STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

October 13, 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. Fulton on behalf of Kody H. Kinsley
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Kody H. Kinsley
Secretary

cc:
Mark Collins
Theresa Matula
Nathan Babcock
Darryl Childers
Joyce Jones
Katherine Restrepo
Francisco Celis Villagrana
Melissa Roark
Lisa Wilks
Amy Jo Johnson
Fred Aikens
Marissa Doctrove
Susie Camilleri
Luke MacDonald
Todd Barlow
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

October 13, 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 Use Services (DMH/DD/SUS), 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) 2022-2023, which covers the period of July 1, 2022 through June 30, 2023.

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 230 deaths were reported: 31 by adult care homes, 48 by private licensed facilities, 150 by private unlicensed facilities, and 1 by a private intermediate care facility for individuals with intellectual disabilities. Of the 230 deaths reported, all were screened and 193 (83.9%) 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 1,918 licensure surveys, 1,534 follow-up visits, 2,297 complaint investigations and 331 other reviews were conducted during the SFY. A total of 170 citations were issued for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion.

Citations covered a wide range of deficiencies, including failure to provide training, failure to obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, failure to complete a proper assessment and care planning for the use of restraints, failure to ensure the individual is monitored by a medically trained professional at the required intervals, failure to document use of mechanical restraints and release times, 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=89 or 52.7%) and "training in seclusion, physical restraint and isolation time-out" (N=42 or 24.9%). These citations accounted for 96.4% 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 2022-2023, which spans the period July 1, 2022 through June 30, 2023. 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-4 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 170 facilities – 100 private unlicensed facilities, 38 private licensed facilities, 31 adult care homes, 1 private intermediate care facility for individuals with intellectual disabilities – reported a total of 230 deaths that were subject to these statutory reporting requirements.

2 Of the total 230 deaths reported, 150 deaths occurred at private unlicensed facilities, 48 deaths occurred at private licensed facilities, 31 deaths occurred at adult care homes and 1 death occurred at a private intermediate care facility for individuals with intellectual disabilities.

3 All deaths that were reported were screened; a total of 193 deaths (83.9%) 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 2022-2023

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	1,109	40,460	31	31	31	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,334	11,890	38	48	11	0
A-3	Community ICF-IID	338	2,806	1	1	1	0
N/A[6]	Psychiatric Hospitals, Units, & Hospital PRTFs	74	2,593	0	0	0	0
Subtotal		4,855	57,749	70	80	43	0
Private Unlicensed Facilities							
A-4	Private Unlicensed[5]			100	150	150	0
State-Operated Facilities							
N/A[6]	Alcohol and Drug Treatment Centers	2	96	0	0	0	0
N/A[6]	Developmental Centers (ICF-IID)	3	962	0	0	0	0
N/A[6]	Neuro-Medical Treatment Centers[6]	3	506	0	0	0	0
N/A[6]	Psychiatric Hospitals	3	902	0	0	0	0
N/A[6]	Residential Programs for Children	2	30	0	0	0	0
Subtotal		13	2,496	0	0	0	0
Grand Total		**4,868**	**60,245**	**170**	**230**	**193**	**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, 2023).
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. 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, 2022, and ending June 30, 2023. 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 121 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. One (1) citation was issued to a state-operated psychiatric hospital. No citations were issued to private unlicensed facilities or to the other 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 1,918 initial, renewal and change-of-ownership licensure surveys, 1,534 follow-up visits, 2,297 complaint investigations and 331 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 169 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 with the exception of one (1) citation received by a state psychiatric hospital. 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=89 or 52.7%) and “training in seclusion, physical restraint and isolation time-out” (N=42 or 24.9%); these accounted for 96.4% 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 2022-2023[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	7	• Rule 10A NCAC 13F .1501(c) Failure to complete proper assessment and care planning for the use of restraints (6 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 (1 citation)
B-2	Group Homes, Community-Based PRTFs and Outpatient and Day Treatment Facilities	109	154	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (V536) (89 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (V537) (40 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) (6 citations)	• Rule 10A NCAC 27E .0104(c)(d) Client Rights – Seclusion, Physical Restraint, Isolation Time-Out (V517) (1 citation) • Rule 10A NCAC 27E .0104(3)(3-7) Client Rights – Seclusion, Physical Restraint, Isolation Time-Out (V519) (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 .0105(a) Protective Devices (V31) (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	4	5	• A178: When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention by a Physician or other licensed practitioner; or Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section. (2 citations)	• A154: Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. (1 citation) • A168: Use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner (1 citation) • A196: Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a client in restraint or seclusion: (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. (1 citation) • Rule 10A NCAC 27E .0104: Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (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-4	Community ICFs/IID	1	2	W306: Release from mechanical restraint (glove and helmet use for self-injurious behavior) must occur for 10 minutes every 2 hours. (1 citation) W307: Record of use of mechanical restraint and release times must be kept. (1 citation)	None
Subtotal		121	168		
Private Unlicensed Facilities					
N/A[2]	Private Unlicensed	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
State-Operated Facilities					
B-5	Psychiatric Hospitals	1	1	A196: Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion: (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. (1 citation)	None
N/A[2]	Alcohol and Drug Treatment Centers (ADATC)	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Center	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Residential Programs for Children	0	0	No Citations were issued.	No Citations were issued.
Subtotal		1	1		
Grand Total		**122**	**169**		

