STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

October 21, 2024

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 Joyce Krawiec, 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

The Honorable Carla Cunningham, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 403, 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. Gordon
65A1EF320AD6419...
on behalf of Kody H. Kinsley

Kody H. Kinsley
Secretary

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

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 21, 2024

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 of the 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) 2023-2024, which covers the period of July 1, 2023 through June 30, 2024.

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 214 deaths were reported: 21 by adult care homes, 73 by private licensed facilities, 118 by private unlicensed facilities, one on a psychiatric unit in a hospital and one in a state psychiatric hospital. Of the 214 deaths reported, all were screened and 147(68.7%) were investigated. No deaths were found to be related to the use of physical restraint, physical holds, or seclusion.

No deaths occurred in the community-based intermediate care facilities for individuals with intellectual and developmental disabilities (ICF-IID), the mental health hospitals, the community-based PRTFs or in the state-operated alcohol and treatment centers (ADATC), developmental centers (ICF-IID), neuro-

treatment centers, or in the residential programs for children.

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; however, a total of 2,571 licensure surveys, 1,511 follow-up visits and 1,791 complaint investigations were conducted during the SFY.

A total of 110 private licensed facilities were issued a total of 152 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 unlicensed facilities or to the state-operated alcohol and drug treatment centers (ADATC), intermediate care facilities for individuals with intellectual disabilities (ICF-IID), neuro-medical treatment centers, psychiatric hospitals or residential programs for children.

Citations covered a wide range of deficiencies, including failure to provide training, 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 and improper use of protective devices for behavioral control. The largest number of citations issued involved deficiencies related to training on alternatives to restrictive interventions (N=78 or 51.3%), training in seclusion, physical restraint and isolation time-out (N=30 or 19.7%) and failure to use least restrictive alternatives before implementing more restrictive interventions (N=23 or 15.1%). These citations accounted for 86.1% of the total issued.

Introduction

G.S. § 122C-31, *Report Required Upon Death of a Client*, requires a facility to notify the Secretary of the 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 2023-2024, which spans the period July 1, 2023 through June 30, 2024. 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 156 facilities reported a total of 214 deaths that were subject to these statutory reporting requirements. This included 83 private unlicensed facilities, 53 private licensed community-based facilities, 18 adult care homes, one psychiatric unit in a hospital, and one state psychiatric hospital.

2 Of the total 214 deaths reported, 118 deaths occurred at private unlicensed facilities, 73 deaths occurred at private licensed community-based facilities, 21 occurred in adult care homes, one death occurred on a psychiatric unit in a hospital and one death occurred at a state psychiatric hospital.

3 All deaths that were reported were screened; a total of 147 deaths (68.7%) 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 2023-2024

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	1,094	40,169	18	21	21	0
A-2	Group Homes, Day & Outpatient Treatment	2,908	13,117	53	73	7	0
A-3	Psychiatric Hospitals, Hospitals with Psychiatric Units, & Hospital PRTFs	40	2,582	1	1	1	0
N/A[6]	Community ICF-IID	338	2,799	0	0	0	0
N/A[6]	Mental Health Hospital PRTFs and Community-Based PRTFs	22	225	0	0	0	0
Subtotal		4,402	58,892	72	95	29	0
A-4	Private Unlicensed[5]			83	118	118	0
State-Operated Facilities							
A-5	Psychiatric Hospitals	3	901	1	1	0	0
N/A[6]	Alcohol and Drug Treatment Centers	3	92	0	0	0	0
N/A[6]	Developmental Centers (ICF-IID)	3	954	0	0	0	0
N/A[6]	Neuro-Medical Treatment Centers	3	400	0	0	0	0
N/A[6]	Residential Programs for Children	2	30	0	0	0	0
Subtotal		14	2,377	1	1	0	0
Grand Total		**4,416**	**61,269**	**156**	**214**	**147**	**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, 2024).
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, 2023, and ending June 30, 2024. 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 110 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 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 2,571 initial, renewal and change-of-ownership licensure surveys, 1,511 follow-up visits and 1,791 complaint investigations 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 152 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=78 or 51.3%), training in seclusion, physical restraint and isolation time-out (N=30 or 19.7%) and failure to use a least restrictive alternative before implementing a restrictive intervention (N=23 or 15.1%). These citations accounted for 86.1% 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 2023-2024[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	5	6	• Rule 10A NCAC 13F .1501(a) Failure to ensure a restraint is only used after informed consent has been obtained from the resident or the resident's legal representative. (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 ,1501(d) Failure to ensure orders for restraints are provided by the physician and are completed in accordance with rules and regulations. (2 citations)	
B-2	Group Homes, Outpatient and Day Treatment Facilities	94	132	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (V536) (76 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (V537) (27 citations) • Rule 10A NCAC 27E .0101 Least Restrictive Alternative (V513) (23 citations) • Rule 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V519) (2 citations)	• Rule 10A NCAC 27E .0104(c)(d) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V517) (2 citations) • Rule 10A NCAC 27E .0104(e)(3-7) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V519) (2 citations)
B-3	Mental Health Hospitals and Community-Based PRTFs	4	6	• Rule 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint and Isolation Time-Out V537) (CB-PRTF) (3 citations) • Rule 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536) (CB-PRTF) (2 citations)	• Rule 10A NCAC27E .0104(e)(10) Client Rights - Seclusion, Physical Restraint and Isolation Time-Out (V522)(MHH-PRTF) (1 citation)

