Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

on

DEATHS REPORTED AND FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING PHYSICAL RESTRAINTS AND SECLUSION

as required by NC General Statutes 122C-5, 131D-2.13 and 131D-10.6

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
and Division of Health Services Regulation

October 1 2015

DEATHS REPORTED AND FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING PHYSICAL RESTRAINTS AND SECLUSION

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EXECUTIVE SUMMARY

State law requires the Department of Health and Human Services (Department or DHHS) to provide an annual report to the Joint Legislative Oversight Committee on Health and Human Services on consumer deaths related to the use of physical restraint, physical hold, and seclusion, and compliance with policies and procedures governing the use of these restrictive interventions. The introduction to this report includes a brief summary of those reporting requirements. The data in this report is for State Fiscal Year (SFY) 2014-2015, which covers the period July 1, 2014 through June 30, 2015.

PART A: DEATHS RELATED TO PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION

In North Carolina, deaths are reported to DHHS by private licensed, private unlicensed, and state-operated facilities. The reporting requirements differ by type of facility. The data reported here include deaths meeting the following criteria: (a) occurred within seven days after the use of physical restraint, physical hold, or seclusion; or (b) resulted from violence, accident, suicide, or homicide.

A total of 186 deaths were reported: 61 by private licensed facilities, 117 by private unlicensed facilities, and 8 by state-operated facilities. Of the 186 deaths reported, all were screened, 148 (80%) were investigated, and **none** were found to be related to the use of physical restraint, physical hold, or seclusion.

PART B: FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION

The compliance data summarized here was collected from facilities that received an on-site visit by DHHS or Local Management Entity-Managed Care Organization (LME-MCO) staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed. A total of 3,154 licensure surveys, 1,561 follow-up visits, and 1,591 complaint investigations were conducted during the year.

A total of 153 facilities -- 152 private licensed facilities and 1 private unlicensed facility were issued a total of 214 citations for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. No state operated facility was issued any citations during this period. Citations covered a wide range of deficiencies from inadequate documentation and training to improper or inappropriate use of physical restraints. The largest number of citations issued involved deficiencies related to “training on alternatives to restrictive interventions” (92 or 45%) and “training in seclusion, physical restraint and isolation time-out” (64 or 31%). These citations accounted for 76% of the total issued.

INTRODUCTION

North Carolina General Statutes 122C-5; 131D-2.13; and 131D-10.6, require the Department of Health and Human Services to report annually on October 1 to the Joint Legislative Oversight Committee on Health and Human Services on the following for the immediately preceding fiscal year:

- The total number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6B, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number found by the investigation to be related to the use of restraint, physical hold, or seclusion.
- The level of compliance of certain facilities with applicable State and federal laws, rules, and regulations governing the use of restraints, physical hold, and seclusion. The information shall include areas of highest and lowest levels of compliance.

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

The private licensed facilities include:

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

The private unlicensed facilities include:

- Periodic Service Providers
- Community Alternatives Program for Persons with Intellectual or Developmental Disabilities (CAP-I/DD) Providers

The state-operated facilities include:

- Alcohol and Drug Abuse Treatment Centers (ADATCs)
- Developmental Centers (ICFs/IID)
- Neuro-Medical Treatment Centers
- Psychiatric Hospitals
- Residential Programs for Children

This report covers **SFY 2014-2015**, the period **July 1, 2014 through June 30, 2015**. The report 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 these facilities and investigated by DHHS.
- Part B provides summary data on deficiencies related to the use of physical restraints, physical hold, and seclusion compiled from monitoring reports, surveys and investigations conducted by Department and LME-MCO staff.
- The Appendices contain tables that provide the information from Parts A and B by licensure or facility type and by county and facility name.

PART A. DEATHS REPORTED AND INVESTIGATED

In the 2000, 2003 and 2009 legislative sessions, General Statutes 122C-31, 131D-10.6B and 131D-34.1 were amended to require certain facilities to notify the North Carolina Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

North Carolina Administrative Codes 10A NCAC 26C .0300, 10A NCAC 13F .1207 and .1208, 10A NCAC 13G .1208 and .1209, and 10A NCAC 13H .1902 and .1903 implement the death reporting requirements of these laws and provide specific instructions for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5, **facilities licensed** under G.S. 131D, and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Health Services Regulation** (DHSR).
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services** (DMH/DD/SAS).