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 1,918 licensure surveys, 1,534 follow-up visits, 2,297 complaint investigations and 331 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, 2022, and ending June 30, 2023, 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]
Bertie	Winston Gardens	1	1	0
	Windsor House	1	1	0
Brunswick	Arbor Landing	1	1	0
Buncombe	Chase Samaritan Assisted Living	1	1	0
Burke	Clara's Cottage	1	1	0
	The Berkeley	1	1	0
Cabarrus	The Drake	1	1	0
	The Landings of Cabarrus	1	1	0
Carteret	Carteret Landing Assisted Living and Memory Care	1	1	0
Cleveland	Terrabella Shelby	1	1	0
Forsyth	Cadence of Clemmons	1	1	0
	The Bradford Village West	1	1	0
Gaston	Rosewood Assisted Living	1	1	0
Guilford	Brookdale Lawn Park	1	1	0
	Brookdale High Point North AL	1	1	0
Henderson	Carolina Reserve of Laurel Park	1	1	0
	The Landings of Mills River	1	1	0
Hoke	Wickshire Creeks Crossing	1	1	0
Iredell	Heritage Place	1	1	0
Johnston	Four Oaks Senior Living	1	1	0
	The Landings of Smithfield	1	1	0
Lenoir	Rose Vista Assisted Living	1	1	0
Mecklenburg	Arbor Ridge at Huntersville	1	1	0
	The Parc at Sharon Amity	1	1	0
	The Cadence at Mint Hill	1	1	0
New Hanover	Coastal Cove of Wilmington	1	1	0
	Cedar Cove Assisted Living	1	1	0
	The Kempton of Brightmore	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Pamlico	The Gardens of Pamlico	1	1	0
Richmond	Hamlet House	1	1	0
	Hermitage Retirement Center	1	1	0
Total	**31 Facilities Reporting**	**31**	**31**	**0**

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

1. There were 1,109 Licensed Adult Care Homes with a total of 40,460 beds as of June 30, 2023.
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]
Brunswick	Shallotte Treatment Associates	1	0	0
Buncombe	BHG Asheville Treatment Center	1	0	0
	First Step Farm-Men	1	0	0
Burke	New Season Morganton	1	0	0
Cabarrus	McLeod Centers for Wellbeing	1	0	0
Caldwell	New Horizons, P.S.R.	1	1	0
Carteret	Port Health Services-Morehead City	2	0	0
Catawba	Hickory Metro Treatment Center	1	1	0
Cumberland	Carolina Outreach 1	1	0	0
	Carolina Treatment Center of Fayetteville	1	0	0
	Fayetteville Treatment Center	1	1	0
Davidson	Lexington Treatment Associates	1	0	0
Durham	Triangle Residential Options for Substance Abusers	2	0	0
Forsyth	Insight Human Services-Forsyth	1	0	0
	Sharpe and Williams #6	1	1	0
	Winston-Salem Comprehensive Treatment	1	1	0
Greene	Edwards Group Home #4	1	1	0
Guilford	Greensboro Treatment Center	1	0	0
Halifax	Morse Clinic of Roanoke Rapids	2	2	0
Harnett	Sanford Treatment Center, LLC	1	0	0
Haywood	Smoky Mountain House	1	0	0
Iredell	McLeod Centers for Wellbeing	1	0	0
Madison	RHA Health Services-Marshall	1	0	0
McDowell	McLeod Centers for Wellbeing	1	0	0
Mecklenburg	Anuvia Prevention and Recovery Center	1	0	0
	Hillsborough Recovery Solutions	1	0	0
	McLeod Centers for Wellbeing	2	0	0
	Queen City Treatment Center	1	1	0
New Hanover	Coastal Horizons Center, Inc.	4	0	0
	Lifeline Treatment Center	1	0	0
Orange	Hillsborough Recovery Solutions	1	0	0
Pitt	Port Health Services-Adult Outpatient	1	0	0

