). In addition, data submitted by the Local Management Entities/Managed Care Organizations (LME/MCOs) and provider agencies through the Incident Response Improvement System (IRIS) are included in this report. The report reflects data for State Fiscal Year (SFY) 2021-2022, which covers the period of July 1, 2021 through June 30, 2022.

Part A of the report includes deaths reported to DHHS by private licensed, private unlicensed, and state-operated facilities. While the reporting requirements differ by type of facility, the data reported herein includes deaths which (a) occurred within seven days after the use of physical restraint, physical holds, or seclusion; or (b) resulted from violence, accident, suicide, or homicide. A total of 275 deaths were reported: 38 by adult care homes, 64 by private licensed facilities, 169 by private unlicensed facilities, 2 by private inpatient psychiatric units, and 2 by state-operated facilities. Of the 275 deaths reported, all were screened, 214 (77.8%) were investigated. No deaths were found to be related to the use of physical restraint, physical holds, or seclusion.

Part B of this report reflects information gathered related to facility compliance with laws, rules, and regulations governing the use of physical restraint, physical holds, and seclusion. The compliance data summarized herein was collected from facilities that received an on-site visit or an administrative desk review by DHHS or LME/MCO staff. Those interactions include initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed, but a total of 2,584 licensure surveys, 1,481 follow-up visits, 1,725 complaint investigations and 141 other reviews were conducted during the SFY. A total of 160 private licensed facilities were issued a total of 241 citations for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private community-based intermediate care facilities for individuals with intellectual disabilities (ICF/IID), to private unlicensed facilities or to any state-operated facilities during this reporting period.

Citations covered a wide range of deficiencies, including failure to provide training, obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, as well as improper or inappropriate use of physical restraints. The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (N=119 or 49.3%) and "training in seclusion, physical restraint and isolation time-out" (N=54 or 22.4%). These citations accounted for 71.7% of the total issued.

Introduction

G.S. § 122C-31, *Report Required Upon Death of a Client*, requires a facility to notify the Secretary, Department of Health and Human Services (DHHS), upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client and to notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. In turn, the Secretary is required to provide an annual report October 1 on the following to the Joint Legislative Oversight Committee on Health and Human Services for the immediately preceding fiscal year:

1. the level of compliance of each adult care home with applicable State law and rules which govern the use of physical restraint and physical holds of residents which indicates the areas of highest and lowest levels of compliance; and the total number of adult care homes that reported client deaths pursuant to G.S. § 131D-34.1 reflecting the number of deaths reported by each facility, the number of deaths investigated, and the number of deaths found upon investigation to be related to the adult care home's use of physical restraint or physical hold. (G.S. § 131D-2.13) G.S. § 131D-34.1 requires an adult care home to notify DHHS upon the death of any resident that occurs in the facility or that occurs within 24 hours of the resident's transfer to a hospital if the death occurred within seven days of the adult care home's use of physical restraint or physical hold of the resident; the statute also requires the adult care home to notify DHHS within three days of the death of any resident resulting from violence, accident, suicide, or homicide.
2. the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities including the total number of facilities that reported deaths per this statute, the number of deaths reported by each facility, the number of deaths investigated, and the number found by investigation to be related to the use of physical restraint or time-out. (G.S. § 131D-10.6)
3. the level of facility compliance with applicable State law and federal laws, rules, and regulations governing the use of restraints and seclusion indicating the areas of highest and lowest levels of compliance; and the total number of facilities that reported deaths pursuant to G.S. § 122C-31, as well as the number found by investigation to be related to the use of restraint or seclusion. (G.S. § 122C-5)

The facilities covered by these statutory requirements are organized by this report into three groups: private licensed facilities, private unlicensed facilities, and state-operated facilities.

The private licensed facilities include:

1. Adult Care Homes
2. Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day Treatment and Outpatient Treatment Programs
3. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
4. Psychiatric Hospitals and Hospitals with Acute Care Psychiatric Units and PRTFs

The private unlicensed facilities include:

1. Periodic Service Providers
2. North Carolina Innovations

The state-operated facilities include:

1. Alcohol and Drug Abuse Treatment Centers (ADATCs)
2. Developmental Centers (ICF/IID)
3. Neuro-Medical Treatment Centers
4. Psychiatric Hospitals
5. Residential Programs for Children

This report covers SFY 2021-2022, which spans the period July 1, 2021 through June 30, 2022. It is organized into two sections (Parts A and B) and includes two Appendices (A and B). Part A provides summary data on deaths reported by the facilities and investigated by DHHS. Part B provides summary data on deficiencies related to the use of physical restraints, physical holds, and seclusion compiled from monitoring reports, surveys and investigations conducted by DHHS and LME/MCO staff. The Appendices contain tables that provide information from Parts A and B of the report listed by licensure or facility type and by county and facility name.