North Carolina Administrative Code 10A NCAC 27G .0600 and DHHS policies and procedures require some types of facilities to report other deaths. For example:

- State-operated facilities report **all deaths** that occur in the facility, and if known, those that occur within 14 days of discharge, regardless of the manner of death. This includes deaths due to terminal illness, natural causes, and unknown causes.
- Private community-based providers report **deaths due to unknown causes** to DMH/DD/SAS. They also report deaths of individuals to whom they are providing services regardless of **whether or not the consumer was receiving services** when the death occurred.

Though not required, some providers voluntarily report all deaths of consumers to DHHS regardless of cause or where the death occurs.

All deaths reported to DHHS, regardless of whether or not reporting is required, are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to evaluate the cause of the death and any contributing factors, to determine if the death may have been preventable, and to ensure that the facility appropriately identifies and takes action to correct any deficiencies or to pursue opportunities for improvement that may exist in order to protect consumers and to prevent similar occurrences in the future. Deaths are also screened and investigated to determine if they were related to the use of physical restraint, physical hold, or seclusion.

As noted above, the number of deaths reported to DHHS, and the focus of screening and investigation activities go beyond what is required to be included in this report.

For the purposes of this report, only content specified by state law is included: (a) deaths occurring within seven days of the use of physical restraint, physical hold, or seclusion or resulting

from violence, accident, suicide or homicide; and (b) investigation findings that indicate whether the death was related to the use of physical restraint, physical hold, or seclusion.

Table A provides a summary of the number of deaths (referenced in (a) above) reported during the state fiscal year by private licensed, private unlicensed, and state-operated facilities, the number of deaths investigated, and the number found by the investigation to be related to the facility's use of physical restraint, physical hold, or seclusion.

Tables A-1 through A-10 in Appendix A provide additional information on the number of deaths reported by county and facility name.

Table A: Summary Data on Consumer Deaths Reported During SFY 2014-2015

Table in Appendix	Type of Facility	# Facilities Providing Services[1]	# Beds at Facilities[1]	# Facilities Reporting Deaths	# Death Reports Received & Screened[2]	# Death Reports Investigated[3]	# Deaths Related to Restraints / Seclusion[4]
PRIVATE LICENSED							
A-1	Adult Care Homes	1,252	41,001	33	38	27	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,387	10,275	14	19	0	0
A-3	Community ICFs/IID	337	2,785	1	1	1	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	73	2,240	3	3	1	0
	Subtotal	5,049	56,301	51	61	29	0
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			92	117	117	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	196	1	1	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,237	0	0	0	0
A-8	Neuro-Medical Treatment Centers	3	NF= 457	0	0	0	0
			ICF= 125	0	0	0	0
A-9	Psychiatric Hospitals	3	892	3	7	2	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	2,949	4[6]	8	2	0
	Grand Total	5,063	59,250	147	186	148	0

NOTES:

1. The number of facilities and beds can change during the year. The numbers shown are as of the end of the state fiscal year (June 30, 2015).
2. Numbers reflect only reportable deaths (occurring within seven days of physical restraint, physical hold, 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. 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 included as a State Operated ICFs/IID Center and State Operated Neuro-Medical Treatment Center because the O'Berry Facility serves both populations.

SUMMARY OF FINDINGS RELATED TO REPORTED DEATHS

As Table A shows:

- A total of 147 facilities – 51 private licensed facilities, 92 private unlicensed facilities, and 4 state-operated facilities -- reported a total of 186 deaths that were subject to statutory reporting requirements.
- Of the total 186 deaths reported, 61 deaths were reported by private licensed facilities, 117 deaths were reported by private unlicensed facilities, and 8 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 148 deaths (80%) were investigated.
- There were **no** deaths determined to be related to the use of physical restraint, physical hold, or seclusion.

PART B. FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINTS, PHYSICAL HOLD AND SECLUSION

The General Statutes also require DHHS to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical hold, 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 state fiscal year beginning July 1, 2014 and ending June 30, 2015. Please note that DHHS and LME-MCO staff did not visit all facilities. Therefore, the data summarized in this section is limited to those facilities that received an on-site visit by DHHS and LME-MCO staff.