County	Facility	Deaths Reported and Screened	Death Reports Invest0igated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Robeson	Lumberton Treatment Center	1	0	0
Wake	Southlight Healthcare-Garner Road	4	1	0
	The Morse Clinic of North Raleigh	1	1	0
Watauga	Stepping Stone of Boone	1	0	0
Wilkes	Mountain Health Solutions-North Wilkesboro	1	0	0
	Stepping Stone of Wilkes	1	0	0
Total	**38 Facilities Reporting**	**48**	**11**	**0**

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

1. There were 3,334 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 11,890 beds as of June 30, 2023.
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 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion[2]
Davie	Boxwood Acres	1	1	0
Total	**1 Facility Reporting**	**1**	**1**	**0**

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

1. There were 338 Intermediate Care Facilities for Individuals with Intellectual Disabilities and a total of 2,806 beds as of June 30, 2023.
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]
Beaufort	Coastal Horizons Center Region 1 TASC	1	1	0
Bladen	Monarch	1	1	0
Brunswick	Coastal Horizons Center Region 2 TASC	1	1	0
Buncombe	RHA Behavioral Health Services	4	4	0
	SPARC Services and Programs	1	1	0
Burke	A Caring Alternative	1	1	0
	New Season Treatment Center	1	1	0
Caldwell	RHA Behavioral Health Services	1	1	0
Carteret	PORT Health Services	4	4	0
Chatham	Daymark Recovery Services	2	2	0
Columbus	Coastal Horizons Center Region 2 TASC	1	1	0
	RHA Behavioral Health Services	1	1	0
Cumberland	Carolina Outreach	3	3	0
	Coastal Horizons Center Region 2 TASC	1	1	0
	Easterseals UCP North Carolina and Virginia	1	1	0
	Fayetteville Treatment Center	1	1	0
Davidson	Monarch Davidson ACT Team	2	2	0
	RHA Behavioral Health Services	1	1	0
Durham	B&D Integrated Health Services	2	2	0
	Baart Community Healthcare	1	1	0
	Carolina Outreach	4	4	0
	Coastal Horizons Center, Inc.	1	1	0
	El Futuro	1	1	0
	Recovery Response Center Durham	1	1	0
	TROSA	2	2	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Edgecombe	Coastal Horizons Center Region 1 TASC	1	1	0
Forsyth	Daymark Treatment Services	3	3	0
	Monarch	3	3	0
Gaston	Amara Wellness Services	1	1	0
	Monarch	1	1	0
	Support Incorporated	1	1	0
Guilford	Envisions of Life, LLC	1	1	0
	Greensboro Treatment Center	1	1	0
	Psychotherapeutic Services	1	1	0
	SPARC Services & Programs, LLC	1	1	0
Halifax	Day by Day Solutions, LLC	1	1	0
Harnett	Coastal Horizons Center Region 2 TASC	1	1	0
Haywood	Meridian Behavioral Health Services	2	2	0
Hertford	PORT Health Services	2	2	0
Hoke	Coastal Horizons Center Region 1 TASC	2	2	0
Iredell	Daymark Recovery Services Iredell Clinic	1	1	0
	Partners Health Management	1	1	0
Jackson	Blue Ridge Health/Meridian Behavioral Health	1	1	0
	Carolina Outreach	1	1	0
Lee	Coastal Horizons Center Region 2 TASC	1	1	0
	Sanford Treatment Center	1	1	0
Lenoir	Coastal Horizons Center Region 1 TASC	2	2	0
Macon	Blue Ridge Health/Meridian Behavioral Health	1	1	0