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2023-2024[1] – continued

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 ICF/IID	1	1	• W303-A Record of Checks and Usage Must Be Kept (1 citation)	
B-5	Psychiatric Hospitals, Hospitals with Acute Care Psychiatric Units and Hospital PRTFs	6	7	• A0178: When restraint or seclusion is used for the management of violent or self-destructive behavior the 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 (2 citations) • A0168: CFR 482.13(e)(5) – The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. (2 citations)	• A0196: 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 (1 citation) • A0179: The patient must be seen face-to-face within 1 hour after the initiation of the intervention (1 citation) • A0161: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or the methods that involve the physical holding of a patient for the purpose of conducting routine physical examination or tests….Failed to have a physician's order for the application of restrictive interventions for a patient and failed to perform a 1-hour face-to-face evaluation in 1 of 3 records reviewed. (1 citation)
Subtotal		110	152		

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2023-2024[1] – continued

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE UNLICENSED FACILITIES					
N/A[2]	Private Unlicensed	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
STATE-OPERATED FACILITIES					
N/A[2]	Alcohol and Drug Treatment Centers (ADATC)	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers (ICF-IID)	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Centers	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Psychiatric Hospitals	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		0	0		
Grand Total		**110**	**152**		

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 2,571 licensure surveys, 1,511 follow-up visits, and 1,791 complaint investigations 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, 2023 and ending June 30, 2024, 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	Windsor House	1	1	0
Brunswick	The Bluefields	1	1	0
	Arbor Landing at Ocean Isle	1	1	0
Burke	Ciara's Cottage ECH #1	1	0	0
Carteret	Carteret Landing	3	3	0
Chatham	Carolina Meadows Fairways	1	1	0
Cumberland	Harmony at Hope Mills	1	1	0
Durham	Calyx of Durham	1	2	0
Forsyth	Kerner Ridge AL	1	1	0
	Creekside Manor	1	1	0
Guilford	Richland Square	1	1	0
	Brookdale Skeet Club	2	2	0
Henderson	Carolina Reserve of Hendersonville	1	1	0
Hoke	Wilkshire Creeks Crossing	1	1	0
Nash	The Landings of Rocky Mount	1	1	0
Pasquotank	Brookdale Elizabeth City	1	1	0
Person	Roxboro Assisted Living	1	1	0
Warren	Alpha Magnolia Gardens	1	1	0
Total	**18 Facilities Reporting**	**21**	**21**	**0**

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

1. There were 1,094 Licensed Adult Care Homes with a total of 40,169 beds as of June 30, 2024.
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 (0) indicate that there were no deaths related to restraint/ seclusion; 1 indicates that restraint/seclusion may have been a factor, but not necessarily the cause of death; 2 indicates that restraint/seclusion may have resulted in the death.

