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

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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) is included in this report. The report reflects data for State Fiscal Year (SFY) 2017-2018, which covers the period of July 1, 2017 through June 30, 2018.

Part A of the report includes deaths 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 226 deaths were reported: 68 by private licensed facilities, 156 by private unlicensed facilities, and 2 by state-operated facilities. Of the 226 deaths reported, all were screened, 193 (85%) were investigated, and one 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 3,245 licensure surveys, 1,418 follow-up visits, and 2,219 complaint investigations were conducted during the SFY. And a total of 109 private licensed facilities were issued a total of 170 citations for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private unlicensed facilities or to 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=74 or 44%) and "training in seclusion, physical restraint and isolation time-out" (N=46 or 27%). These citations accounted for 71% 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 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) 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:

- 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 (ICF/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 2017-2018, which spans the period July 1, 2017 through June 30, 2018. It is also 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-10 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 180 facilities – 66 private licensed facilities, 112 private unlicensed facilities, and 2 state-operated facilities – reported a total of 226 deaths that were subject to these statutory reporting requirements.
2 Of the total 226 deaths reported, 68 deaths were reported by private licensed facilities, 156 deaths were reported by private unlicensed facilities, and 2 deaths were reported by state-operated facilities.
3 All deaths that were reported were screened; a total of 193 deaths (85%) 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 2017-2018

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	1,232	41,131	33	34	32	1
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,862	10,692	29	30	4	0
A-3	Community ICFs/IDD	337	2,786	1	1	1	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	59	2,400	3	3	0	0
Subtotal		4,490	57,009	66	68	37	1
Private Unlicensed Facilities							
A-5	Private Unlicensed[5]			112	156	156	0
State-Operated Facilities							
A-6	Alcohol and Drug Treatment Centers	3	146	2	2	0	0
N/A[7]	Developmental Centers	3	1,101	0	0	0	0
N/A[7]	Neuro-Medical Treatment Centers[6]	3	NF=415	0	0	0	0
			ICF=92	0	0	0	0
N/A[7]	Psychiatric Hospitals	3	932	0	0	0	0
N/A[7]	Residential Programs for Children	2	34	0	0	0	0
Subtotal		14	2,720	2	2	0	0
Grand Total		**4,504**	**59,729**	**180**	**226**	**193**	**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, 2018).
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 a State-Operated ICFs/IID Center and as State-Operated Neuro-Medical Treatment Center, 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, 2017 and ending June 30, 2018. 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 restraint, 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 109 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private unlicensed facilities or 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 3,245 initial, renewal and change-of-ownership licensure surveys, 1,418 follow-up visits, and 2,219 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.

3 A total of 170 citations were issued across all facility types 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=74 or 44%) and "training in seclusion, physical restraint and isolation time-out" (N=46 or 27%); these accounted for 71% 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 2017-2018[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	10	12	• Rules 10A NCAC 13F.1501(a) and 10A NCAC 13G .1301(a) Inappropriate use of restraints (failure to obtain physical order, assessment and to use least restrictive device or no alternative attempted) (9 citations) • Rule 10A NCAC 13F.1501(d) Failure to assure a complete restraint order was obtained and updated every 3 months (2citations)	• Rule 19A NCAC 13F .0506(a) Failure to provide physical restraint training to staff (1citation)
B-2	Group Homes, Day Outpatient Treatment, Community Based PRTFs	87	143	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (74 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (46 citations)	• Rule 10A NCAC 27E.0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavior Control (11 citations) • Rule 10A NCAC 27E.0101 Least Restrictive Alternative (10 citations) • Rule 10A NCAC 27E.0102 Prohibited Procedures (2 citations)
N/A[2]	Community ICFs/IDD	0	0	No Citations were issued.	No Citations were issued.
B-3	Psychiatric Hospitals, Units, and Hospital PRTFs	12	15	• A-0168: The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State Law (2 citations)	• A-0160: [A restraint is-] (B) A drug or medication when it is used as a restriction to manage the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition (1 citation)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				• A-0175: Condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff (4 citations) • N-0143: The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record (1 citation) • N-0167: A physician or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed (1 citation) • State Operations Manual Appendix A – Survey Protocol Regulations and Interpretive Guidelines for Hospitals; Appendix N – Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance	• A-0162: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for management of violent or self-destructive behavior (1 citation) • A-0166: Use of restraint or seclusion must be – (i) in accordance with a written modification to the patient's plan of care (1 citation) • A-167: Use of restraint or seclusion must be – (ii) in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State Law (1 citation) • A-0169: Order for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (1 citation) • A-0170: The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion (1 citation) • A-0201: Monitoring the physical/psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
					integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. (1 citation)
Subtotal		109	170		
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		**109**	**170**		

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 3,245 licensure surveys, 1,418 follow-up visits, and 2,219 complaint investigations during the SFY.
2. N/A means not applicable and is used to indicate that no tables are provided in Appendix B for facilities for which no citations were issued.

