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

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

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By
North Carolina Department of Health and Human Services

October 1, 2016

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) 2015-2016, which covers the period July 1, 2015 through June 30, 2016.

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 249 deaths were reported: 101 by private licensed facilities, 147 by private unlicensed facilities, and 1 by state-operated facilities. Of the 249 deaths reported, all were screened, 193 (78%) 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 3,371 licensure surveys, 1,525 follow-up visits, and 2,740 complaint investigations were conducted during the year.

A total of 96 facilities -- 96 private licensed facilities were issued a total of 135 citations for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. No private unlicensed facility and state operated facility were 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” (64 or 47%) and “training in seclusion, physical restraint and isolation time-out” (41 or 30%). These citations accounted for 78% 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
- North Carolina Innovations

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 2015-2016**, the period **July 1, 2015 through June 30, 2016**. 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 2015-2016

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	1,237	40,929	43	49	40	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,888	12,760	40	50	5	0
A-3	Community ICFs/IID	337	2,786	1	1	1	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	60	2,229	1	1	0	0
	Subtotal	4,522	58,704	85	101	46	0
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			106	147	147	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	196	0	0	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,195	0	0	0	0
A-8	Neuro-Medical Treatment Centers	3	NF= 452	0	0	0	0
			ICF= 125	0	0	0	0
A-9	Psychiatric Hospitals	3	892	1	1	0	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	2,902	1[6]	1	0	0
	Grand Total	4,536	61,606	192	249	193	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, 2016).
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 192 facilities – 85 private licensed facilities, 106 private unlicensed facilities, and 1 state-operated facility -- reported a total of 249 deaths that were subject to statutory reporting requirements.
- Of the total 249 deaths reported, 101 deaths were reported by private licensed facilities, 147 deaths were reported by private unlicensed facilities, and 1 death was reported by state-operated facilities.
- All deaths that were reported were screened. A total of 193 deaths (78%) 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, 2015 and ending June 30, 2016. 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 2015-2016[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	10	12	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted (8 citations) • Lack of compliance related to the restraint order requirements (components of order and signing of order by physician) (3 citations)	• Insufficient or lack of documentation for restraints (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	77	112	• Training on alternatives to restrictive interventions (64 citations)	• Seclusion, physical restraint and isolation time-out (6 citations)

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				• Training in seclusion, physical restraint and isolation time-out (41 citations)	• General Policies (1 citation)
B-3	Community ICFs/IID	0	0	• No citations were issued	• No citations were issued
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	9	11	• Failure to obtain physician order prior to restraint (3 citations) • Failure to renew restraint orders in accordance with facility policy (2 citations) • Failure to provide ongoing reassessment and monitoring in accordance with facility policy (2 citations)	• Least Restrictive Alternative (1 citation) • Failed to discontinue use of restraint at the earliest time (1 citation) • Failed to document the patient's condition and symptoms that warranted application of restraint (1 citation)
	Subtotal	96	135		
	PRIVATE UNLICENSED				
B-5	Private Unlicensed	0	0	• No citations were issued	• No 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	**96**	**135**		

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 3,371 licensure surveys, 1,525 follow-up visits, and 2,740 complaint investigations during the year.

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

As Table B shows:

- A total of 96 facilities -- 96 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. No private unlicensed facility and state operated facility were 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 3,371 initial, renewal and change-of-ownership licensure surveys, 1,525 follow-up visits, and 2,740 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 135 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 135 citations. No private unlicensed facility or 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" (64 or 47%) and "training in seclusion, physical restraint and isolation time-out" (41 or 30%). These citations accounted for 78% 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, 2015 and ending June 30, 2016 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	Brookdale Burlington	1	1	0
Ashe	Forest Ridge	2	2	0
Brunswick	Leland House	1	1	0
Buncombe	Brookdale Asheville Overlook	2	1	0
	Serenity Heart FCH# 234	1	1	0
Burke	Jonas Ridge Adult Care	1	0	0
	Morganton Long Term Care Facility	1	1	0
Cabarrus	Carillon Assisted Living of Harrisburg	1	0	0
	Morningside of Concord	1	1	0
Catawba	Springs of Catawba	1	1	0
Cleveland	Kings Mountain Care Center	1	1	0
Cumberland	Valley Pine Adult Care	1	1	0
Currituck	Currituck House	1	1	0
Davidson	Spring Arbor of Thomasville	1	0	0
Davie	Davie Place Residential Care	1	1	0
Duplin	Wallace Gardens	1	1	0
Durham	Atria Southpoint Walk	2	2	0
	Brookdale Chapel Hill	3	2	0
	Eno Pointe Assisted Living	1	1	0
	Seasons at Southpoint	2	2	0
Franklin	The Jordan	1	1	0
Gaston	Terrace Ridge Assisted Living	1	1	0
Guilford	Brookdale Lawndale Drive	1	1	0
	Morningview at Irving Park	1	1	0
	Westchester Harbour	1	1	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Harnett	Green Leaf Care Center	1	1	0
Haywood	Creekside Villas	1	1	0
Henderson	Spring Arbor West	1	1	0
Johnston	Gabriel Manor Assisted Living	1	1	0
Macon	Grandview Manor Care Center	1	1	0
Mecklenburg	The Crossings at Steele Creek	1	1	0
Moore	Fox Hollow Senior Living Community	1	0	0
	The Coventry	1	0	0
Nash	Hunter Hill Assisted Living	1	1	0
Robeson	Red Springs Assisted Living	1	1	0
Rowan	Carillon Assisted Living of Salisbury	1	1	0
Rutherford	Holly Springs Senior Citizens Home	1	1	0
	Nana's Assisted Living Facility #2	1	1	0
Stokes	Mountain Valley Living Center	1	1	0
Transylvania	Kingsbridge House	1	1	0
Wake	Bright Horizon	1	0	0
	Tender Touch FCH	1	0	0
Watauga	Deerfield Ridge Assisted Living	1	1	0
Total	43 Facilities Reporting	**49**	**40**	**0**

NOTES:

1. There were 1,237 Licensed Adult Care Homes with a total of 40,929 beds as of June 30, 2016.
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]
Alamance	OE Enterprises of Alamance	1	0	0
	The Together House	1	0	0
Brunswick	Coastal Horizons Center	1	0	0
Buncombe	Crossroads Treatment Center - Asheville	1	0	0
Cabarrus	McLeod Addictive Disease Center - Concord	1	0	0
Caldwell	McLeod Addictive Disease Center - Lenoir	1	0	0
Carteret	The Beach House	1	0	0
Craven	PORT Human Services	1	0	0
	PORT Human Services -New Bern	1	0	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Cumberland	Carolina Outreach II	1	0	0
	Fayetteville Treatment Center	1	0	0
Davidson	Lexington Treatment Associates	4	0	0
Durham	BAART	2	1	0
	Durham Center	1	0	0
Forsyth	Care #2	1	1	0
Gaston	McLeod Addictive Disease Center - Gastonia	2	1	0
Guilford	Alcohol and Drug Services - East	1	0	0
	Greensboro Treatment Center	1	0	0
Haywood	The Balsam Center Adult Recovery Unit	1	0	0
Hoke	Sandhills Behavioral Center	1	0	0
Iredell	McLeod Addictive Disease Center - Statesville	1	0	0
Johnston	Johnston Recovery Services	1	0	0
McDowell	McLeod Addictive Disease Center - Marion	4	1	0
Mecklenburg	Innervision II	1	0	0
	McLeod Addictive Disease Center - 4th Floor	1	0	0
	Queen City Treatment	1	0	0
New Hanover	Coastal Horizons Center, Inc.	1	0	0
Onslow	Jackson Treatment Center, LLC	3	0	0
Pender	Coastal Horizons Center	1	0	0
Pitt	Port Human Services Adult Outpatient	1	0	0
Robeson	Southeastern Behavioral Healthcare	1	0	0
Rowan	Rowan Treatment Associates	1	0	0
Sampson	Family First Support Center	1	0	0
Union	McLeod Addictive Disease Center - Union	1	0	0
	Monroe Crisis Recovery Center	1	0	0
Vance	Advantage Care community Services	1	0	0
Wake	Community Workforce Solutions	1	0	0
	Southlight Healthcare - Garner	1	0	0
	Wake Enterprises	1	1	0
Wilson	Stepping Stones Community Resources, Inc.	1	0	0
Total	40 Facilities Reporting	**50**	**5**	**0**

