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, 2017

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) 2016-2017, which covers the period July 1, 2016 through June 30, 2017.

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 235 deaths were reported: 72 by private licensed facilities, 160 by private unlicensed facilities, and 3 by state-operated facilities. Of the 235 deaths reported, all were screened, 178 (76%) 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 3,862 licensure surveys, 1,423 follow-up visits, and 1,588 complaint investigations were conducted during the year.

A total of 136 facilities -- 136 private licensed facilities were issued a total of 181 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” (101 or 56%) and “training in seclusion, physical restraint and isolation time-out” (51 or 28%). These citations accounted for 84% 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 State Fiscal Year (**SFY) 2016-2017**, the period **July 1, 2016 through June 30, 2017**. 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 2016-2017

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	1,247	41,096	16	16	13	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,867	10,599	44	53	1	0
A-3	Community ICFs/IID	337	2,786	2	2	2	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	55	2,382	1	1	0	0
	Subtotal	4,506	56,863	63	72	16	0
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			114	160	160	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	145	0	0	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,124	0	0	0	0
A-8	Neuro-Medical Treatment Centers	3	NF= 452	2	2	1	0
			ICF= 123	0	0	0	0
A-9	Psychiatric Hospitals	3	892	1	1	1	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	2,778	3	3	2	0

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]
	Grand Total	4,520	59,641	180	235	178	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, 2017).
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 181 facilities – 63 private licensed facilities, 114 private unlicensed facilities, and 3 state-operated facilities -- reported a total of 235 deaths that were subject to statutory reporting requirements.
- Of the total 235 deaths reported, 72 deaths were reported by private licensed facilities, 160 deaths were reported by private unlicensed facilities, and 3 deaths was reported by state-operated facilities.
- All deaths that were reported were screened. A total of 178 deaths (76%) 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, 2016, and ending June 30, 2017. 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 2016-2017[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	4	4	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted) (3 citations)	• Insufficient or lack of documentation for restraints (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	120	155	• Training on alternatives to restrictive interventions (101 citations) • Seclusion, physical restraint and isolation time-out (51 citations)	• General Policies (1 citation)
B-3	Community ICFs/IID	0	0	• No citations were issued	• No citations were issued

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	12	22	● Failure to obtain an order prior to restraint application (10 citations) ● Failure to complete a face to face within 1 hour of application (5 citations)	• Failure to use less restrictive interventions to protect the patient, a staff member, or others from harm. • Failure to review and update of care or treatment plan with restrictive interventions in writing within a timeframe specified by hospital policy (1 citation)
	Subtotal	136	181		
	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	**136**	**181**		

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 3,862 licensure surveys, 1,423 follow-up visits, and 1,588 complaint investigations during the year.

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

As Table B shows:

- A total of 136 facilities -- 136 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 3,862 initial, renewal and change-of-ownership licensure surveys, 1,588 follow-up visits, and 1,423 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 181 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 181 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" (101 or 56%) and "training in seclusion, physical restraint and isolation time-out" (51 or 28%). These citations accounted for 84% 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, 2016, and ending June 30, 2017, 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	0	0
Brunswick	Carillon Assisted Living of Southport	1	1	0
Carteret	Carteret House	1	0	0
Chatham	Chatham Ridge Assisted Living	1	1	0
Chowan	Edenton House	1	1	0
Currituck	Currituck House	1	1	0
Duplin	Autumn Village	1	1	0
Iredell	The Gardens of Statesville	1	1	0
Jackson	The Hermitage	1	1	0
Macon	Grandview Manor Care Center	1	1	0
Mecklenburg	Northlake House	1	1	0
Moore	Elmcroft of Southern Pines	1	1	0
Onslow	Onslow House	1	1	0
Pasquotank	Brookdale Elizabeth City	1	1	0
Rockingham	Kellam's Family Care Home	1	0	0
Stokes	Priddy Manor Assisted Living	1	1	0
Total	16 Facilities Reporting	**16**	**13**	**0**

NOTES:

1. There were 1,247 Licensed Adult Care Homes with a total of 41,096 beds as of June 30, 2017.
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	Crossroads Treatment Center of Asheville	2	0	0
	Crossroads Treatment Center of Weaverville	1	0	0
	Neil Dobbins Center	1	0	0
Carteret	Life, Inc. Grey Fox Run Group Home	1	0	0
Catawba	McLeod Addictive Disease Center Hickory	1	0	0
Chatham	Chatham Recovery	1	0	0
Caldwell	Port Human Services - New Bern	1	0	0
Craven	Carolina Outreach III	1	0	0
	Carolina Treatment Center of Fayetteville	1	0	0
Durham	BAART Community Healthcare	1	0	0
	Chandler Road	1	0	0
	Durham Treatment Center	1	0	0
	Triangle Residential Options for substance Abusers	1	0	0
Forsyth	The Unity Center	1	0	0
Gaston	McLeod Addictive Disease Center	1	0	0
	McLeod Addictive Disease Center	1	0	0
	Outreach Management Services PH Program	1	0	0
Guilford	Alcohol and Drug Services - East	1	0	0
	Crossroad Treatment Center of Greensboro	1	0	0
	Greensboro Treatment Center	1	0	0
	Legacy Freedom Treatment Center- Greensboro	1	0	0
Haywood	Lifespan Enrichment Center	1	0	0
Henderson	A Step Forward	1	0	0
Iredell	McLeod Addictive Disease Center	4	0	0
Lee	Sanford Treatment Center, LLC	1	0	0
McDowell	McLeod Addictive Disease Center Marion	1	0	0
Mecklenburg	Amara Wellness	1	0	0
	Anuvia Prevention and Recovery Center	2	0	0
	Cascade Services	1	0	0
	McLeod Addictive Disease Center	4	0	0
	Mr. Bills Place	1	1	0
New Hanover	The Harbor	1	0	0
Randolph	Oakwood Acres	1	0	0
Rowan	Rowan Treatment Associates	1	0	0
Union	Daymark Recovery Services	1	0	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	McLeod Addictive Disease Center	1	0	0
Vance	Vance Recovery	1	0	0
Wake	Favour Home II	1	0	0
	First Step Services, LLC	1	0	0
	Southlight Healthcare - Garner Road	3	0	0
	Wake Area Counseling Halfway House	1	0	0
	Western Wake Treatment Center, LLC	1	0	0
	Carolina Outreach III	1	0	0
Total	43 Facilities Reporting	**53**	**1**	**0**