Appendix A: Consumer Deaths Reported by County and Facility

Tables A-1 through A-10 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the SFY beginning July 1, 2017, and ending June 30, 2018, 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.

It should be noted that all deaths that were reported were screened and investigated by DHHS when required by law. One death was 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]
Bladen	West Bladen Assisted Living	1	1	1[4]
Catawba	Austin Adult Care	1	1	0
Chatham	Carolina Meadows Fairways	2	2	0
Cleveland	Summit Place of Kings Mountain	1	1	0
Forsyth	Clemmons Village II	1	1	0
	Kerner Ridge Assisted Living	1	1	0
Franklin	Franklin Manor Assisted Living	1	1	0
	Pioneer Healthcare #2	1	1	0
Guilford	Morningview at Irving Park	1	1	0
Harnett	Green Leaf Care Center	1	1	0
Haywood	Spicewood Cottages Oaks	1	1	0
Henderson	Just In Time FCH Unit 1	1	1	0
Iredell	Brookdale Peachtree MC	1	1	0
	Carillon Assisted Living of Mooresville	1	1	0
Johnston	Gabriel Manor Assisted Living	1	1	0
Lenoir	Classic Care of Kinston	1	0	0
Mecklenburg	Parker Terrace	1	1	0
	Sunrise on Providence	1	1	0
	The Terrace at Brightmore of South Charlotte	1	1	0
	True Care Rest Home	1	1	0
Moore	Brookdale Pinehurst	1	1	0
New Hanover	Cedar Cove Assisted Living	1	1	0
Pender	Ashe Gardens	1	1	0
Pitt	Brookdale W Arlington Boulevard	1	1	0
Polk	Laurel Woods	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Randolph	Carillon Assisted Living of Asheboro	1	1	0
Rockingham	Brookdale Eden	1	1	0
Rowan	Alpha Concord Plantation	1	1	0
Sampson	Serenity FCH #2	1	1	0
Stanly	Woodhaven Court	1	0	0
Stokes	Priddy Manor Assisted Living	1	1	0
	Walnut Ridge Assisted Living	1	1	0
Wake	The Covington	1	1	0
Total	**33 Facilities Reporting**	**34**	**32**	**1**

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

1. There were 1,232 Licensed Adult Care Homes with a total of 41,131 beds as of June 30, 2018.
2. For these 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. 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 resident had a history of moving excessively in bed and became entangled in the bed covers; the resident fell off the bed and was found on the floor entangled in the bed covers. A Type A1 violated was cited per Rule 10A NCAC 13F .1501(a) for failure to assure use of a physical restraint only after an assessment and care plan had been completed; a Type A1 violation was also cited per Rule 10A NCAC 13F .0901(a) for failure to assure supervision by not implementing interventions to address the resident's symptoms and diagnosis. Plans of correction were implemented to ensure assessment of all residents with bed rails and to ensure use of bed rails only for repositioning and turning in the bed as well as to provide in-service training to staff on fall prevention and recognizing status changes in residents; the Plan of Correction also required staff to complete 30-minute checks on all residents in the special care unit and to update residents' assessments and care plans as needed and to document the same. A follow-up survey completed June 4, 2018 determined both violations had been abated. No penalty has been issued at the time of this report.