Part A: Deaths Reported and Investigated

Table A provides a summary of the number of deaths reported during the SFY by private licensed, private unlicensed, and state-operated facilities; the number of deaths investigated; and the number of deaths found by investigation to be related to the facility's use of physical restraint, physical holds, or seclusion. Tables A-1 through A-5 in Appendix A provide additional information on the number of deaths reported by county and facility name.

The data in Table A reflects the following:

1 A total of 209 facilities – 110 private unlicensed facilities, 64 private licensed facilities, 31 adult care homes, 2 private inpatient psychiatric units and 2 state-operated facilities– reported a total of 275 deaths that were subject to these statutory reporting requirements.

2 Of the total 275 deaths reported, 169 deaths occurred at private unlicensed facilities, 64 deaths occurred at private licensed facilities, 38 deaths occurred at adult care homes, 2 deaths occurred at private inpatient psychiatric units and 2 deaths occurred at the state-operated facilities.

3 All deaths that were reported were screened; a total of 214 deaths (77.8%) were investigated.

4 No deaths were determined to be related to the use of physical restraint, physical holds, or seclusion.

Table A: Summary Data on Consumer Deaths Reported During SFY 2021-2022

Table in Appendix	Type of Facility	Facilities Providing Services[1]	Beds at Facilities[1]	Facilities Reporting Deaths	Death Reports Received & Screened[2]	Deaths Reports Investigated[3]	Deaths Related to Restraints/ Seclusion[4]
Private Licensed Facilities							
A-1	Adult Care Homes	1,142	40,529	31	38	34	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,854	10,610	64	64	10	0
A-3	Psychiatric Hospitals, Units, & Hospital PRTFs	56	2,593	2	2	1	0
N/A[7]	Community ICFs/IID	338	2,796	0	0	0	0
Subtotal		4,390	56,528	97	104	45	0
Private Unlicensed Facilities							
A-4	Private Unlicensed[5]			**110**	**169**	**169**	**0**
State-Operated Facilities							
A-5	Alcohol and Drug Treatment Centers	3	180	2	2	0	0
A-6	Psychiatric Hospitals	3	922	0	0	0	0
N/A[6,7]	Neuro-Medical Treatment Centers[6]	3	LTC=500	0	0	0	0
			ICF=12	0	0	0	0
N/A[7]	Developmental Centers	3	992	0	0	0	0
N/A[7]	Residential Programs for Children	2	30	0	0	0	0
Subtotal		14	2,636	2	2	0	0
Grand Total		**4,404**	**59,164**	**209**	**275**	**214**	**0**

The following notes pertain to the superscripts in the table above.

1. The number of facilities and beds can change during the year. The numbers shown reflect those existing at the end of the SFY (June 30, 2022).
2. Numbers reflect only deaths required to be reported by statute and/or rule. (i.e., those occurring within seven days of physical restraint, physical holds, or seclusion, or the result of violence, accident, suicide, or homicide). All death reports were screened. Due to reporting requirements, a death may be reported by more than one licensed and/or non-licensed provider if an individual is receiving services from more than one provider. Therefore, not all reports reflect unduplicated numbers. Each provider is required to report deaths to the appropriate oversight agency.

3. Deaths that occur within seven days of restraint/seclusion are required to be investigated. For other deaths, the decision to investigate and the level of investigation depends on the circumstances and information provided. Some investigations may be limited to confirming information or obtaining additional information.
4. Findings in this column indicate that restraint/seclusion either: (a) may have been a factor, but not necessarily the cause of death, or (b) may have resulted in the death.
5. The number of these facilities is unknown as they are not licensed or state-operated.
6. The data for O'Berry Facility is reflected in two categories, as a State-Operated ICF/IID Center (N=12 ICF Beds) and as State-Operated Neuro-Medical Treatment Center (N=144 LTC Beds) since this facility serves both populations.
7. N/A (not applicable) indicates that no tables are provided in Appendix A for facilities in which no deaths were reported.

Part B. Facility Compliance with Laws, Rules, and Regulations Governing the Use of Physical Restraints, Physical Holds, and Seclusion

As noted above, DHHS is also required to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical holds, and seclusion to include areas of highest and lowest levels of compliance. The compliance data summarized in this section was collected from on-site visits by DHHS and LME/MCO staff for licensure surveys, follow-up visits, and complaint and death investigations during the SFY beginning July 1, 2021 and ending June 30, 2022. DHHS and LME/MCO staff did not visit all facilities; therefore, the data summarized is limited to those facilities that received an on-site visit or an administrative desk review by DHHS and LME/MCO staff.

