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 7, 2021

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) 2020-2021, which covers the period of July 1, 2020 through June 30, 2021.

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 392 deaths were reported: 117 by adult care homes, 87 by private licensed facilities, 184 by private unlicensed facilities, 2 by private inpatient psychiatric units, and 2 by state-operated facilities. Of the 392 deaths reported, all were screened, 307(78.3%) were investigated. One death was 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 994 licensure surveys, 791 follow-up visits, 2,496 complaint investigations and 1,470 other reviews were conducted during the SFY. A total of 66 private licensed facilities were issued a total of 108 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=42 or 38.9%) and "training in seclusion, physical restraint and isolation time-out" (N=36 or 33.3%). These citations accounted for 72.2% 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 2020-2021, which spans the period July 1, 2020 through June 30, 2021. 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 267 facilities – 124 private unlicensed facilities, 64 private licensed facilities, 75 adult care homes, 2 private inpatient psychiatric unit and 2 state-operated facility– reported a total of 392 deaths that were subject to these statutory reporting requirements.

2 Of the total 392 deaths reported, 184 deaths were reported by private unlicensed facilities, 87 deaths were reported by private licensed facilities, 117 were reported by adult care homes, 2 deaths were reported by private inpatient psychiatric units and 2 deaths were reported by the state-operated facilities.

3 All deaths that were reported were screened; a total of 307 deaths (78.3%) were investigated.

4 One death was determined to be related to the use of physical restraint, physical holds, or seclusion.

Table A: Summary Data on Consumer Deaths Reported During SFY 2020-2021

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	1,188	41,067	75	117	117	1
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,738	10,233	64	87	6	0
A-3	Psychiatric Hospitals, Units, & Hospital PRTFs	74	2,740	2	2	1	0
N/A[7]	Community ICFs/IID	337	2,786	0	0	0	0
Subtotal		3,149	56,826	141	206	124	1
Private Unlicensed Facilities							
A-4	Private Unlicensed[5]			124	184	182	0
State-Operated Facilities							
A-5	Alcohol and Drug Treatment Centers	3	200	1	1	0	0
A-6	Developmental Centers	3	1,050	1	1	1	0
N/A[6,7]	Neuro-Medical Treatment Centers[6]	3	LTC=453	0	0	0	0
			ICF=28	0	0	0	0
N/A[7]	Psychiatric Hospitals	3	916	0	0	0	0
N/A[7]	Residential Programs for Children	2	30	0	0	0	0
Subtotal		14	2,705	2	2	0	0
Grand Total		**4,351**	**59,531**	**267**	**392**	**307**	**1**

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, 2021).
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 State-Operated ICF/IID Center (N=28 ICF Beds) and as State-Operated Neuro-Medical Treatment Center (N=172 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, 2020 and ending June 30, 2021. 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, private unlicensed, and 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 66 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. A total of 994 initial, renewal and change-of-ownership licensure surveys, 791 follow-up visits, 2,496 complaint investigations and 1,470 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.

3 A total of 108 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.

4 The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (N=42 or 38.9% and "training in seclusion, physical restraint and isolation time-out" (N=36 or 33.3%); these accounted for 72.2% 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 2020-2021[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	11	11	• Rule 10A NCAC 13G .1301(a) Failure to obtain physical order, assessment and to use least restrictive device or no alternative attempted (5 citations) • Rule 10A NCAC 13F .1501(a) Failure to assure restraint device cannot be removed easily or restricts freedom of movement or normal access to person's body (7 citations)	• Rule 10A NCAC 13G.1301(b) Failure to obtain consent from resident (1 citation) • Rule 10A NCAC 13F .1501(c) Failure to implement resident assessment and care planning per rule requirements prior to the use of restraints (2 citations • Rule 10A NCAC 15F .1501(d)(1)(B) Restraint order failed to identify the type restraint to be used (1 citation) • Rule 10A NCAC 13F.1501(e) Failure to document restraints (3 citations)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-2	Group Homes, Day Outpatient Treatment, Community Based PRTFs	47	85	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (V536) (42 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (V537) (36 citations) • Rule 10A NCAC 27E.0101 Least Restrictive Alternative (V513) (9 citations) • Rule 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-Out (V521) (4 citations)	• Rule 10A NCAC 27E .0101 Least Restrictive Alternative (V517) (3 citations) • Rule 10A NCAC 27E .0104(e)(10) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V522) (2 citations) • Rule 10A NCAC 27E .0104(e)(12-16) (V524) (1 citation) • Rule 10A NCAC 27E.0103 General Policies Regarding Intervention Procedures (V515) (1 citation)
N/A[2]	Community ICFs/IID	0	0	No Citations were issued.	No Citations were issued.