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]
Buncombe	October Road, Inc.	1	0	0
Cabarrus	Alexander Youth Network - Furr Day Treatment	1	0	0
Chowan	Heritage Club - Chowan	1	0	0
Cumberland	Carolina Outreach II	1	1	0
	Carolina Treatment Center of Fayetteville	1	1	0
Davidson	Addiction Recovery Care Association	1	0	0
	Western Carolina Treatment Center	1	1	0
Durham	Durham Recovery Response	2	0	0
	Durham Treatment Center	1	0	0
	Visions Counseling Studio	1	0	0
Gaston	Gastonia Treatment Center	1	0	0
Guilford	Crossroads Treatment Center of Greensboro	1	0	0
	Legacy Freedom Treatment Center-	1	0	0
Henderson	Premier Treatment Specialists, LLC	1	0	0
Iredell	Daymark Recovery CRC Statesville	1	0	0
McDowell	McDowell Psychosocial Rehabilitation	1	0	0
	McLeod Addictive Disease Center-Marion	1	0	0
Mecklenburg	Family Innovations	1	0	0
	McLeod Addictive Disease Center	1	0	0
Montgomery	Loretta	1	1	0
Moore	Carolina Treatment Center of Pinehurst	1	1	0
New Hanover	NH Treatment Center	1	0	0
Robeson	Premier Behavioral Services	1	0	0
	RHA Innovations PSR	1	0	0
	Robeson Treatment Center	1	0	0
Sampson	Christian's House of Hope	1	0	0
Wake	Life Skills Independent Care	1	0	0
Watauga	McLeod Addictive Disease Center-Watauga	1	0	0
Wilson	Stepping Stones	1	0	0
Total	**29 Facilities Reporting**	**30**	**4**	**0**

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

1. There were 2,862 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,692 beds as of June 30, 2018.
2. This indicates the number of death reports that were investigated.

3. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

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

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

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

1. There were 337 Private ICFs/IID with a total of 2,786 beds as of June 30, 2018.
2. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-4: 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]
Chowan	Vidant Roanoke Chowan	1	0	0
Moore	Firsthealth Moore Regional	1	0	0
Richmond	Sandhills Regional	1	0	0
Total	**3 Facilities Reporting**	**3**	**0**	**0**

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

1. There were 8 Private Psychiatric Hospitals, 46 Hospitals with Acute Care Psychiatric Units, and 5 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,400 beds as of June 30, 2018.
2. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-5: Private Unlicensed Facilities