Table A-2: Private Group Homes, 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	Hall Avenue Facility	1	0	0
Brunswick	Shallotte Treatment Associates	1	0	0
Buncombe	BHG Asheville Treatment Center	1	0	0
	Crossroads Treatment Center of Weaverville	1	0	0
	Tender Loving Care Homes, Inc.	1	0	0
Cabarrus	McLeod Centers for Wellbeing	1	0	0
Caldwell	McLeod Centers for Wellbeing	4	0	0
Carteret	Morehead City Treatment Center	1	0	0
Catawba	McLeod Centers for Wellbeing	1	0	0
Cumberland	Carolina Treatment Center of Fayetteville	4	0	0
Davidson	Davidson Crisis Center	1	0	0
	Thomasville Treatment Associates	1	0	0
Durham	Baart Community Healthcare	1	0	0
	Durham Treatment Center	1	0	0
	Morse Clinic of Durham	1	0	0
	Roshaun's House of Care	1	0	0
Forsyth	Insight Human Services-Forsyth	1	0	0
	Winston-Salem Comprehensive Treatment Center	1	0	0
Gaston	Gastonia Treatment Center	1	0	0
	Outreach Management Services LLC	1	0	0
	Phoenix Counseling Center-Outpatient Center	1	0	0
Guilford	Servant's Heart IV	1	1	0
Harnett	Daymark Recovery Services Lee Center	1	0	0
Haywood	Meridian Behavioral Health Services, Inc.	1	0	0
Henderson	Premier Treatment Specialists, LLC	1	0	0
Iredell	Addiction Recovery Medical Services	1	1	0
Johnston	Johnston Recovery Services	1	0	0
Lincoln	Phoenix Counseling Center	1	0	0
Mecklenburg	Anuvia Prevention and Recovery Center	2	0	0
	Harmony Recovery Center, LLC	1	0	0
	Hopeway	1	0	0
	Zenith Hope Center, LLC	1	0	0

Table A-2: Private Group Homes, Day and Outpatient Treatment Facilities[1] continued

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Moore	Carolina Treatment Center of Pinehurst	2	0	0
Nash	Rocky Mount Treatment Center	1	0	0
New Hanover	Coastal Horizons Center, Inc.	6	1	0
Onslow	Project Vision	1	0	0
Pender	Coastal Horizons Center-Pender	1	0	0
Pitt	Better Connections Midland Ct	1	1	0
	Port Health Services-Greenville Detox	1	0	0
	Port Health Services-Paladin	2	0	0
Randolph	Asheboro Crisis Center	3	0	0
Richmond	Daymark Recovery Services, Inc.-Richmond	1	0	0
Roberson	Lumberton Treatment Center	2	0	0
Rockingham	North Carolina Wellness Center-Reidsville	1	0	0
Surry	Hope Valley Men's Division	1	0	0
Union	Monroe Crisis Recovery Center	1	1	0
Vance	Vance Recovery	2	0	0
Wake	The Morse Center of North Raleigh	1	0	0
Warren	Lake Area Counseling Halfway House	1	1	0
Wayne	Carolina Treatment Center of Goldsboro	3	1	0
	Waynesboro Family Clinic PA	1	0	0
Wilson	Dixon Interactive Services, Inc.	1	0	0
	Wilson Professional Services Treatment	1	0	0
Total	**53 Facilities Reporting**	**73**	**7**	**0**

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

1. There were 2,908 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 13,117 beds as of June 30, 2024.
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 PRTFs[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Forsyth	Novant Health Forsyth	1	1	0
Total	**1 Facility Reporting**	**1**	**1**	**0**

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

1. There were 40 Private Psychiatric Hospitals, Inpatient Units in Hospitals and Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) for a total of 2,582 beds as of June 30, 2024.
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-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	RHA Health Services	1	1	0
Avery	Daymark Recovery Services, Inc. – Avery Unit	1	1	0
Beaufort	Dream Provider Care Services	1	1	0
Bertie	Coastal Horizons Center Region 1 TASC - Bertie	1	1	0
Brunswick	Coastal Horizons Center Brunswick	3	3	0
Buncombe	Insight Human Services	2	2	0
	Mountain Area Heath Education Center, Inc.	1	1	0
	October Road, Inc.	2	2	0
	RHA Behavioral Health	4	4	0
Burke	SAIS – Repay, Inc.	1	1	0
	Sparc Services and Programs	1	1	0
	Strategic Interventions, LLC	1	1	0
Cabarrus	RHA Concord	1	1	0
Caldwell	Foothills Regional Treatment Center	1	1	0
Carteret	PORT Health Services	1	1	0
Catawba	Catawba Valley Healthcare	4	4	0
	Insight Human Services	1	1	0
Cleveland	Monarch BH Cleveland	2	2	0
Craven	Coastal Horizons Center Region 1 TASC - Craven	1	1	0