Table B provides a summary of the number of physical restraints, physical holds, and seclusion related citations that were issued to private licensed, to private unlicensed, or to state-operated facilities. The table shows the number of facilities that received a citation, the number of citations issued, and examples of the most frequent and least frequent citations issued.

Table B reflects the following:

1 A total of 160 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private community-based ICF/IIDs, to private unlicensed facilities or to the state-operated facilities during this reporting period.

2 Compliance data do not reflect all facilities. Rather, the data is limited to those facilities that required an on-site visit or a desk review by DHHS or LME/MCO staff.

3 A total of 2,584 initial, renewal and change-of-ownership licensure surveys, 1,481 follow-up visits, 1,725 complaint investigations and 141 other reviews were conducted during the year. Because of the potential for some facilities to have had more than one type of review, an exact unduplicated count of facilities reviewed is not available.

4 A total of 241 citations were issued for non-compliance with rules governing the use of physical restraint, physical holds, or seclusion. All of these citations occurred in private licensed facilities. Citations covered a wide range of deficiencies including failure to obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, and improper or inappropriate use of physical restraints.

5 The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (N=119 or 49.2% and "training in seclusion,

physical restraint and isolation time-out" (N=54 or 22.3%); these accounted for 71.5% of the total issued. The tables in Appendix B provide additional information on the number of citations issued by county and facility name.

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2021-2022[1]

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
Private Licensed Facilities					
B-1	Adult Care Homes	7	10	• Rule 10A NCAC 13F .1501(a) Inappropriate use of restraints (Failure to obtain physician order, assessment, and use of least restrictive device or no alternative attempted (4 citations)	• Rule 10A NCAC 13F.1501(b) Failure to obtain consent from resident the resident or the resident's legal representative for the use of restraint (2 citations) • Rule 10A NCAC 13F .1501(c) Failure to complete proper assessment and care planning for the use of restraints (2 citations) • Rule 10A NCAC 13F .0506 Failure to provide staff training on the use of restraints (2 citations)
B-2	Group Homes, Community-Based PRTFs and Outpatient and Day Treatment Facilities	137	199	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (V536) (118 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (V537) (53 citations) • Rule 10A NCAC 27E.0101 Least Restrictive Alternative (V513) (15 citations) • Rule 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-Out (V521) (9 citations)	• Rule 10A NCAC 27E .0102 Prohibited Procedures (V514) (1 citation) • Rule 10A NCAC 27E .0104(e)(10) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V522) (1 citation) • Rule 10A NCAC 27E .0104(e)(11) Precautions and Actions to be Employed When a Client is in Seclusion or Physical Restraint (V523) (1 citation) • Rule 10A NCAC 27E .0104(g)(1-2) (V528) (1 citation)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
Private Licensed Facilities					
B-3	Psychiatric Hospitals, Units, and Hospital PRTFs	16	32	• A-0168: Facility staff failed to obtain orders for restrictive interventions, restraints and/or seclusion (4 citations) • A-0175: Facility staff failed to monitor patients in chemical and/or physical restraints (4 citations) • A-0178: Facility staff failed to ensure a face-to-face assessment within one hour of restraint intervention (4 citations) • A-0167: Facility staff failed to obtain appropriate orders (2 citations) • A-0169: Facility staff failed to document and/or obtain physician orders (2 citations) • V521: 10A NCAC 27E .0104(e)(9) Seclusion, Restraint and Time-Out (2 citations)	• A-0160: Facility staff failed to identify the use of chemical restraints (1 citation) • A-0166: Facility staff failed to update the patient's plan of care for use of restraint application (1 citation) • A-0170: Facility staff failed to notify the attending provider of restrictive intervention (1 citation) • A-0171: Facility staff failed to order violent restraints in 4-hour increments (1 citation) • A-0174: Facility staff failed to discontinue restraints at the earlies possible time (1 citation) • A-0176: Facility staff to ensure completeness of physician orders (1 citation) • A-0179: Facility staff failed physician or licensed practitioner documented the one-hour face-to-face evaluation with one hour after initiation of restraints (1 citation) • A0184: Facility staff failed to perform the face-to-face evaluation within one hour of a violent restraint (1 citation)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
Private Licensed Facilities					
					• A-0213: Facility staff failed to report the death of a patient that died within 24 hours of restraint to CMS (1 citation) • A-0214: Facility staff failed to document in the medical record the date and time an entry was made on the internal log for the death record (1 citation) • V522: 10A NCAC 27E.0104(e)(10) Seclusion, Restraint, Isolation Time-Out (1 citation) • V525: 10A NCAC 27E.0104 Seclusion, Physical Restraint, Isolation Time-Out and Protective Devices for Behavioral Control (1 citation) • V536: 10A NCAC 27E.0107 Training on Alternatives to Restrictive Interventions (1 citation) • V537: 10A NCAC 27E.0108 Training in Seclusion, Restraint and Isolation Time-Out (1 citation)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
Private Licensed Facilities					
N/A[2]	Community ICFs/IID			No Citations were issued.	No Citations were issued.
Subtotal		160	241		
Private Unlicensed Facilities					
N/A[2]	Private Unlicensed			No Citations were issued.	No Citations were issued.
Subtotal		0	0		
State-Operated Facilities					
N/A[2]	Alcohol and Drug Treatment			No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers			No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Center			No Citations were issued.	No Citations were issued.
N/A[2]	Psychiatric Hospitals			No Citations were issued.	No Citations were issued.
N/A[2]	Residential Programs for Children			No Citations were issued.	No Citations were issued.
Subtotal		0	0		
Grand Total		**160**	**241**		