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Alamance	Pinnacle Family Services	1	1	0
	RHA Behavioral Health	2	2	0
	Trinity Behavioral Healthcare PC	1	1	0
Avery	Daymark Recovery Services	1	1	0
Brunswick	Physician Alliance for MH	1	1	0
	RHA Behavioral Health	1	1	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Buncombe	C3@356 Comprehensive Care Center	1	1	0
	Family Preservation Services of NC, Inc.	1	1	0
	Region 4 Justice Services TASC	1	1	0
	RHA Behavioral Health	3	3	0
Burke	A Caring Alternative LLC	1	1	0
	Catawba Valley Behavioral Healthcare	1	1	0
Cabarrus	Cabarrus Center	5	5	0
	RHA Health Services	1	1	0
Caldwell	Region 4 Justice Services - TASC	1	1	0
Caswell	Psychotherapeutic Services	1	1	0
Catawba	Catawba Valley Behavioral Healthcare	2	2	0
Chatham	Chatham Recovery	1	1	0
	Coastal Horizons Center, Inc.	3	3	0
Cleveland	Support Incorporated	1	1	0
Columbus	RHA	2	2	0
Craven	Port Health Services	1	1	0
Cumberland	Greater Image Healthcare Corporation	1	1	0
	Yelverton's Enrichment Services	1	1	0
Davidson	Daymark Recovery Center Davidson Center	2	2	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Durham	Coastal Horizons Center	2	2	0
	Freedom House Recovery Center Durham Outpatient Clinic	1	1	0
	Telecare Durham ACTT	1	1	0
Forsyth	Behavioral Health-Forsyth	1	1	0
	Daymark Recovery Services, Inc	2	2	0
	Region 3 Justice Services	2	2	0
Franklin	Vision Behavioral Health Services	2	2	0
Gaston	BH - Gaston	2	2	0
Guilford	Alcohol and Drug Services - East	3	3	0
	Bellemeade	3	3	0
	PSI	1	1	0
	Region 3 TASC	2	2	0
	RHA Health Services	3	3	0
	Strategic Interventions	1	1	0
Halifax	RHA Behavioral Health	1	1	0
Harnett	Daymark Recovery Services	1	1	0
	RHA Health Services	1	1	0
	Therapeutic Alternatives, Inc.	1	1	0
Haywood	Appalachian Community Services	2	2	0
	C3@356 Comprehensive Care Center	1	1	0
	Meridian Behavioral Health Services	1	1	0
Henderson	Family Preservation Services	1	1	0
	NC Brookhaven Behavioral Health	1	1	0
	Region 4 Justice Services	1	1	0
Hoke	Daymark Recovery Services- Hoke Center	1	1	0
Iredell	HomeCare Management Corp	1	1	0
	Iredell Clinic	1	1	0
Jackson	Meridian Behavioral Health	1	1	0
Johnston	Carolina Outreach LLC	1	1	0
	Easterseals UCP	1	1	0
	Johnston Public Health Behavioral Health Division	2	2	0
	Pathways to Life	1	1	0
Lenoir	PORT Health Services	3	3	0
Lincoln	Outreach Management Services	1	1	0
Macon	Macon REC	1	1	0
Madison	RHA Health Services	1	1	0
Mecklenburg	Access Family Services	1	1	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
	Carolina Outreach	1	1	0
	Family Innovations LLC	2	2	0
	McLeod Addictive Disease Center	4	4	0
	Meck ACTT	1	1	0
Montgomery	Daymark Recovery Services - Montgomery Center	1	1	0
Moore	Carolina Behavioral Care, PA	2	2	0
	Daymark Recovery Moore Center	2	2	0
	ME GREENHOUSE	1	1	0
New Hanover	Access Family Services, Inc.	1	1	0
	Coastal Horizons Center, Inc.	1	1	0
	RHA Behavioral Health	1	1	0
Northampton	Northeastern Home Care	1	1	0
Onslow	Jacksonville Office	1	1	0
Orange	UNC Center for Excellence in Community Mental Health	1	1	0
Pender	Alexander Youth Network	1	1	0
	Coastal Horizons Center, Inc.	3	3	0
Pitt	PORT HEALTH	2	2	0
Robeson	Coastal Horizons Center, Inc.	1	1	0
	RHA	2	2	0
	Riverbend Services, Inc.	2	2	0
Rockingham	Rockingham	1	1	0
Rowan	Daymark Recovery Center	2	2	0
Sampson	Family First Support Center Inc.	1	1	0
Scotland	ReNew Life Group LLC	1	1	0
	Scotland BH	1	1	0
Stanly	BH-Stanly	1	1	0
Stokes	PQA Healthcare, Inc	1	1	0
Transylvania	Recovery Education Center	1	1	0
	Region 4 Justice Services - TASC	1	1	0
Union	Daymark Recovery Services	5	5	0
Vance	Beyond Challenges Community Services, LLC	1	1	0
	Carolina Community Support Services	1	1	0
	Daymark Recovery Services	2	2	0
Wake	B&D Integrated Health Services	1	1	0
	BH - Wake	1	1	0
	Carolina Outreach, LLC	1	1	0
	Coastal Horizons Center TASC	1	1	0
	EasterSeals UCP	1	1	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
	North Carolina Recovery Support Services	1	1	0
	Southlight Healthcare	1	1	0
	Wake BH	1	1	0
Warren	Strategic Interventions	1	1	0
Watauga	Region 4 Justice Services - TASC	1	1	0
Wayne	Client First of NC	1	1	0
	Waynesboro Family Clinic, P.A.	1	1	0
Wilkes	Daymark Recovery Services Wilkes	1	1	0
Wilson	BH - Wilson	1	1	0
	Carolina Outreach, LLC	1	1	0
Yadkin	Daymark Recovery Services Avery	1	1	0
Total	**112 Facilities Reporting**	**156**	**156**	**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 SFY18, for example, 150 deaths met the reporting requirement for this report; however, a total of 156 deaths were reported due to six instances where the individuals were enrolled in multiple services and each provider reported the death in IRIS.
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 2017-June 2018, 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-6: State Alcohol and Drug Abuse 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
Granville	R. J. Blackley	1	0	0
Total	**2 Facilities Reporting**	**2**	**0**	**0**

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

1. There were three State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 146 beds as of June 30, 2018. These 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 including those resulting from natural causes, terminal illness, and unknown causes.
2. Findings indicate there were no deaths related to the use of restraint/seclusion. Rather, both reported deaths were determined accidental and occurred within 14 days of discharge.