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-3	Psychiatric Hospitals, Units, and Hospital PRTFs	8	12	• A68: A restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. (2 citations) • A168: Use of restraints must be in accordance with order of a physician or other licensed independent practitioner (LIP). (2 citations) • A175: Patient must be monitored by physician, LIP or trained staff. (2 citations)	• A161: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient form falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). (1 citation) • A167: The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. (1 citation) • A171: Order shall be used for management of violent or self-destructive behavior that jeopardizes the safety of the patient. (1 citation) • A178: When restraint or seclusion is used for the management of violent or self-destructive behavior, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician, LIP, or registered nurse who has been trained. (1 citation) • A206: The hospital must require appropriate staff to have education, training, and demonstrated knowledge in at least the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. (1 citation) • 10A NCAC 27E .0108 Training on Seclusion, Physical 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
Subtotal		66	108		
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	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]	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		**66**	**108**		

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 994 licensure surveys, 791 follow-up visits, 2,496 complaint investigations and 1,470 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, 2020, and ending June 30, 2021, 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	Alamance House	1	1	0
	Eliot Family Care Home	1	1	0
	Mebane Ridge Assisted Living	1	1	0
	Sheridanville	1	1	0
Anson	Meadowview Terrace of Wadesboro	4	4	0
Ashe	Forest Ridge Assisted Living	1	1	0
Brunswick	Leland House	1	1	0
	Ocean Isle Operations	1	1	0
Buncombe	Marjorie McCune Memorial Center	1	1	0
Cabarrus	Morningside of Concord	1	1	0
	Mt. Pleasant House	1	1	0
Carteret	Carteret Landing	4	4	0
Caswell	Caswell House	2	2	0
Catawba	Catawba Valley Living at Rock Barn	1	1	0
	Hickory Village	1	1	0
Chatham	Chatham Ridge Assisted Living	1	1	0
Cumberland	Fayetteville Manor	8	8	0
	McLeod Family Care Center of Fayetteville	2	2	0
Davidson	Grayson Creek of Welcome[4]	1	1	1
	Mallard Ridge Assisted Living	1	1	0
	Spring Arbor of Thomasville	1	1	0
Davie	Mocksville Senior Living & Memory Care	3	3	0
	Somerset Court of Mocksville	5	1	0
Duplin	Wellington Park	1	1	0
Durham	Tower of Blessing A Refuge to Seek #2	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Forsyth	Danby House	1	1	0
	Magnolia Creek Assisted Living	3	3	0
	Memory Care of the Triad	1	1	0
	Shuler Health Care/Crane Villa	1	1	0
Franklin	Franklin Manor Assisted Living Center	4	4	0
Gaston	Country Time Inn	1	1	0
	Elmcroft of Cramerton	1	1	0
Greene	Snow Hill Assisted Living	2	2	0
Guilford	Guilford House	1	1	0
	Wellington Oaks	1	1	0
Harnett	Green Leaf Care Center	1	1	0
Haywood	Haywood Lodge and Retirement	1	1	0
	Spicewood Cottages Elms	1	1	0
Hertford	Ahoskie Assisted Living[5]	1	1	0
	Confidence Builders II	1	1	0
Iredell	Summit Place of Mooresville	2	2	0
Johnston	Four Oaks Senior Living	3	3	0
	Gabriel Manor Assisted Living Center	2	2	0
	Meadowview Assisted Living	1	1	0
	The Villas at Benson 3	1	1	0
Lincoln	Heath House	1	1	0
	Wexford House	1	1	0
McDowell	Rose Hill Retirement Community	1	1	0
Mecklenburg	East Towne	1	1	0
	Mint Hill Senior Living	1	1	0
	Queen City Assisted Living	1	1	0
	The Laurels in the Village at Carolina Place	1	1	0
	The Parc at Sharon Amity	3	3	0
	The Social Cotswold	1	1	0
	The Terrace at Brightmore South Charlotte	1	1	0
New Hanover	Champions Assisted Living	1	1	0
Northampton	Pine Forest Rest Home	2	2	0
Pasquotank	Waterbrooke of Elizabeth City	1	1	0
Richmond	Hamlet House	5	5	0
Robeson	Hope Springs	1	1	0
	Rivers Edge of Lumberton	2	2	0
Sampson	Rolling Ridge Assisted Living	2	2	0
	Serenity Family Care Home #2	1	1	0
Stokes	Priddy Manor Assisted Living	2	2	0
	Walnut Ridge Assisted Living	1	1	0
Union	Woodridge Assisted Living Facility	1	1	0
Wake	Brookdale Macarthur Park	1	1	0
	Coventry House of Zebulon	2	2	0
	Mims Family Care Home	1	1	0
	Morningside of Raleigh	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion [3]
Washington	Cypress Manor	1	1	0
Wayne	Countryside Village	2	2	0
	Eagle's Pointe	1	1	0
Wilkes	Wilkesboro Assisted Living	1	1	0
Total	**75 Facilities Reporting**	**117**	**117**	**1**