The following notes pertain to the superscripts in the table above.

1. The citations summarized in this table do not reflect all facilities. The data is limited to those facilities that received an on-site visit or an administrative desk review by DHHS staff or LME/MCO staff. DHHS and LME/MCO staff conducted a total of 2,584 licensure surveys, 1,481 follow-up visits, 1,725 complaint investigations and 141 other reviews during the SFY.
2. N/A means not applicable and is used to indicate that no tables are provided in Appendix B for facilities for which no citations were issued.

Appendix A: Consumer Deaths Reported by County and Facility

Tables A-1 through A-6 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the SFY beginning July 1, 2021, and ending June 30, 2022, that were subject to the reporting requirements in G.S. §§ 122C-31, 131D-10.6 and 131D-34.1, namely deaths that occurred within seven days of physical restraint, physical holds, or seclusion, or that were the result of violence, accident, suicide or homicide.

These tables do not include deaths that were reported to DHHS for other reasons or that were the result of other causes. Each table represents a separate licensure category or type of facility. Each table lists by county, the name of the reporting facility, number of deaths reported, the number of death reports investigated, and the number investigated that were determined to be related to the use of physical restraint, physical holds, or seclusion.

All deaths that were reported were screened and investigated by DHHS when required by law. No deaths were found to be related to the use of physical restraints, physical holds, or seclusion.

Table A-1: Adult Care Homes[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Alamance	Mebane Ridge	2	2	0
Bladen	Turner's Family Care Home	1	1	0
Buncombe	Chunn's Cove Assisted Living	1	1	0
	Richmond Hill Rest Home #3	1	1	0
Cabarrus	The Landings at Cabarrus	1	0	0
Catawba	Brookdale Hickory Northeast	1	1	0
	Hickory Village	1	1	0
	Terrabella Newton	1	1	0
Duplin	The Gardens of Rose Hill	1	1	0
Durham	Eno Pointe Assisted Living	3	3	0
Forsyth	Kerner Ridge Assisted Living	1	0	0
	Tranquility Care	1	0	0
Franklin	Franklin Manor Assisted Living Center	1	1	0
Henderson	Carolina Reserve of Hendersonville	1	1	0
	The Landings of Miller River	2	2	0
Mecklenburg	Brookdale Southpark	1	0	0
	Elmcroft of Little Avenue	2	2	0
	Terrabella Little Avenue	1	1	0
	The Charlotte Assisted Living	1	1	0
New Hanover	Coastal Cove of Wilmington	1	1	0
Onslow	Light House Village	1	1	0
Pitt	Care One Assisted Living of Greenville	1	1	0
Richmond	Hamlet House	1	1	0
Stokes	Priddy Manor Assisted Living	2	2	0
	Walnut Ridge Assisted Living	1	1	0
Tyrell	Tyrell House	1	1	0
Wake	Ann's Family Care #4	1	1	0
	Elmcroft of Northridge	1	1	0
	Morningside of Raleigh	2	2	0
	Sunrise of Cary	1	1	0
Yancey	Yancey House	1	1	0
Total	**31 Facilities Reporting**	**38**	**34**	**0**

The following notes pertain to the superscripts in the table above.