Table B provides a summary of the number of physical restraint, physical hold, 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.

Tables B-1 through B-10 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 Hold, and Seclusion Issued During SFY 2014-2015[1]

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE LICENSED					
B-1	Adult Care Homes	11	13	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted) (8 citations) • Inadequate assessment and care planning for the use of a restraint (2 citations)	• Failure to obtain physician order and failure to have it updated every 3 months by physician (2 citations) • Failure of facility to ensure staff received training on physical restraints and failure to have been validated on restraint use (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	135	182	• Training on alternatives to restrictive interventions (92 citations) • Training in seclusion, physical restraint and isolation time-out (64 citations)	• Protective Devices (3 citations) • Seclusion, physical restraint and isolation time-out (11 citations)

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				• Least Restrictive Alternative (20 citations) • Seclusion, Physical Restraint and Isolation Time Out (19 citations)	
B-3	Community ICFs/IID	0	0	• No citations were issued	• No citations were issued
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	6	18	• Failure to obtain physician order prior to restraint (6 citations)	• Failure to conduct face to face assessment (2 citations) • Personnel Training (2 citations) • Restraint per policy (2 citations)
	Subtotal	152	213		
				PRIVATE UNLICENSED	
B-5	Private Unlicensed	1	1	• Failure to follow facility policy on restraint application and monitoring	• No additional citations were issued
				STATE OPERATED	
B-6	Alcohol and Drug Treatment Center	0	0	• No citations were issued	• No citations were issued
B-7	Developmental Centers (ICFs/IID)	0	0	• No citations were issued	• No citations were issued
B-8	Neuro-Medical Treatment Center	0	0	• No citations were issued	• No citations were issued
B-9	Psychiatric Hospitals	0	0	• No citations were issued	• No citations were issued
B-10	Residential Programs for Children	0	0	• No citations were issued	• No citations were issued
	Subtotal	0	0		
	Grand Total	**153**	**214**		

NOTES:

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 by DHHS staff and LME-MCO staff. DHHS and LME-MCO staff conducted a total of 3,154 licensure surveys, 1,561 follow-up visits, and 1,591 complaint investigations during the year.

SUMMARY OF FINDINGS RELATED TO COMPLIANCE WITH LAWS, RULES, AND REGULATIONS

As Table B shows:

- A total of 153 facilities -- 152 private licensed facilities and 1 private unlicensed facility were cited for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. No state operated facility was issued any citations during this period.
- It should be noted that the compliance data do not reflect all facilities. Rather, the data is limited to those facilities that warranted an on-site visit by DHHS and LME-MCO staff. A total of 3,154 initial, renewal and change-of-ownership licensure surveys, 1,561 follow-up visits, and 1,591 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.
- A total of 214 citations were issued across all facility types for non-compliance with rules governing the use of physical restraint, physical hold, or seclusion. Private licensed facilities received 213 citations and private unlicensed facilities received 1 citation. No state-operated facilities received citations during this period. Citations covered a wide range of deficiencies from inadequate documentation and training to improper or inappropriate use of physical restraints.
- The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (92 or 45%) and "training in seclusion, physical restraint and isolation time-out" (64 or 31%). These citations accounted for 76% of the total issued.

APPENDIX A: CONSUMER DEATHS REPORTED BY COUNTY AND FACILITY

Tables A-1 through A-10 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the state fiscal year beginning July 1, 2014 and ending June 30, 2015 that were subject to the reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of physical restraint, physical hold, 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 hold, or seclusion.

It should be noted that all deaths that were reported were screened and investigated when circumstances warranted it. As the tables show, **none** of the deaths that were reported and investigated was found to be related to the use of physical restraints, physical hold, or seclusion.