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 restraint, 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, 2017 and ending June 30, 2018. 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 3,245 licensure surveys, 1,418 follow-up visits, and 2,219 complaint investigations were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility Cited	Citations
Bladen	West Bladen Assisted Living	1
Caldwell	The Shaire Center	1
Duplin	Golden Care	2
Hoke	Open Arms Retirement Center	2
Iredell	Aurora of Statesville	1
Jones	Magnolia Cottage Care Building #2	1
Lincoln	Lakewood Care Center	1
Robeson	B & B Assisted Living # 7	1
Rowan	Carillon Assisted Living of Salisbury	1
Wake	North Pointe Assisted Living of Garner	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 Cited	Citations
Alamance	A Solid Foundation	2
	A Solid Foundation	1
	Alamance Academy, LLC	1
	Motivational Residential Care	2
	New Beginnings Group Home	1
	Total Access Care Woodland	1
	Triad Health Care 1	2
	Turning Point	1
Avery	Grandfather Home for Children-Campbell Cottage	1
	BHG Asheville	1
Buncombe	First Step Farm-Women	1

County	Facility Cited	Citations
	Western Carolina Treatment Center	1
	Woman and Children First	1
Cabarrus	Cabarrus County Group Home	1
	IOI Enrichment	1
Catawba	Changing Lives Now #3	2
Chatham	Carolina House	1
Cherokee	The Risin	1
Clay	UMAR-Hayesville I	1
Cleveland	Inward Bound	1
	New Hope Home II	2
Cumberland	College Lakes	2
Durham	Rainbow of Sunshine 2	1
	Upward Process	1
	Absolute Home Roxboro Street	1
	Community Choices, Inc-Cascade@Durham	1
	Devereux Residential Services, LLC	1
	Enhancement Health Care	1
	Morse Clinic of Hillsboro	1
	Recovery Connections II	2
	TLC Adult Group Home	1
Forsyth	Independent Living @ Ransom Rd.	3
	YMCA-Hawley House	1
Gaston	New Hope Home III	1
	Plyler Lake	2
Graham	Tapestry Adolescent Residential Program	1
Greene	Fair Fax	3
Guilford	A Touch From the Heart #2	2
	All About You Residential Home Care LLC	2
	Bisbee Place	1
	De-Borah's Hope House	1
	Guess Community Services, Inc. Day Treatment Center	2
	Mel-Burton School	1
	Mercy Home Services II	1
	Mercy Home Services II	1
	Oakmont Home	1
	Servant's Heart	2
	Tangle Drive Group Home	2
	Watlington's Family Care Home #3	2
	YouthSpring Residential Treatment	4
Harnett	Sierra's Residential Services Group Home III	1
Henderson	Azalea Way	1
Hoke	Grace House	1
Johnston	The Lighthouse	2
McDowell	The Linda Clemmons Home	1
	West Marion Group Home	1
Mecklenburg	Anuvia Prevention and Recovery Center	1
	Clendon Court	2
	Jaspers House of Day Treatment	2
	Jeffery Evan Home	1
	Yorke Cottage	1
Moore	The Bethany House	1

County	Facility Cited	Citations
New Hanover	Coastal Horizons Center, Inc.	1
	El Ogden	1
	Lake Forest Academy Day Treatment	6
	New Hanover Treatment Center	1
Onslow	Jacksonville Treatment Center	1
Orange	RSI-Piney	1
Pender	Lotus	2
	Rainbow Farms	2
Pitt	Emmanuel Residential Facility	1
	Pitt County Group Home #4	2
	Pride in North Carolina Day Treatment – Site A	3
Randolph	New Beginnings Youth Facility	1
Robeson	Hope House	2
	Lumberton Treatment Center	1
	New Horizon Group Home, LLC	11
	Robeson #3	1
Rockingham	Westerly Park Home	1
Rowan	Partee Street	3
Union	Anderson Health Services - Ashford	3
	Anderson Health Services - Walfus	5
Watagua	Three Forks Home	1
Wayne	Grace	1
	Howell & Howell's	1
Wilkes	Wilkes Day Treatment -CC Wright Elementary	1
Wilson	A Caring Heart Independence Center	1
Total	**87 Facilities Cited**	**143**

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

County	Facility	Citations
Durham	Select Specialty	1
Forsyth	NC Baptist	1
Guilford	Select Specialty	1
Johnston	Johnston Memorial	1
Mecklenburg	Carolinas Med University	1
	Strategic BH (PRTF)	2
Randolph	Randolph	1
Robeson	Southeastern	1
Rutherford	Rutherford Regional	3
Surry	Northern Hospital	1
Union	Carolinas HC	1
Wake	Strategic BH Garner	1
Total	**12 Facilities Cited**	**15**

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.