1. There were 1,142 Licensed Adult Care Homes with a total of 40,529 beds as of June 30, 2022.
2. For licensed assisted living facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DHSR and the County Department of Social Services by the DHSR Complaint Intake Unit after screening for compliance issues.
3. No findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-2: Private Group Homes, Community-Based Psychiatric Residential Treatment Facilities, Day and Outpatient Treatment Facilities[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Alamance	Alamance Homes II	1	1	0
Alexander	Addiction Recovery Medical Service	1	0	0
Ashe	Willow Place Group Home	1	1	0
Brunswick	Coastal Horizons Center, Inc.	1	0	0
Buncombe	Family Preservation Services of NC	1	0	0
	RHA Health Services	1	0	0
	Mountain Health Solutions - Asheville	1	0	0
	October Road, Inc.	1	0	0
Burke	New Season Morganton	1	0	0
Caldwell	McLeod Addictive Disease Center-Lenoir	1	0	0
Carteret	Morehead City Treatment Center	1	0	0
Catawba	Hickory Metro Treatment Center	1	0	0
	McLeod Addictive Disease Center-Hickory	1	0	0
Chatham	Chatham Recovery	2	0	0
Cleveland	Cleveland Crisis and Recovery Center	1	0	0
	Caring Way 104	1	1	0
Cumberland	Fayetteville Treatment Center	1	0	0
Davidson	Addiction Recovery Care Association	2	0	0
	Thomasville Treatment Associates	1	1	0
Forsyth	Winston-Salem Comprehensive Treatment Center	1	0	0
	Insight Health Services-Forsyth	1	0	0
Gaston	Gastonia Treatment Center	1	0	0
Guilford	Daymark Guilford Residential Treatment Facility	1	0	0
	Alcohol and Drug Services East	1	0	0
Haywood	Meridian Behavioral Health Services	1	0	0
	The Balsam Center Adult Recovery	1	0	0
Iredell	Arms	2	0	0
	McLeod Addictive Disease Center	1	0	0
Johnston	Johnston Recovery Services	2	0	0
Mecklenburg	McLeod Addictive Disease Center	1	0	0
	McLeod Addictive Disease Center – 1st	1	0	0
	Anuvia Prevention and Recovery Center	1	0	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion [3]
	Midwood Addiction Treatment, LLC	1	0	0
Moore	Carolina Treatment Center of Pinehurst	1	1	0
	Carolina Treatment Center of Pinehurst	2	0	0
New Hanover	Coastal Horizons Center, Inc.	4	0	0
	Coastal Horizons Center, Inc.	1	1	0
	Port Health Services-Wilmington	1	0	0
	Delta Behavioral Health, PC	1	1	0
	RHA Behavioral Health Services	1	0	0
Orange	Hillsborough Recovery Solutions	1	1	0
Pasquotank	Elizabeth City Treatment Center	2	0	0
Pitt	Port Health Services-Greenville Detox	1	0	0
Robeson	Tanglewood Arbor	1	0	0
Rockingham	Alef Behavioral Group, LLC-Eden	1	1	0
Union	Monroe Crisis Recovery Center	1	0	0
Vance	Vance Recovery	2	0	0
Wake	Southlight Healthcare	2	0	0
	Southlight Healthcare-Garner Road	3	0	0
	The Morse Clinic of North Raleigh	2	0	0
Wilkes	Mountain Health Solutions-North Wilkesboro	1	0	0
Total	**48 Facilities Reporting**	**64**	**10**	**0**

The following notes pertain to the superscripts in the table above.

1. There were 2,854 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,610 beds as of June 30, 2022.
2. This indicates the number of death reports that were investigated.
3. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-3: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion[2]
Catawba	Catawba Valley Medical Center	1	0	0
Hertford	Vidant Roanoke-Chowan Hospital	1	1	0
Total	**2 Facilities Reporting**	**2**	**1**	**0**

The following notes pertain to the superscripts in the table above.

1. There were 13 Private Psychiatric Hospitals, 43 Hospitals with Acute Care Psychiatric Units, and 3 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,593 beds as of June 30, 2022.
2. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-4: Private Unlicensed Facilities[1]