NOTES:

1. There were 2,888 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 12,760 beds as of June 30, 2016.
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]
Lincoln	Linoak Group Home	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 337 Private ICFs/IID with a total of 2,786 beds as of June 30, 2016.
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]
Greenville	Vidant Medical Center	1	0	0
Total	1 Facility Reporting	**1**	**0**	**0**

NOTES:

1. There were 9 Private Psychiatric Hospitals, 45 Hospitals with Acute Care Psychiatric Units, and 6 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,229 beds as of June 30, 2016.
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]
Alamance	Universal Mental Health Services	1	1	0
Alexander	RHA	1	1	0
Avery	Daymark Recovery Services	1	1	0
Brunswick	Coastal Horizons Center Brunswick	2	2	0
	Coastal Southeastern United Care	1	1	0
Buncombe	Family Preservation Services of NC, Inc.	1	1	0
	WNC Ray of Hope, Inc.	1	1	0
Burke	A Caring Alternative	2	2	0
	Catawba Valley Behavioral Health	4	4	0
Cabarrus	Daymark Recovery Services	1	1	0
Caldwell	RHA Lenoir	1	1	0
Camden	Coastal Horizons Center, Inc.	1	1	0
Carteret	LeChris Health Systems	1	1	0
Catawba	Catawba Valley Behavioral Health	2	2	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Cherokee	Appalachian Community Services	1	1	0
Cleveland	Behavioral Health – Cleveland	1	1	0
Columbus	Advantage Behavioral HealthCare, Inc.	1	1	0
	Coastal Southeastern United Care	1	1	0
	H & H Mental Health Associates, PLLC	1	1	0
Craven	Coastal Horizons Center	1	1	0
Cumberland	Carolina Outreach, LLC	1	1	0
	Cumberland County TASC	2	2	0
Dare	PORT Human Services	3	3	0
Davidson	Monarch-Davidson	2	2	0
Durham	Alpha Management Services	1	1	0
	Carolina Outreach LLC	1	1	0
	Community Care Service LLC	1	1	0
	Durham Center Access	1	1	0
	UNC Center for Excellence in Community Mental Heal	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
	Insight Human Services	1	1	0
	NC Mentor	1	1	0
Franklin	Strategic Interventions	1	1	0
Gaston	Behavioral Health – Gaston	1	1	0
Greene	Coastal Horizons Center, Inc.	1	1	0
Guilford	Bellemeade	3	3	0
	Family Service of the Piedmont High Point	1	1	0
	High Point Walk-In Clinic	1	1	0
	Mental Health Associates of the Triad	1	1	0
	RHA Health Services	1	1	0
	Strategic Interventions	1	1	0
Halifax	Coastal Horizons Center, Inc.	1	1	0
Harnett	Daymark Recovery Services, Inc.	1	1	0
Haywood	Haywood Recovery Education Center	1	1	0
	Meridian Behavioral Health	1	1	0
Henderson	Family Preservation Services	2	2	0
Iredell	Crisis Recovery Center	1	1	0
	Easterseals UCP	1	1	0
Johnston	Cleveland	1	1	0
Lee	Daymark Recovery Services	2	2	0
	Heartfelt Alternatives	1	1	0
	VC & Associates, Inc.	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Lenoir	PORT Human Services	2	2	0
Macon	Appalachian Community Services	2	2	0
McDowell	RHA	1	1	0