Table A-4: Private Unlicensed Facilities[1] - continued

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Cumberland	Alliance Health	1	1	0
	Coastal Horizons Center Region 2 TASC - Cumberland	1	1	0
	Cumberland County Communicare	1	1	0
	SouthLight Healthcare	1	1	0
Currituck	Coastal Horizons Center Region 1 TASC - Currituck	1	1	0
Davidson	Insight Human Services	2	2	0
Duplin	New Dimension	1	1	0
Durham	Carolina Outreach	3	3	0
	Coastal Horizons Center Region 2 TASC - Durham	1	1	0
	Easterseals, UCP Durham ACTT	1	1	0
	Securing Resources for Consumers, Inc.	1	1	0
	Southlight Healthcare	1	1	0
	Strategic Interventions, LLC	1	1	0
Forsyth	PQA Healthcare, Inc.	1	1	0
Granville	Youth Villages	1	1	0
Greene	Coastal Horizons Center Region 1 TASC - Halifax	1	1	0
	Waynesville Family Clinic, P.A.	1	1	0
Guilford	RHA Services	1	1	0
	Strategic Interventions, LLC	2	2	0
	Youth Villages	1	1	0
Halifax	Coastal Horizons Center Region 1 TASC - Halifax	1	1	0
Harnett	Daymark Recovery Services	1	1	0
Henderson	Insight Human Services	1	1	0
	RHA Health Services	1	1	0
Iredell	Insight Human Services	1	1	0
Johnston	Pathways to Life, Inc.	1	1	0
Lee	Coastal Horizons Center Region 2 TASC - Lee	2	2	0
	Daymark Recovery Services, Inc.	2	2	0
McDowell	A Caring Alternative/OPT/Marion	1	1	0
	Phoenix Counseling Center	1	1	0
	RHA Behavioral Health	2	2	0
Mecklenburg	Carolina Outreach	1	1	0
	Monarch	1	1	0
	SPARC Services and Programs	1	1	0
	The Arc of NC	1	1	0

Table A-4: Private Unlicensed Facilities[1] Continued

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Moore	Monarch	1	1	0
New Hanover	Access Family Services	1	1	0
	Coastal Horizon Center	6	6	1
	Stephens Outreach Center, Inc.	1	1	0
Onslow	Coastal Horizons Center – Region 1 TASC - Onslow	1	1	0
	Covenant Case Management	1	1	0
	RRC Jacksonville	1	1	0
Pender	Coastal Horizons Center	6	6	0
Pitt	Greenville OTP	1	1	0
Randolph	Daymark Recovery Asheboro	1	1	0
	Insight Human Services	3	3	0
Richmond	Daymark Recovery Services Richmond Center	2	2	0
Robeson	Coastal Horizons Center Region 2 TASC - Robeson	1	1	0
	Southeastern Behavioral Healthcare	1	1	0
Rowan	Insight Human Services	1	1	0
Rutherford	North Hillside Apartments	1	1	0
Sampson	New Dimension	1	1	0
Surry	Daymark Recovery Services – Mt. Airy	2	2	0
Vance	Assertive Community Treatment	1	1	0
Wake	Carolina Outreach -Raleigh/Wake County	2	2	0
	Easterseals UCP	2	2	0
	Pathways to Life, Inc.	1	1	0
	SouthLight Healthcare	1	1	0
	Voice Therapeutic Solutions	1	1	0
Warren	Lake Area Men's House	1	1	0
Washington	Person Centered Support Consulting Services, LLC	1	1	0
Wayne	ClientFirst of NC	1	1	0
	Waynesboro Family Clinic, P.A.	2	2	0
Total	**83 Facilities Reporting**	**118**	**118**	**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 SFY24 that met the reporting requirement for this report is 118.

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 2023-June 2024, 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 (now Tailored Plan) can investigate and/or require the facility to develop a plan for correcting these problems. The Tailored Plan (TP) 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, 2023 and ending June 30, 2024. 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 2,571 licensure surveys, 1,511 follow-up visits and 1,791 complaint investigations 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
Guilford	Wellington Oaks	2
Hoke	Open Arms Retirement Center	1
Martin	Vintage Inn	1
Orange	TerraBella Hillsborough	1
Rowan	Best of Care Assisted Living	1
Total	**5 Facilities Cited**	**6**

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities

County	Facility Cited	Citations
Alamance	Alamance Homes	1
	Alamance Homes II	1
	Dee & G Enrichment #2	1
	Lillie's Place #2	1
	New Beginnings Group Home	1
Alexander	Georgie's Helping Hand	1
Buncombe	Cynthia's Place	1
	Riverview Group Home	2
	The Gwen Rash Memorial Group Home	2
Burke	Lake James Alternative Family Living	1
Cabarrus	Cabarrus County Group Home #4	1
Caswell	Levan Place	1
	Levan Place II	1
Catawba	Clay, Wilson & Associates, Inc dba The Cognitive Connection	1
	Pinnacle Therapeutic Services	2