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Alamance	Ariel Community Care	1	1	0
Ashe	Daymark Recovery Services	1	1	0
Beaufort	Dream Provider Care Services, Inc.	1	1	0
Bladen	Coastal Horizons Center, Inc.	1	1	0
Brunswick	Coastal Horizons Center	1	1	0
Buncombe	Family Preservation Services of NC, Inc.	2	2	0
	Hinds Feet Farm	1	1	0
	Meridian Behavioral Health	1	1	0
	October Road	1	1	0
	RHA Behavioral Health	6	6	0
	Youth Villages, Inc.	1	1	0
Burke	A Caring Alternative	1	1	0
	Catawba Valley Behavioral Healthcare	1	1	0
	Strategic Interventions, LLC	1	1	0
Cabarrus	Daymark Recovery Services	1	1	0
	RHA Health Services	1	1	0
Caldwell	Easterseals UCP NC & VA, Inc.	1	1	0
	RHA Health Services	1	1	0
Carteret	Coastal Horizons Center	1	1	0
Catawba	Catawba Valley Behavioral Healthcare	4	4	0
Chatham	Daymark Recovery Services	3	3	0
Cleveland	Monarch	1	1	0
	One on One Care, Inc.	1	1	0
	Premier Service of Carolina, Inc.	13	13	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Columbus	Coastal Horizons Center	3	3	0
	PORT Health Services	1	1	0
	RHA Services	1	1	0
Craven	Educare Community Living dba Community Alternative	1	1	0
	PORT Health Services	2	2	0
	RHA Health Services	1	1	0
Cumberland	Coastal Horizons Center	3	3	0
	Haire Enterprise, LLC	1	1	0
	Youth Villages	1	1	0
Davidson	Daymark Recovery Services Davidson Center	2	2	0
	Monarch	1	1	0
	Youth Villages Inc	1	1	0
Davie	Daymark Recovery Services, Inc.	1	1	0
Durham	Easterseals UCP NC/VA	1	1	0
	Pathways to Life, Inc.	2	2	0
	RI International	1	1	0
Forsyth	Daymark Recovery Services	1	1	0
	Monarch Behavioral Health-Forsyth	3	3	0
	Monarch Forsyth ACTT	3	3	0
Gaston	Monarch Behavioral Health-Gaston	1	1	0
	Outreach Management Services	1	1	0
Guilford	RHA Health Services	2	2	0
Harnett	Coastal Horizons Center	1	1	0
	Johnston County Industries	1	1	0
Haywood	Meridian Behavioral Health Services	1	1	0
Iredell	Addiction Recovery Medical Services	1	1	0
Jackson	Meridian Behavioral Health Services	1	1	0
Johnston	Coastal Horizons Center Region 2 TASC	4	4	0
Jones	Coastal Horizons Center Region 1 TASC	1	1	0
Lee	Coastal Horizons Center Region 2 TASC	1	1	0
	Daymark Recovery Services, Inc.	1	1	0
Lenoir	PORT Human Services	1	1	0
Macon	Meridian Behavioral Health Services	1	1	0
	NCG Acquisition LLC	1	1	0
Madison	RHA Health Services	1	1	0
Mecklenburg	Abound Health	2	2	0
	Anuvia Prevention and Recovery, Inc.	2	2	0
	InReach	1	1	0
	McLeod Addictive Disease Center, Inc.	1	1	0
	Primary Care Solutions	1	1	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Mecklenburg	SPARC Network	2	2	0
	The ARC of NC	1	1	0
	Thompson Child & Family Focus	1	1	0
Montgomery	Daymark Recovery Services	1	1	0
Moore	Alexander Youth Network	1	1	0
	Daymark Recovery Services	1	1	0
Nash	Coastal Horizons Center	1	1	0
	Integrated Family Services, PLLC	1	1	0
New Hanover	Coastal Horizons Center	7	7	0
	Physician Alliance for Mental Health	2	2	0
	PORT Health Services	1	1	0
	RHA Health Services, Inc.	1	1	0
Northampton	Home Care Management	1	1	0
Onslow	Coastal Horizons Center	1	1	0
Orange	Freedom House Recovery Center	1	1	0
Pamlico	Coastal Horizons Center	1	1	0
Pender	Coastal Horizons	2	2	0
Person	Freedom House Recovery Center	2	2	0
Pitt	Coastal Horizons Center Region 1 TASC	1	1	0
	PORT Health Services	1	1	0
Robeson	Coastal Horizons Center Region 2 TASC	1	1	0
	Monarch	2	2	0
	Southeastern Integrated Care Services	1	1	0
Rockingham	Ariel Community Care	1	1	0
Rowan	Daymark Recovery Services, Inc.	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
Scotland	Primary Health Choice	1	1	0
Stokes	Daymark Recovery Services	1	1	0
Surry	Daymark Recovery Services – Mt. Airy	1	1	0
	Easterseals UCP	1	1	0
	PQA Healthcare, Inc.	1	1	0
Transylvania	Meridian Behavioral Health Services	1	1	0
Union	Daymark Recovery Services	2	2	0
Wake	Carolina Outreach	2	2	0
	Coastal Horizons Center Region 2 TASC	1	1	0
	Easterseals UCP	2	2	0
	Monarch	1	1	0
	Rescare dba Community Alternatives of NC	1	1	0
	Southlight Healthcare	2	2	0
Watauga	Daymark Recovery Services	1	1	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Wayne	ClientFirst of NC	2	2	0
	Waynesboro Family Clinic	1	1	0
Wilkes	Daymark Recovery Services	3	3	0
Wilson	Coastal Horizons Center Region 1 TASC	1	1	0
	Monarch	2	2	0
	Pride in North Carolina	1	1	0
Total	**110 Facilities Reporting**	169	169	0

The following notes pertain to the superscripts in the table above.