	Strategic Interventions, Inc.	1	1	0
Mecklenburg	Amara Wellness	1	1	0
	InnerVision	1	1	0
	Mecklenburg Behavioral Health	1	1	0
	Mecklenburg Substance Abuse Services Center	1	1	0
	Pride in North Carolina	1	1	0
	Thompson Child and Family Focus Intensive In-Home	1	1	0
	Youth Villages	1	1	0
Mitchell	RHA Health Services	1	1	0
New Hanover	Alexander Youth Network	1	1	0
	Coastal Horizons Center, Inc.	2	2	0
	CSP Behavioral Health	1	1	0
Northampton	Jackson Office	1	1	0
Pender	Coastal Horizons Center	3	3	0
Person	Freedom House Recovery Center	3	3	0
Pitt	Coastal Horizons Center	1	1	0
	Le'Chris Health Systems of Greenville, Inc.	1	1	0
	PORT Human Services	5	5	0
	Recovery Innovations	1	1	0
Randolph	Alcohol and Drug Services	1	1	0
	Daymark Recovery Services Randolph Center	4	4	0
	Region 3 Justice Services	1	1	0
Richmond	Region 3 Treatment Accountability for Safer Community	1	1	0
Robeson	BH - Robeson – Godwin	2	2	0
	Coastal Southeastern United Care	1	1	0
	Primary Health Choice	2	2	0
	RHA	1	1	0
	Robeson – Outpatient	1	1	0
	Southeastern Behavioral Healthcare Services	1	1	0
Rockingham	Youth Haven Services, Inc.	1	1	0
Rowan	Daymark - Rowan Center	2	2	0
Stanly	Daymark Recovery Services	2	2	0
	Stanly Outpatient	1	1	0
Surry	Easter Seals UCP NC & VA, Inc.	2	2	0
Transylvania	Meridian	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Recovery Education Center	1	1	0
Union	Daymark Recovery Services	1	1	0
Vance	Daymark Recovery Services	2	2	0
Wake	Behavioral Health - Wake Forest	1	1	0
	Cottage Health Care Services, Inc.	1	1	0
	Freedom House Recovery	1	1	0
	Heartfelt Alternatives	1	1	0
	Lindley Habilitation Services	1	1	0
	Turning Point Family Care	3	3	0
	UNC Wake ACT Team	1	1	0
	UNC Wake STEP Clinic	1	1	0
Watauga	Daymark Recovery Services	1	1	0
Wayne	Client First Behavioral Health	1	1	0
Wilkes	Daymark Recovery Services	4	4	0
Wilson	Coastal Horizons Center	1	1	0
Yancey	RHA Behavioral Health Services	2	2	0
Total	106 Facilities Reporting	**147**	**147**	**0**

NOTES:

1. The number of these facilities is unknown as they are not licensed or state-operated.
2. All deaths reported by unlicensed facilities are reviewed 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 can investigate and/or require the facility to develop a plan for correcting these problems. The LME-MCO 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]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**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, 2016.
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 1,195 beds as of June 30, 2016.
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 577 beds as of June 30, 2016 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]
Granville	Central Regional	1	0	0
Total	1 Facility Reporting	**1**	**0**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 892 beds as of June 30, 2016.
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, 2016.