Table A-1: Private Licensed Adult Care Homes[1]

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alamance	Alamance House	1	1	0
	B and N Family Care Home	1	1	0
Ashe	Forest Ridge Assisted Living	1	0	0
Bertie	Windsor House	2	2	0
Buncombe	Asheville Manor	1	0	0
Burke	Morganton Long Term Care, Southview Facility	1	1	0
Chatham	Cambridge Hills AL of Pittsboro	1	0	0
Craven	Riverstone	1	1	0
Cumberland	Carillon Assisted Living of Fayetteville	1	1	0
Davidson	Mallard Ridge Assisted Living	2	1	0
Davie	The Heritage at Cedar Rock	1	1	0
Durham	Eno Pointe Assisted Living	1	0	0
	Seasons at Southpoint	3	2	0
Forsyth	Salem Terrace	1	1	0
Guilford	Emeritus at Greensboro	1	1	0
	Morningview at Irving Park	1	0	0
	Woodland Place-Greensboro	1	0	0
Henderson	Cardinal Care Center - Hendersonville	1	1	0
Iredell	Rosewood Assisted Living	1	1	0
	The Gardens of Statesville	1	1	0
Lee	Victorian Manor	1	1	0
Lenoir	Lenoir Assisted Living	1	1	0
Lincoln	Lakewood Care Center	1	0	0
Mecklenburg	Lawyers Glen Assisted Living	1	1	0
Montgomery	Sandy Ridge Assisted Living	1	0	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Nash	Breckenridge Retirement Center	1	1	0
New Hanover	Pacifica Senior Living of Wilmington	1	1	0
Orange	Carillon Assisted Living of Hillsborough	1	1	0
Randolph	North Pointe Assisted Living of Archdale	1	1	0
Robeson	B & B Assisted Living #1	1	1	0
Rockingham	North Pointe of Mayodan	1	1	0
Wake	Wrenette's Place	1	1	0
Watauga	Deerfield Ridge Assisted Living	2	1	0
Total	33 Facilities Reporting	**38**	**27**	**0**

NOTES:

1. There were 1,252 Licensed Adult Care Homes with a total of 41,001 beds as of June 30, 2015.
2. For licensed adult care homes, 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. 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	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Buncombe	Mountain Health Solutions - Asheville	1	0	0
Cabarrus	Crisis Recovery Center of Kannapolis	1	0	0
	McLeod Addictive Disease Center	4	0	0
Duplin	Light House PSR	1	0	0
Durham	BAART Community Healthcare	2	0	0
	Durham Treatment Center	1	0	0
Guilford	1st Choice Health Services Center	1	0	0
	Merciful Hands Day Program	1	0	0
Lenoir	Hills DDA	1	0	0
McDowell	McLeod Addictive Disease Center	1	0	0
Mecklenburg	Charlotte Treatment Center	2	0	0
	McLeod Addictive Disease Center	1	0	0
Transylvania	FPS of NC Brevard Middle	1	0	0
Union	Monroe Crisis and Recovery Center	1	0	0
Total	14 Facility Reporting	**19**	**0**	**0**

NOTES:

1. There were 3,387 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,275 beds as of June 30, 2015.

2. 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-3: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Craven	RHA/Howells C.C.C.- Riverbend	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 337 Private ICFs/IID with a total of 2,785 beds as of June 30, 2015.
2. 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-4: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Mecklenburg	Novant Presbyterian	1	1	0
Nash	Nash General Hospital	1	0	0
Orange	UNC Hospital	1	0	0
Total	3 Facilities Reporting	**3**	**1**	**0**

NOTES:

1. There were 10 Private Psychiatric Hospitals, 59 Hospitals with Acute Care Psychiatric Units, and 4 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,240 beds as of June 30, 2015.
2. 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-5: Private Unlicensed Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alexander	RHA Behavioral Health	2	2	0
Anson	Daymark Recovery Services	1	1	0
Beaufort	Dream Provider Care Services	1	1	0
	Monarch	1	1	0
Bladen	Primary Health Choice, Inc.	1	1	0
Brunswick	Brunswick County Treatment Alternatives for Street Crimes	1	1	0
	Physician Alliance for Mental Health	1	1	0
Buncombe	Family Preservation Services of NC, Inc.	1	1	0
	October Road Inc.	2	2	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Partnership for Drug Free NC REGION 4 Treatment Alternatives for Street Crimes	1	1	0
	RHA Behavioral Health	1	1	0
	Smoky Mountain LME/MCO	1	1	0
	Universal Mental Health Services	1	1	0
Burke	A Caring Alternative	1	1	0
	Dream Connections Day Activity	1	1	0
	Universal Mental Health Services	1	1	0
Cabarrus	Daymark Recovery Services	2	2	0
Catawba	Catawba Valley Behavioral Healthcare	1	1	0
	Family NET	1	1	0
Clay	Appalachian Community Services	1	1	0
Craven	Coastal Horizons Center, Inc.	2	2	0
	PORT Human Services -	1	1	0
Cumberland	Alliance Behavioral Healthcare	1	1	0
	Carolina Outreach, LLC	1	1	0
	Yelverston's Enrichment Services, Inc.	1	1	0
Dare	Port Human Services	2	2	0
Davidson	Barium Springs	1	1	0
	Monarch	1	1	0
Duplin	New Dimension Group	1	1	0
Durham	B & D Behavioral Health	1	1	0
	Carolina Outreach	1	1	0
	Durham Center Access	1	1	0
	Turning Point Family CARE	3	3	0
	Upward Change Health Services	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
Guilford	Family Service of the Piedmont High Point	1	1	0
	1st Choice Health Services	1	1	0
	Monarch	1	1	0
	RHA Crisis Walk In Center	1	1	0
Halifax	Coastal Horizons Center, Inc.	1	1	0
Henderson	Family Preservation Services of NC, Inc.	1	1	0
Hertford	PORT Human Services	1	1	0
	Vidant Roanoke Chowan Hospital	1	1	
Iredell	Daymark Recovery Service - Iredell Center	1	1	0
Jackson	Meridian Behavioral Health Services	2	2	0
Johnston	North Carolina Recovery Support Services	1	1	0
	Pathways to Life	1	1	0
Martin	Integrated Family Services, PLLC	1	1	0
McDowell	RHA Behavioral Health	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Mecklenburg	Cardinal Innovations Healthcare Solutions	1	1	0
	Friendship Flight	1	1	0
	Person Centered Partnership	1	1	
	RHA ACCESS	1	1	0
Moore	Daymark Recovery Services - Moore County	1	1	
New Hanover	A Helping Hand of Wilmington, LLC	2	2	0
	Coastal Horizons Center, Inc.	1	1	0
	CoastalCare	1	1	0
	Lindley Habilitation Services	1	1	0
	Physician Alliance for Mental Health	1	1	0
Onslow	Coastal Horizons Center, Inc.	1	1	0
	PORT Human Services	1	1	0
	RHA Community Crisis Center	1	1	0
Orange	Freedom House Recovery Center	1	1	0
	UNC Center for Excellence in Community Mental Heal	1	1	0
Pender	Coastal Horizons Center Inc.	1	1	0
Person	Freedom House Recovery Center	3	3	0
Pitt	Coastal Horizons Center, Inc.	1	1	0
	PORT Human Services	2	2	0
Polk	Family Preservation Services, NC	2	2	0
Robeson	Positive Progress Services	1	1	0
	Southeastern Behavioral Healthcare Services	1	1	0
Rowan	Daymark Recovery Services	1	1	0
	Rowan ACTT	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
Sampson	Easter Seals UCP NC & VA	1	1	0
Stanly	Monarch	2	2	0
Transylvania	Meridian BHS	2	2	0
Union	Daymark Recovery Services	5	5	0
Wake	Carolina Outreach	1	1	0
	Fellowship Health Resources	2	2	0
	Monarch	3	3	0
	Solaz, LLC	1	1	0
	Turning Point Family CARE	2	2	0
	Wake County TASC Program	1	1	
Warren	Lake Area Counseling Halfway House	1	1	0
Watauga	Daymark Recovery Services	1	1	0
Wayne	Carolina Outreach LLC	1	1	0
	Waynesboro Family Clinic	1	1	0
Wilkes	Daymark Recovery Services	1	1	0
Yadkin	Daymark Recovery Services	2	2	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Easter Seals UCP NC & VA, Inc.	1	1	0
	Strategic Interventions	1	1	0
Total	92 Facilities Reporting	**117**	**117**	**0**

NOTES:

1. The total number of these facilities is unknown as they are not licensed or state-operated.
2. All deaths reported by unlicensed facilities are investigated by the responsible Local Management Entity-Managed Care Organization providing oversight, and the findings are discussed with the Division of MH/DD/SAS. If problems are identified, the LME-MCO requires the facility to develop a plan for correcting these problems then monitors the implementation of the plan.
3. 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-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Pitt	Walter B. Jones	1	0	0
Total	1 Facility Reporting	**1**	**0**	**0**

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 196 beds as of June 30, 2015.
2. 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-7: State Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 3 State-Operated ICFs/IID with a total of 1,237 beds as of June 30, 2015.
2. 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-8: State Neuro-Medical Treatment Center[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 582 beds as of June 30, 2015 which includes 125 ICFs/IID beds at O'Berry Facility.
2. 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-9: State Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Burke	Broughton	1	0	0
Granville	Central Regional	4	2	0
Wayne	Cherry	2	0	0
Total	3 Facilities Reporting	**7**	**2**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 892 beds as of June 30, 2015.
2. 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-10: State Residential Program For Children[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 2 State-Operated Residential Programs for Children with a total of 42 beds as of June 30, 2015.
2. 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.

APPENDIX B: NUMBER OF CITATIONS RELATED TO PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION BY COUNTY AND FACILITY

Tables B-1 through B-10 provide data regarding the number of physical restraint, physical hold, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2014 and ending June 30, 2015. Each table represents a separate licensure category or type of facility. Each table 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 conducted by DHHS and LME-MCO staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits and complaint investigations. Please note that DHHS and LME-MCO staff did not visit all facilities. Therefore, the data summarized in this section is limited to those facilities that received an on-site visit by DHHS and LME-MCO staff. A total of 3,154 licensure surveys, 1,561 follow-up visits, and 1,591 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	# Citations
Caldwell	Brockford Inn, Inc.	1
Davidson	Brookdale Lexington	1
Davie	Davie Place Residential Care	3
Durham	Durham Ridge Assisted Living	1
Granville	Granville House	1
	Heritage Meadows Long Term Care Facility	1
Henderson	Cardinal Care Center-Hendersonville	1
Robeson	Morning Star Assisted Living #3	1
Rowan	The Meadows of Rockwell Retirement Center	1
Wake	Nana's Touch FCH	1
Wayne	Countryside Village	1
Total	11 Facilities Cited	**13**

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

County	Facility	# Citations
Alamance	A Solid Foundation	1
	Alamance Nome	1
	Angelic Heartz Care Facility	2
	Cedar's DDA Group Home	1
	Enoch Group Home	1
	Restorations	1
	Sixth Street DDA Group Hoe	2
	Star Pointe	1
	Triad Health Care I	1
Beaufort	Wooded Acres #1	1
	Wooded Acres #2	1
	Wooded Acres #3	4

County	Facility	# Citations
Buncombe	Biltmore Housing	2
	Lions Cottage	1
Burke	Self Direction	1
Cabarrus	LIMS	3
	Rose of Sharon	1
Caswell	Ruth's Cove	1
Catawba	Kincaid Home	1
Cleveland	One on One Home D	1
	Shelby Day Habilitation	1
Cumberland	Brown Therapeutic Home	2
	Mother's Love Group Home	4
	New Horizons Group Home	1
	New Horizons Group Home #3	2
	S&S Spoonridge #2	2
	Sunrise Residential Care	2
Davidson	Arlington House	1
Durham	BAART Community Healthcare	1
	Carolina	1
	Loving Arms Tender Touch	2
	Quality Care Solutions	1
Edgecombe	Edwards Residential Care	1
Forsyth	Friendly People That Care	1
	Home Care Solutions of NC, LLC	1
	The Fellowship home	1
Gaston	Belmont House	1
	McLeod Addictive Disease Center-Gastonia	1
	Mélange Health Solutions	1
	The Essential Home	1
Granville	Crossings	1
Greene	Fair Fax	1
Guilford	Acres on Russwood Assisted Living Home	2
	Bisbee Place	2
	Center of Progressive Strides	1
	Chisholm Homes I	2
	Chisholm Homes II	5
	Chisholm Homes III	1
	Deborah's Hope House	1
	Envisions of Life Gatwick House	1
	Gentlehands Day Program	1
	GGH Northridge Home	1
	Independent Living at Ransom Road	1
	Lockwood II	2
	M&S Creekside	1
	Murphy's Group Home	2
	Our Home	2
	Precious Pearls Group Home	1
	Progressive Steps	2
	The Shoppe by Morgan Support Services	1
	Virpark Residential Facility, Inc.	1
Harnett	Forest Hills Family Care	1