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities - continued

Cleveland	Adventure House	1
	Sandra's House	1
Cumberland	C.R.E.S.T. Group Home #2	1
	C.R.E.S.T. Group Home #5	1
	Sharper Images	2
Durham	Cascade @ Durham	1
	Durham County Government dba Justice Services Department	1
	House of Care, Inc.	1
	Innovative Care of RTP	1
Edgecombe	DA-Queens Home	1
	Open Arms Family Services, Inc.	1
Forsyth	Davis House at Bethabara	1
	Hinkle House at Bethabara	1
	Lippard Lodge	1
	Sharpe and Williams #6	1
	The Center for Creating Opportunities	1
Franklin	Eason Court	1
	Eason Court #2	1
Gaston	Elizabeth Group Home	2
	Guiding Light	2
	Jay's House	2
Guilford	Agape Home Living Care, LLC	1
	Bisbee Place	2
	Chatwick Home	2
	Lindley College XI	1
	Mercy Home Services, Inc.	2
	Person Centered Care	2
	Royalty Care	1
	Successful Visions-Rolling Road	2
	Three Meadows	2
Harnett	Peach Farm Road	1
Henderson	Tapestry Adolescent Program	1
Hoke	Multicultural Resources Center-Group Home #2	1
	Serenity Therapeutic Services #8	2
Iredell	Weaver	1
Johnston	Freedom Care Services, LLC-King Mill	1
	Savin Grace II	2
	Savin Grace Transition	2
Lee	Lanier Home	1
Lenoir	Jospeh's Empowerment Center	1
	With a Purpose Family Care #2-"Woody House"	1
Mecklenburg	Bright Touch House	1
	Carolina Center for Recovery	1
	Newport Academy-Lodge	1
	SECU Crisis Center, A Monarch Facility	2
	Turn Around	3
	Wings Group Home	2
Moore	Bethesda, Inc.	1
	Linden Lodge	2
	The Bethany House, Inc.	1

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities - continued

County	Facility Cited	Citations
New Hanover	Project Transition-Wilmington	5
Onslow	Dix Crisis Center	1
	Harris Home	2
	SA Caring Heart independence Center-Jacksonville	1
Orange	Hillsborough Comprehensive Treatment Center	1
Robeson	Renewed Grace Residential Home Building B	6
Rutherford	Kelly's Care	1
Stanly	Lowder Reunion Group Home	1
Transylvania	Tapestry Eating Disorder Program	2
	Trails Carolina	1
Union	Pena Cottage	2
Vance	House of Blessings II	3
Wake	Absolute Home and Community Services 2	1
	Access Health System 1	1
	Access Health System 2	2
	Alpha Home Care Services, Inc.	1
	Destiny Family Care Home	1
	Divine Supportive Homes	1
	Learning Services Corporation-Willow House	1
	Residential Support Services of Wake County-Atlantic Ave	1
	Rose Residential Services	1
	United Family Network at Willow Springs	1
	Wilkins Home	1
Warren	Destiny Family Care Home #5	1
Wayne	ASA Living I	1
Wilkes	AFL-Espenshade	1
Wilson	Kyseem's Unity Group Home LLC #3	2
Yancey	Calloway Cottage	1
Total	**94 Facilities Cited**	**132**

Table B-3: Mental Health Hospitals and Community-Based PRTFs

County	Facility	Citations
Anson	Cornerstone Treatment Facility (CB)	2
Brunswick	Carolina Dunes Behavioral Health (MMH)	1
Hoke	Canyon Hills Treatment Facility (CB)	1
Stanly	Loretta's Place (CB)	2
Total	**4 Facilities Cited**	**6**

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

County	Facility	Citations
Cumberland	Hope Mills Home	1
Total	**1 Facility Cited**	**1**

Table B-5: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities

County	Facility	Citations
Guilford	Cone Health (196)	1
Harnett	Good Hope (178)	1
Nash	UNC Nash (179)	1
Randolph	Randolph (168)	1
Stanly	Atrium Stanly (161)	1
Wake	Holly Hills (168, 178)	2
Total	**6 Facilities Cited**	**7**

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, State Psychiatric Hospitals or State Residential Programs for Children.