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

1. There were 1,188 Licensed Adult Care Homes with a total of 41,067 beds as of June 30, 2021.
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.
4. The Medical Examiner's death certificate stated asphyxia related to the bed rail being the immediate cause of death and under description listed hung/strangled while getting/ falling out of bed. A Statement of Deficiencies was issued 08/07/2020. A Plan of Protection was required. A Suspension of Admissions was issued and a Directed Plan of Protection after an onsite follow-up on 09/04/2020. A follow-up inspection determined the facility was in compliance and the Suspension of Admissions was lifted 12/8/2020.
5. Resident records were reviewed noting signed medical orders for use of the "lapp buddy" restraint to prevent the resident from sliding out of his wheelchair. Interview of the funeral home staff noted that the family did not request an autopsy and the cause of death was advanced dementia and a failure to thrive. Restraint was not the cause of death. DSS investigation was unsubstantiated.

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 Academy, LLC	1	1	0
	Morse Clinic of Zebulon	3	0	0
Alexander	Addiction Recovery Medical Services	1	0	0
Beaufort	Country Living Guest Home #7	1	1	0
	Dream Provider Care Svcs Outpatient Treatment	1	0	0
	Port Health Services – Ray G.	1	0	0
Brunswick	Coastal Horizons Center, Inc	1	0	0
	New Hanover Treatment Center	1	0	0
	Shallotte Treatment Associates	1	1	0
Buncombe	Crossroads Treatment Center of Asheville	1	0	0
	First Step Farm-Men	1	0	0
	Mountain House	1	0	0
	Neil Dobbins Center	1	0	0
	October Road, Inc.	1	0	0
	Universal PSR	1	0	0
Burke	New Season Morganton	1	0	0
Cabarrus	McLeod Addictive Disease Center-Concord	2	0	0
Carteret	Morehead City Treatment Center	2	0	0
Columbus	Port Health-Whiteville	1	0	0
Cumberland	Fayetteville Treatment Center	1	0	0
Dare	Nags Head Treatment Center	1	0	0
Davidson	Addiction Recovery Care Center (ARCA)	2	0	0
	Lexington Treatment Associates	1	0	0
	Thomasville Treatment Associates	1	1	0
Durham	B & D Integrated Health Services	1	0	0
Forsyth	Insight Human Services-Forsyth	2	0	0
	Winston-Salem Comprehensive Treatment Center	1	0	0
Gaston	Gastonia Treatment Center	1	0	0
	Outreach Management Services LLC	1	0	0
Guilford	Alcohol and Drug Services-East	1	0	0
	Crossroads Treatment Center of Greensboro	2	0	0
Halifax	Morse Clinic of Roanoke Rapids	1	0	0
Harnett	Morse Clinic of Dunn	1	0	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Henderson	Family Preservation Services of NC, LLC-Green River	1	0	0
	Premier Treatment Specialists, LLC	2	1	0
Iredell	ARMS	1	0	0
	Daymark Recovery CRC Statesville	1	0	0
	Lifespan at IVW-Troutman	1	0	0
Mecklenburg	Anuvia Prevention and Recovery Center	3	0	0
	McLeod Addictive Disease Center	1	0	0
	New Season North Charlotte	1	0	0
Nash	Port Health Services-Rocky Mount	1	0	0
	Rocky Mount Treatment Center	1	0	0
New Hanover	A Helping Hand of Wilmington	1	0	0
	Coastal Horizons Center	7	0	0
	Reflections of Hope, LLP	1	0	0
	RHA Behavioral Health Services	1	0	0
	The Harbor	1	0	0
Pasquotank	Elizabeth City Treatment Center	1	0	0
Pender	Coastal Horizons Center-Pender	1	0	0
Pitt	Port Health Services-Paladin	1	0	0
Robeson	Southeastern Integrated Care, LLC	1	0	0
Union	Monroe Crisis Recovery Center	1	0	0
Vance	Recovery Response Center	1	0	0
	Vance Recovery	1	0	0
Wake	Building Foundations	1	0	0
	Eagle Home III	1	1	0
	Southlight Healthcare	4	0	0
	The Morse Clinic of North Raleigh	4	0	0
	Western Wake Treatment Center	1	0	0
Warren	Lake Area Counseling Halfway House	1	0	0
Watauga	Daymark Recovery Services-Watauga	1	0	0
	Stepping Stone of Boone	1	0	0
Wayne	Carolina Treatment Center of Goldsboro	1	0	0
Total	**64 Facilities Reporting**	**87**	**6**	**0**