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, 2015 and ending June 30, 2016. 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 3,371 licensure surveys, 1,525 follow-up visits, and 2,740 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
Brunswick	Shallotte Assisted Living	1
Craven	Brookdale New Bern	1
	New Bern House	1
Edgecombe	Heritage Care of Rocky Mount	1
Forsyth	Homestead Hills Assisted Living	1
Granville	Summit Communities	2
Macon	Grandview Manor Care Center	1
Rutherford	Henderson Care Center	2
Transylvania	Tore's Home #3	1
Wayne	Goldsboro Assisted Living & Alzheimer's Care	1
Total	10 Facilities Cited	**12**

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

County	Facility	# Citations
Alamance	Angelic Heartz Care Facility	1
	Dee & G Enrichment Center #2	1
	New Beginnings Group Home	3
Anson	W&G Community Services	1
Beaufort	Wooded Acres #2	1
Brunswick	Wall Brown Home,	2
Buncombe	Montford Hall	1
Craven	Dixon Social Interactive Services, Inc.	4
Cumberland	Extended Reach Day Treatment	2
	Luv-N-Arms	2
	McDuffie DDA Group Home	2
	New Horizons Group Home #3	2

County	Facility	# Citations
Cumberland	Stanberry Place	3
	Willowbrook Treatment Center	1
Duplin	White Oak Group Home 1	2
Durham	Adventure House	1
	Recovery Connections	1
	Rose Castle Residential Services, Inc.	2
Forsyth	Independent Living Group Home at Old Salisbury Road	2
	Raven Ridge Group Home	1
	YWCA-Hawley House	1
Gaston	Dorothy's Place	1
	McLeod Addictive Disease Center - Gastonia	1
	New Hope Group Home III	2
	New Hope Group Home IV	1
	Plyler Lake	2
Greene	Fair Fax	2
Guilford	A Place of Their Own, LLC	2
	A Touch From The Heart #2	1
	Center of Progressive Strides	2
	Covenant Care Services, LLC	1
	De-Borah's Hope House	2
	GHH-Northridge Home	1
	Mag's House II	1
	Our Home - High Point	1
	Precious Pearls Group home	1
Harnett	Sierra's Residential Services, Inc.	2
Hoke	Grace House	1
	Jackson Springs Treatment Facility	1
	Serenity Therapeutic Services	1
Johnston	Carolina Support Services Day Treatment	1
	Passionate Care Home #1	1
Lincoln	Support Day Treatment	2
Mecklenburg	Alexander Youth Network Charlotte Day Treatment	1
	Charlotte Treatment Center	1
	Community Treatment Alternatives	1
	Harris Home	1
	Idlewild	1
	Jireh's Place	1
	McAlway Road	1
	McEntyre	1
	New Place	1
	Strategic Behavioral Center - Charlotte	1
	The Harris Home	1
	The Villages of Hope Haven	1
	UMAR - Myer's Park Home	1
Moore	Carolina Treatment Center of Pinehurst	2
New Hanover	Cape Fear Group Homes Day Program	2
	Pride in NC Day Treatment Center	1
	Yahweh Center PPD PRTF	1
Onslow	Coastal Transitional Services	1

County	Facility	# Citations
	Harris Home	2
Pitt	Better Connections Day Program	1
	Dixon Social Interactive Services, Inc.	4
Randolph	E's House	2
Richmond	Samaritan Colony	1
Robeson	Stephen's Outreach Center	2
Rowan	ACE Program	1
	Timber Ridge Treatment Center	1
Scotland	Miracle Haven of Wagram	2
Surry	Peace Lily #1	2
	Peace Lily #2	2
Union	Friendship Home, Inc.	1
	Hampton Meadows	1
Wayne	Graham's New Horizon 1	2
	Howell's and Howells	2
Total	77 Facilities Cited	**112**

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
Buncombe	Care Partners Rehab	1
Forsyth	NC Baptist	1
	Novant Presbyterian	1
Henderson	Maria Parham	3
Lee	Central Carolina	1
Mecklenburg	Novant Presbyterian	1
Onslow	Onslow Memorial	1
Pitt	Vidant Health	1
Wake	UNC Rex Hospital	1
Total	9 Facilities Cited	**11**

Table B-5: Private Unlicensed Facilities:

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

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**