Madison	RHA Behavioral Health Services	3	3	0
McDowell	RHA Behavioral Health Services	2	2	0
Mecklenburg	Monarch	3	3	0
	Pathways of Life, Inc.	1	1	0
Montgomery	Insight Human Services	1	1	0
Moore	Insight Human Services	1	1	0
Nash	Monarch	1	1	0
New Hanover	Coastal Horizons Center, Inc.	6	6	0
	Wilmington Health Access for Teens	1	1	0
	Lifeline Treatment Center	1	1	0
	Physician Alliance for MH	1	1	0
	RHA Behavioral Health Services	1	1	0
Onslow	Coastal Horizons Center Region 1 TASC	1	1	0
	Physician Alliance for MH, LLC	1	1	0
Pamlico	Coastal Horizons Center, Inc	1	1	0
Person	Person Counseling Center	1	1	0
Pitt	Coastal Horizons Center Region 1 TASC	1	1	0
	PORT Human Services Greenville Clinic	1	1	0
Randolph	Insight Human Services	2	2	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Robeson	Coastal Horizons Center Region 2 TASC	2	2	0
	Monarch	2	2	0
	Positive Progress Services	1	1	0
	Southeastern Integrated Care	1	1	0
	Stephens Outreach Center	2	2	0
Rowan	Insight Human Services/TASC	1	1	0
	Youth Villages	1	1	0
Sampson	Coastal Horizons Center Region 1 TASC	1	1	0
Scotland	Coastal Horizons Center Region 2 TASC	1	1	0
	Monarch	2	2	0
	RHA Behavioral Health Services	1	1	0
Stanly	Monarch	3	3	0
Stokes	Daymark Recovery Services-Stokes Center	1	1	0
Surry	Partners Behavioral Health Management	1	1	0
Union	Daymark Recovery Services	1	1	0
Vance	Henderson Recovery Response Center	1	1	0
Wake	Carolina Outreach	5	5	0
	Coastal Horizons Center Region 2 TASC	1	1	0
	Community Partnerships	2	2	0
	Hope Services, LLC	1	1	0
	North Carolina Recovery Support Services	2	2	0
	Quality Care Solutions, INC	1	1	0
	UNC Wake STEP Clinic	1	1	0
	Universal Mental Health Services Inc.	1	1	0
Warren	Strategic Interventions	2	2	0
Wayne	Coastal Horizons Center Region 1 TASC	2	2	0
	Easterseals UCP North Carolina and Virginia	2	2	0
Wilkes	Daymark Recovery Services	1	1	0
Wilson	Wilson Professional Services	1	1	0
	Coastal Horizons Center Region 1 TASC	1	1	0
	Pride in NC	1	1	0
Yadkin	Daymark Recovery Services	1	1	0
Total	**100 Facilities Reporting**	150	150	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 SFY23 that met the reporting requirement for this report is 150.

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 2022-June 2023, 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/SUS. 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.

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

Tables B-1 through B-4 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, 2022 and ending June 30, 2023. 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 1,918 licensure surveys, 1,534 follow-up visits, 2,297 complaint investigations and 331 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
Craven	Croatan Village	1
Haywood	Haywood House	1
Johnston	The Enclave at Buffalo	1
Mecklenburg	The Sanctuary at StoneHaven	1
Surry	Twelve Oaks	1
Wake	Morningside of Raleigh	1
	North Pointe Assisted Living of Garner	1
Total	**7 Facilities Cited**	**7**