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

1. There were 2,738 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,233 beds as of June 30, 2021.
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]
Gaston	Caromont Regional Medical	1	0	0
Pitt	Vidant Medical Center	1	1	0
Total	**2 Facilities Reporting**	**2**	**1**	**0**

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

1. There were 12 Private Psychiatric Hospitals, 58 Hospitals with Acute Care Psychiatric Units, and 4 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,740 beds as of June 30, 2021.
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	Psychotherapeutic Services	1	1	0
	RHA Health Services	1	1	0
Alexander	Taylorsville Behavioral Health	1	1	0
Beaufort	PORT Health Services	2	2	0
Bladen	Coastal Southeastern United Care	1	1	0
Brunswick	Coastal Horizons Center Region 2 TASC	1	1	0
Buncombe	Carolina Pediatric Therapy	1	1	0
	Family Preservation Services of NC, Inc.	2	2	0
	Men's First Step Farm of WNC, Inc.	1	1	0
	NC Brookhaven Behavioral Health	1	1	0
	Real Recovery	1	1	0
	RHA Behavioral Health Services	9	9	0
	Universal Mental Health Services - Asheville	1	1	0
Burke	Strategic Interventions, LLC	1	1	0
Cabarrus	Cabarrus Center	2	2	0
	Monarch ACTT Stanly	1	1	0
	RHA Health Services	2	2	0
Caldwell	Lenoir Behavioral Health Services	3	3	0
Catawba	Catawba Valley Behavioral Healthcare	1	1	0
Chowan	Coastal Horizons Center Region 1 TASC	1	1	0
Clay	Appalachian Community Services	1	1	0
Cleveland	BH Gaston	1	1	0
	Support Incorporated	1	1	0
Columbus	Columbus Behavioral Health	1	1	0
	PORT Health Services	1	1	0
Craven	PORT Health Services – New Bern Clinic	4	4	0
	RHA New Bern	1	1	0
Cumberland	Carolina Outreach	2	2	0
Dare	PORT Health Services	1	1	0
Davidson	Daymark Recovery Center Davidson	6	6	0
	Wake Forest Behavioral Health	1	1	0
Duplin	Coastal Horizons Center Region 1 TASC	1	1	0
Durham	Coastal Horizons Center Region 2 TASC	1	1	0
	El Futuro	1	1	0
	Enhanced Supportive Housing	1	1	0
	Quality Care Solutions	1	1	0
Edgecombe	Coastal Horizons Center Region 1 TASC	1	1	0
Forsyth	Cardinal Innovations	1	1	0
	Charles Hines & Son	1	1	0
	Daymark Recovery Services	1	1	0
	Forsyth Behavioral Health	1	1	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Guilford	ACTT	1	1	0
	Daymark Recovery Services, Inc. - Guilford	1	1	0
	Psychotherapeutic Services	1	1	0
	RHA Health Services	2	2	0
Halifax	RHA Health Services	2	2	0
Harnett	Coastal Horizons Center Region 2 TASC	1	1	0
Haywood	Haywood Recovery Education Center	2	2	0
	Meridian	1	1	0
Hoke	Daymark Recovery Services – Hoke Center	1	1	0
Iredell	Easter Seals UCP	1	1	0
	PQA Healthcare, Inc.	1	1	0
Jackson	Meridian Behavioral Health	2	2	0
Johnston	Coastal Horizons Center Region 2 TASC2	2	2	0
	Johnston Public Health Behavioral Health Division	1	1	0
Lenoir	PORT Health	2	2	0
	Tyree Road AFL	1	1	0
McDowell	Marion Behavioral Health Services	2	2	0
Mecklenburg	Anuvia Prevention Recovery, Inc.	2	2	0
	Cardinal Innovations Healthcare	2	2	0
	Developmental Disabilities Resources, Inc.	1	1	0
	Hope Haven INC	1	1	0
	McLeod Addictive Disease Center	1	1	0
	Monarch – Meck ACTT	3	3	0
	Sparc Network	1	1	0
	SPARC Services & Programs	1	1	0
	TFC-Charlotte	1	1	0
	The Arc of North Carolina	1	1	0
Mitchell	Spruce Pine Behavioral Health Services	1	1	0