County	Facility	# Citations
	Multicultural Resource Center - Group Home #1	1
	Sierra's Residential Services Group Home III	1
Haywood	Balsam Center Adult Recovery	1
Henderson	Hopeful	1
	Topic Home	1
Iredell	Barium Springs Home for Children - Sullivan Home	1
Lee	I Innovations, Inc.	2
Lenoir	Kristi's Homes Inc.	2
	Oakwood Facility	1
	Pinewood	2
	White Oak Group Home IX	1
Martin	New Beginnings with Love Inc. Adult Facility	1
McDowell	McDowell Elementary Day Treatment	1
	Morris Home	1
	Ruthie's Place	1
	SUWS of the Carolina's, Inc.	1
	Taylor Home	2
Mecklenburg	Family Support Services	1
	In Reach/Old Bell Road	1
	Linda Lake Home	1
	McAlway Home	1
	Strategic Behavioral Center - Charlotte	1
Moore	The Bethany House, Inc.	1
New Hanover	Carolina Support Services Day Treatment Center - Site P	1
	Kerr House	1
	Yahweh Center Children's Village PRTF	1
Northampton	Family Advantage LLC	2
Pender	A Special Touch, Inc.	1
Perquimans	TLC on the Water	2
Richmond	Samaritan Colony	1
Rowan	Cabarrus County Group Home #10	1
	Cabarrus County Group Home #7	1
	Cabarrus County Group Home #8	1
	Cabarrus County Group Home #9	1
Sampson	Upscale Residential Care, Inc.	1
Stanly	Loretta's Place	3
	Valleyview Home	1
Surry	Hope Valley Men's Division	1
	Hope Valley Women's Division	1
	Peace Lily I	1
Transylvania	Trails Carolina	2
Union	Agape I	1
	Friendship Home, Inc.	1
Vance	Recovery Response Center	2
Wake	Ann's Country Manor II	1

County	Facility	# Citations
	Ann's Haven of Rest II	2
	Azalea Gardens Mental Health Facility	2
	Brighthaven Home	1
	Dutchess II	2
	Easter Seals UCP - Zebulon Group Home	2
	Etta's Residential Services & Supports, Inc.	1
	Glen Forest Home	1
	Neuro Restorative	1
	New Beginnings	1
	Pine Forest II	2
	Pine Forrest II	1
	Residential Support Services Wake County - Millbrook Road	1
	Serenity Home, LLC	2
	United Family Network at Fuquay-Varina	2
	Victory Healthcare Services, Inc.	2
	Victory Residential Services 092-835	1
	Victory Residential Services LLC 092-830	1
	Walnut Street Group Home	1
	Whittecar Group Home	1
Wayne	ASA Living I	2
	Daez Of New Vision, Inc.	2
	Graham New Horizons I	1
	The Vaughn-Fam Home	2
Wilkes	Mountain Health Solutions-North Wilkesboro	1
Wilson	Gentle Hands	1
	Wilson Professional Services Treatment Center	1
Yadkin	AFL- Donardt	1
Total	135 Facilities Cited	**182**

Table B-3: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-4: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities

County	Facility	# Citations
Cumberland	Cape Fear Valley	1
Henderson	Maria Parham Hospital	4
Mecklenburg	Carolinas Medical Center-Behavioral	2
	Novant Presbyterian	1
Rutherford	Rutherford Regional Medical Center	7
Wake	Rex Hospital	3
Total	6 Facilities Cited	**18**

Table B-5: Private Unlicensed Facilities:

County	Facility	# Citations
Vance	Hughes Home (AFL)	1
Total	1 Facility Cited	**1**

Table B-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-7: State Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-8: State Neuro-Medical Treatment Center

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-9: State Psychiatric Hospitals

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-10: State Residential Program For Children

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**