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

County	Facility Cited	Citations
Alamance	Cozie's Supervised Living	1
	Lakeside Avenue Group Home	1
	Lillie's Place	2
	Trinity Behavioral Healthcare PC	1
Beaufort	Country Living Guest Home #5	1
	Wooded Acres #1	1
Brunswick	The Trinity Home	1
Buncombe	BHG Asheville Treatment Center	1
	Willow Place	1
Burke	126C Air Park Drive	1
Cabarrus	Adrienne's House	2
Catawba	Pinnacle Therapeutic Services	1
Cherokee	The Overlook	1
Cleveland	Healthy Choices	2
Cumberland	C.R.E.S.T. Group Home #2	2
	Hearts of Hope Home Place	1
	Myrover-Reese Fellowship Home	1
Duplin	Magnolia Group Home	1
Durham	Absolute Home-Roxboro Street	1
	Community Choices, Inc.-Cascade @ Durham	1
	Melody House #1, LLC	1
	TLC Adult Group Home	1
Edgecombe	Edwards Residential Care	2
	Open Arms Family Services	2
Forsyth	Johnson Enrichment Services, LLC	1
	Sharpe & Williams #6	1
	Sharpe & Williams #7	2
	Sharpe & Williams #8	2
Gaston	Harmony House	1
	Powell	1
Granville	Crossings	2
	Learning Services Neurobehavioral Institute	1
	Learning Services Neurobehavioral Institute 2	1
Guilford	Adult Day and Respite Care Center	2
	Beautiful Beginnings	2
	Hicks House of Care	1
	Majestic Solutions, Inc.	2
	Mercy Home Services	2
	Successful Transitions, LLC Residential Home	2
	Successful Visions, LLC	2
	Watlington's Family Care Homes #3	2
Harnett	AMAT Group Homes, LLC #3	1
	Elmore-Blackley Fellowship Home	1
	Freedom Care Services, LLC #4	1
	Sierra's Residential Services, Inc.	2
Henderson	Hillpark Group Home	2
Hoke	Multicultural Resources Center-Group Home #2	1
Iredell	Greenbrier Road	2
	Whalen House	2

County	Facility Cited	Citations
Jackson	Hawthorn Heights	1
Johnston	Children Under Construction Treatment Center	2
	Lee County Group Home II	2
	Lee County Group Home, Inc. #1	1
	Mercer Home	1
	Triangle Residential Options for Substance Abusers	1
Martin	Charlotte Counseling and Consulting, PLLC	2
McDowell	Clear Sky Behavioral	2
Mecklenburg	AYN-Nisbet Unit	2
	Harmony Recovery Center	1
	Lendon Cottage	2
	Life-Way Homes, LLC	1
	Merancas Cottage	2
	Mr. Bill's Place	2
	Residential Adolescent Community Services	2
	SECU Youth Crisis Center, a Monarch Program	2
	Smith Cottage	2
	Solomon Palace	1
	Williamson Cottage	2
Moore	Linden Lodge	1
	The Bethany House, Inc.	1
Nash	MACTA, LLC	1
New Hanover	Reflections of Hope, L.L.P.	1
Onslow	Linda Shorts Home	1
Orange	Care Health Services 1	1
	Hillsborough Recovery Solutions	1
	RSI-Umstead	1
Person	Sharpe & Williams Eden's Home #1	1
Pitt	Port Health Services-Paladin	1
Richmond	Charlotte Street	1
	Samaritan Colony	1
Robeson	Chaparral Youth Services, LLC	3
	Hope House	1
	Nu-Image	1
	Renewing Grace Residential Home	8
Rockingham	Academy Place	1
	Faith House	1
Rowan	Catawba House	1
	Pine Street	1
	Timber Ridge Treatment Center	1
Sampson	Garland Group Home	1
Scotland	Miracle Haven of Wagram	1
Stanly	Coggins Group Home	1
Transylvania	Trails Carolina	2
Union	My Brothers House	3
	The Stegall Home	1
Wake	Blessed Home, LLC	2
	Bradley Home Extension-Pkeds House	1
	Bradley Home Extension-Kimberly House	1
	Care One Homes	1
	Eagle Home III	1

County	Facility Cited	Citations
Wake	Herbert Reid Home	1
	New Beginnings Health Care	1
	The Agape House	1
	Victory Healthcare Services, Inc.	1
Wilson	Hinton's Residential Services	1
	The Wellman Center 1	1
	Wellman Center 3	1
	Wellman Center 4	1
Total	**109 Facilities Cited**	**154**

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

County	Facility	Citations
Columbus	Columbus Regional Healthcare	1
Mecklenburg	Atrium Health University	1
Onslow	Brynn Marr Hospital	2
Wilson	Wilson Medical Center	1
Total	**4 Facilities Cited**	**5**

Table B-4: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities

County	Facility	Citations
Lenoir	Skill Creations of Kinston	2
Total	**1 Facility Cited**	**2**

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