Moore	Daymark Recovery Services Moore County	2	2	0
Nash	Behavioral Health Nash	2	2	0
	PORT Health Services	2	2	0
New Hanover	A Helping Hand of Wilmington	2	2	0
	ACI - Dungarvin	1	1	0
	Coastal Horizons Center	7	7	0
	RHA Behavioral Health	3	3	0
	The Harbor	1	1	0
Onslow	Dix Crisis Intervention Center	1	1	0
	Easter Seals UCP	1	1	0
	PORT Health	1	1	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Orange	Caramore Community Inc.	1	1	0
	Chapel Hill Outpatient Clinic	1	1	0
	Freedom House Recovery Center	2	2	0
	UNC STEP CLINIC	1	1	0
Pender	Coastal Horizons Center Region 1 TASC	3	3	0
Person	Person Counseling Center	1	1	0
Robeson	CARTER CLINIC	1	1	0
	Coastal Horizons Center Region 2 TASC	2	2	0
	COASTAL SOUTHEASTERN UNITED CARE	1	1	0
	Monarch Behavioral Health – Robeson Mobile Crisis	1	1	0
	Primary Health Choice, Inc	1	1	0
	Robeson Behavioral Health	2	2	0
	Southeastern Integrated Care	2	2	0
	Stephens Outreach Center	1	1	0
Rowan	Cardinal Innovations Healthcare	1	1	0
	Daymark Recovery Services	2	2	0
	Monarch Behavioral Health – Davidson ACTT	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
	KD Support Services Unlicensed AFL	1	1	0
Stanly	Daymark Recovery Services	1	1	0
	Monarch Stanly BH	1	1	0
Surry	Daymark Recovery Services – Mt. Airy	1	1	0
Swain	Appalachian Community Services	1	1	0
Vance	Community Care Service, LLC	1	1	0
	Daymark Recovery Services	1	1	0
Wake	B&D Integrated Health Services	1	1	0
	Carolina Outreach	2	2	0
	Coastal Horizons Center Region 2 TASC	1	1	0
	Eagle Home 3	1	1	0
	Easter Seals UCP	2	2	0
	Millbrook Road Group Home	1	1	0
	Monarch Behavioral Health Urgent Care	1	1	0
	Monarch Behavioral Health Wake	2	2	0
	North Carolina Recovery Support Services	1	1	0
	Southlight Healthcare	3	3	0
	Supervised Living Program	1	1	0
	UNC STEP Community Clinic of Wake County	1	1	0
Warren	Recovery Response Center Henderson	1	1	0
Watauga	Daymark Watauga Center	2	2	0
Wayne	Waynesboro Family Clinic, P.A.	1	1	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Wilkes	Daymark Recovery Services Wilkes Co.	2	2	0
Wilson	Carolina Outreach	1	1	0
	One to One with Youth, Inc.	1	1	0
Yancey	RHA Health Services	1	1	0
Total	**124 Facilities Reporting**	**184**	**184**	**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 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. During SFY21, for example, 184 deaths were reported, however the deaths of two individuals were reported by two different providers, resulting in a duplicated count in those two instances. The total number of deaths that occurred in unlicensed facilities during SFY21 that met the reporting requirement for this report is 182.
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 2020-June 2021, 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. 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
Total	**1 Facility Reporting**	**1**	**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 200 beds as of June 30, 2021.
2. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-6: State-Operated Developmental Centers (Intermediate Care Facilities for Individuals with Intellectual Disorders (ICF/IID)[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion[2]
Burke	J. Iverson Riddle	1	1	0
Total	**1 Facility Reporting**	**1**	**1**	**0**