1. This report includes private facilities not required to be licensed by G.S. § 122C. The number of unlicensed facilities in the state is unknown as they are not licensed or state-operated. Rule 10A NCAC 27G .0604 requires each provider agency to self-report an incident based on the information learned if an individual was receiving services in the last 90 days before the death occurred. Since one individual may receive services from more than one provider, the total count may not be an unduplicated count of the number of deaths by suicide, accident, homicide or violence. The total number of deaths that occurred in unlicensed facilities during SFY22 that met the reporting requirement for this report is 169.
2. Information regarding the actual cause of death for many cases is obtained from Death Certificates and/or Medical Examination reports. This information generally takes over 12 months to obtain. Providers use the term “unknown” to report deaths the cause of which is not known. Since the timeframe for this report is July 2021-June 2022, providers have not received copies of the death certificate or medical examiner's reports for some of the deaths submitted during this time period.
3. All deaths reported by unlicensed facilities are reviewed by the responsible LME/MCO providing oversight, and the findings are discussed with DMH/DD/SAS. If problems are identified, the LME/MCO can investigate and/or require the facility to develop a plan for correcting these problems. The LME/MCO then monitors implementation of the plan of correction.
4. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-5: State-Operated Alcohol and Drug Treatment Centers (ADATC)[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion[2]
Buncombe	Julian F. Keith	1	0	0
Granville	R. J. Blackley	1	0	0
Total	**2 Facilities Reporting**	**2**	**0**	**0**

The following notes pertain to the superscripts in the table above.

1. There were 3 State-Operated Alcohol and Drug Treatment Centers (ADATCs) with a total of 180 beds as of June 30, 2022.
2. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Appendix B: Number of Citations Related to Physical Restraint, Physical Holds, and Seclusion by County and Facility

Tables B-1 through B-3 provide data regarding the number of physical restraints, physical holds, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2021 and ending June 30, 2022. Each table represents a separate licensure category or type of facility, shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits and administrative desk reviews conducted by DHHS and LME/MCO staff for initial, renewal and change-of- ownership licensure surveys, follow-up visits and complaint investigations. A total of 2,584 licensure surveys, 1,481 follow-up visits, 1,725 complaint investigations and 141 other reviews were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility Cited	Citations
Burke	Morganton LTC Southview	4
Wilson	Morningside AL #5	1
Craven	Croatan Village	1
Guilford	Verra Springs at Heritage Green	1
Harnett	Pinecrest Gardens	1
Mecklenburg	Elmcroft of Little Avenue	1
Wake	Morningside of Raleigh	1
Total	**7 Facilities Cited**	**10**

Table B-2: Private Group Homes, Community-Based Psychiatric Residential Treatment Facilities, Outpatient and Day Treatment Facilities

County	Facility Cited	Citations
Alamance	North Mebane Street Group Home	1
	Alamance Homes II	2
	Williamson Avenue Group Home	1
Buncombe	Clayton	1
	Riverview Group Home	1
	Haw Creek	2
	Reuter Cottage	1
Cabarrus	Arey	1
	Brookwood	2
Caldwell	McLeod Addictive Disease Center-Lenoir	1
Cleveland	Ann's House	2
	Cleveland Crisis and Recovery	2
	Alternatives Residential Care Home	2
	Healthy Choices	6
	Sandra's House	1
Cumberland	CREST Group Home #2	2
	Pearl's Angel Care, Inc.	2
	S&S Spoonridge Group Home	2
	Graceland Manor DDA #3	1
	New Horizons Group Home	1
	Hearts of Hope Home Place	1
	Joyful Living #1	1
	Myrover-Reese Fellowship Home	1
	Ashton W. Lilly Fellowship Home	1
	Pat Reese Fellowship Home	1
	Excel Care Agency Incorporated	2
	CREST Group Home #4	1
	Carolina's DDA Group Home	2
Davidson	Lexington Treatment Center	1
	Davidson Crisis Center	2
Durham	Triangle Options for Substance Abusers, Inc. MHL-032-582	1
	Triangle Options for Substance Abusers, Inc. MHL-032-561	1
	Durham Women's Halfway House	1
	TLC Adult Group Home	1
	Care Health Services I	2
	Veritas Collaborative, LLC	2
	Durham Men's Halfway House	1
	Melody House (MHL-032-383)	1
	Melody House (MHL-032-423)	1
	Durham Treatment Center	1
Edgecombe	Open Arms Family Services, Inc.	1
Forsyth	Wake Forest Health Services SA Program	1
	Garvin's Mental Management	1
	Sharpe & Williams #4	1
Franklin	Healthy Moral Homes, LLC	1
	Mables Home	1
Gaston	Trinity House	2
	Hoffman	1