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

1. There were 3 State-Operated Developmental Centers with a total of 1,078 beds (including 28 ICF/IID beds at O'Berry Center) as of June 30, 2021.
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, 2020 and ending June 30, 2021. 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 994 licensure surveys, 791 follow-up visits, 2,496 complaint investigations and 1,470 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
Davidson	Grayson Creek of Welcome	1
Forsyth	Tranquility Care	1
Henderson	Tore's Home #22	1
Hertford	Ahoskie Assisted Living	1
Johnston	Clayton House	1
Mecklenburg	UP at 13931	1
	Kestral Ridge	1
Onslow	The Arc Community	1
Person	Maple Heights Assisted	1
Wake	Elsie's Place	1
	Avendelle Assisted Living at Southern Oaks	1
Total	**11 Facilities Cited**	**11**

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

County	Facility Cited	Citations
Alamance	R&S Independent Health Services, Inc.	1
	Trinity Behavioral Healthcare PC	1
Anson	Cornerstone Treatment Facility	3
Buncombe	Montford Hall	3
	Solstice East	4
Cabarrus	McLeod Addictive Disease Center - Concord	1
Caldwell	VOCA 8th Ave	1
Catawba	TLCW	2
Chatham	Carolina House	1
Clay	Medmark Treatment Centers Murphy	1
Gaston	Blossom Community Services	2
	Brighter Dayz	4
	Fresh New Start	2
	Harmony House	1
	Serenity House	1
Greene	Hopewell	1
Guilford	AGAPE Home Living Care LLC	2
	Cynthia's Heart	2
	M & S Creekside	2
	Union Group Home II	2
Harnett	I Innovations, Inc. – Sean Lane	2
	I Innovations, Inc. – 2071 Heritage Way	2
	Sierra's Residential Services Group Home III	2
Henderson	Equinox RTC	1
	Tapestry Adolescent Residential Program	1
Lenoir	Pinewood Facility	2
Mecklenburg	Alexander Youth Network Oak Unit	1
	Jasper's House Day Treatment	2
	Merancas Cottage	1
	Peters Home	2
	Queen City Quality Crew	2
	SECU Youth Crisis Center	1
	Spruce Cottage	2
Robeson	A Better Way Residential	3
	Renewing Grace Residential Home	3
Rowan	TMR Residential	2
Rutherford	Foothills at Red Oak Recovery	1
Sampson	Candii Homes	2
Vance	Alpha Residential Services - Oakland	1
Wake	Alpha Home Care Services #9	1
	Meeks #2	2
	Meeks #3	3
	Meeks Group Home	3
	Southlight Healthcare – Garner Road	1
	The Emanuel Home IV	1

County	Facility Cited	Citations
Wayne	Country Pines #1	1
	The Vaughn-Fam Home	2
Wilkes	Horizon Kids	2
Total	**48 Facilities Cited**	**86**

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

County	**Facility**	**Citations**
Buncombe	Memorial Mission Hospital	1
Catawba	Frye Regional Medical Center	3
Iredell	Davis Regional Medical Center	1
Pitt	Vidant Medical Center	1
Rockingham	UNC Rockingham	1
Wake	Rex Hospital	1
	Strategic Behavioral Center	3
	Triangle Springs	1
Total	**8 Facilities Cited**	**12**

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.