County	Facility Cited	Citations
	Blossom Community Services	4
	NU Generation	2
	Elizabeth Group Home	1
	Intervention Concepts, Inc.	2
	Freedom	4
	Cultivating Minds	2
	McLeod Addictive Disease Center	1
	New Hope Home III	2
Granville	House of Angels	1
Guilford	The Umbrella Company	2
	Successful Transitions, LLC Residential Home Level III	4
	Three Meadows	2
	Lockwood II	1
	Mercy Homes Services, Inc.	2
	Mercy Homes Services, II	2
	Quality Care III LLC/Hickory Tree Home	2
	Royalty Care	2
	Successful Visions, LLC	2
Harnett	Sierras Residential Services, Inc.	2
	Harmony Home	2
	Woodhaven Family Care Facility	3
	Peach Farm Road	1
Henderson	Pieridae Treatment Center	1
	Equinox RTC	2
Hoke	Multicultural Resources Center Group Home #1	1
	Canyon Hills Treatment Facility	1
Iredell	The McLeod Addictive Disease Center	1
	Chestnut Grove	2
Johnston	Passionate Care Group Home #1	2
	Savin Grace II	1
Lee	Mercer Home	1
	Lee County Group Home, Inc. #1	1
	Lee County Group Home II	1
Lenoir	Pinewood Facility	1
Martin	New Destiny	1
McDowell	Wes Marion Supervised Living	3
Mecklenburg	NeuroRestorative Sardis	1
	Alphin Cottage	2
	Yorke Cottage	1
	Williamson Cottage	1
	Dickson Unit	1
	Diamond's House	1
	McLeod Additive Disease Center	2
	Nisbet Unit	3
	Water Mill	2
	McLeod Addictive Disease Center 4th Floor	1
	Nevins	1
	Harmony Recovery Center	1

County	Facility Cited	Citations
Moore	Bethesda, Inc.	1
	Alan Circle	2
New Hanover	Wilmington Home	1
Orange	Hillsborough Recovery Solutions	1
	RSI – Ephesus Church Road	1
	RSI – Hamilton Road	1
	Facility Based Crisis Services	1
	Maggie Alvis Women's Halfway House	1
Pender	Lotus	2
Person	The Farm	1
	Eden Square	1
Richmond	Diligent Care Group Home #II	1
Robeson	A Better Way Residential Services	1
Rockingham	Laverne's Haven Residential Services, LLC	2
Rowan	Timber Ridge Treatment Center	1
	Revive Housing	2
Rutherford	Direct Care Group Home	2
Sampson	Candii Homes	2
Stokes	Pinnacle Homes #1	1
	Pinnacle Homes #II	1
Vance	Brightside Homes IV	1
Wake	Alston Home	1
	Whittecare Group Home	1
	Learning Services Corporation – Cedar House	1
	Learning Services Corporation – Willow House	1
	Learning Services Corporation – River Ridge	1
	Alpha Home Care Services #9	1
	Care One Homes	1
	The Manor at Riverbrooke	1
	Ann's Haven of Rest	1
	Prosperous Living Community Center (PLCC)	1
	Beyond Measures	1
	Walnut Street Group Home	1
	Wilkins Home	1
Watauga	Three Forks Home	2
Wilkes	Mountain Health Solutions – North Wilkesboro	1
Wilson	The Wellman Center 1	1
	Wellman Center 3	1
	Wellman Center 4	1
	Supreme Love	1
Yancey	Calloway Cottage	2
Total	**137 Facilities Cited**	**199**

Table B-3: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities

County	Facility	Citations
Brunswick	Carolina Dunes Behavioral Health	3
Cabarrus	Atrium Health Services	2
Craven	Carolina East Medical Center	1
Durham	Duke Regional	2
Forsyth	Novant Health Forsyth	1
	Old Vineyard	2
Moore	FirstHealth Moore	3
Nash	Nash General Hospital	3
New Hanover	Novant Health New Hanover	2
Onslow	Brynn Marr Hospital	1
Orange	UNC Hospitals	1
Rutherford	DLP Rutherford Regional	2
Wake	Duke Raleigh	2
	Strategic Behavioral Health	3
	Strategic Behavioral Health-Garner	2
Wilson	DLP Wilson Medical	2
Total	**13 Facilities Cited**	**32**

No citations were issued for the following types of facilities: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities; Private Unlicensed Facilities; State Alcohol and Drug Abuse Treatment Centers; State Intermediate Care Facilities for Individuals with Intellectual Disabilities; State Neuro-Medical Treatment Centers; State Psychiatric Hospitals or State Residential Programs for Children.