NOTES:

1. There were 2,867 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,599 beds as of June 30, 2017.
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]
Carteret	Life Inc. / Greyfox	1	1	0
Edgecombe	Skills Creation of Tarboro	1	1	0
Total	2 Facilities Reporting	**2**	**2**	**0**

NOTES:

1. There were 337 Private ICFs/IID with a total of 2,786 beds as of June 30, 2017.
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]
Surry	Northern Hospital of Surry	1	0	0
Total	1 Facility Reporting	**1**	**0**	**0**

NOTES:

1. There were 10 Private Psychiatric Hospitals, 40 Hospitals with Acute Care Psychiatric Units, and 5 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,382 beds as of June 30, 2017.

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	Easter Seals UCP NC & VA, Inc.	2	2	0
	PSI	1	1	0
	RHA Health Services Inc.	2	2	0
	Trinity Behavioral Healthcare PC	1	1	0
Anson	Daymark Recovery Services Inc. Anson Center	1	1	0
Brunswick	Coastal Horizons Center	1	1	0
	Coastal Southern United Care	1	1	0
Buncombe	Carolina Outreach	1	1	0
	Family Preservation Services of NC, Inc.	1	1	0
	RHA Behavioral Health Services, Inc.	2	2	0
	Youth Villages, INC	1	1	0
Burke	A Caring Alternative	2	2	0
	Catawba Valley Behavioral Health	1	1	0
Cabarrus	Daymark Recovery Services	3	3	0
Caswell	RHA Health Services Inc.	1	1	0
Chatham	UNC Center for Excellence in Community Mental Health	1	1	0
Cherokee	Appalachian Community Services	2	2	0
Clay	Appalachian Community Services	1	1	0
Columbus	Advantage Behavioral Healthcare, Inc.	1	1	0
	Allied Behavioral Management	1	1	0
	Coastal Horizons Center, Inc.	1	1	0
	RHA Behavioral Health Services, Inc.	1	1	0
Craven	PORT Health Services	3	3	0
Cumberland	Carolina Outreach	2	2	0
	Coastal Horizons Center, Inc.	1	1	0
Currituck	Integrated Family Services, PLLC	1	1	0
Davidson	Monarch	3	3	0
	Nazareth Children's Home	1	1	0
Durham	B & D Behavioral Health Services	2	2	0
	Carolina Outreach, LLC	4	4	0
	Coastal Horizons Center, Inc.	2	2	0
	V.O.I.C.E Therapeutic Solutions	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Edgecombe	Easter Seals, UCP	1	1	0
Forsyth	Daymark Recovery Services	3	3	0
	Insight Human Services	1	1	0
	PQA Healthcare, Inc.	1	1	0
	The Children's Home	1	1	0
	Top Priority Care Services, LLC	1	1	0
	Wake Forest Health Science Division	1	1	0
Gaston	Coastal Southeastern United Care	1	1	0
	Insight Human Services	1	1	0
	Monarch	2	2	0
	Outreach Management Services	1	1	0
Greene	Coastal Horizons Center	1	1	0
Guilford	Alcohol and Drug Services	1	1	0
	Continuum Care Services Inc.	1	1	0
	Easter Seals UCP of NC and VA	1	1	0
	Family Service of the Piedmont, Inc.	1	1	0
	Monarch	3	3	0
	Psychotherapeutic Services	1	1	0
	RHA Health Services	3	3	0
	The Right Choice	1	1	0
	Youth Focus, Inc.	1	1	0
Halifax	Coastal Horizons Center, Inc.	1	1	0
Haywood	Appalachian Community Services	1	1	0
	Easter Seals UCP	1	1	0
	Meridian Behavioral Health	1	1	0
Henderson	Family Preservation Services	1	1	0
Hertford	Coastal Horizons Center, Inc.	1	1	0
	Integrated Family Services, PLLC	1	1	0
	Port Human Services	1	1	0
Iredell	Insight Human Services	1	1	0
Jones	Coastal Horizons Center, Inc.	1	1	0
Madison	RHA Health Services	1	1	0
McDowell	RHA Health Services	1	1	0
Mecklenburg	A Small Miracle Inc.	1	1	0
	DDR, Inc.	1	1	0
	Monarch	1	1	0
	RHA Behavioral Health for the DHH	1	1	0
	Thompson Child and Family Focus	1	1	0
Mitchell	RHA Health Services	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Montgomery	Daymark Recovery Services	1	1	0
Moore	Daymark Recovery Services, Inc.	1	1	0
Nash	Monarch	2	2	0
New Hanover	Coastal Horizons Center, Inc.	2	2	0
	Physician Alliance for Mental Health	1	1	0
	RHA Behavioral Health	1	1	0
	Trillium Health Resources	1	1	0
Onslow	Coastal Horizons Center, Inc.	1	1	0
Orange	Carolina Behavioral Care	1	1	0
	UNC OASIS Program	1	1	0
Pasquotank	Integrated Family Services, PLLC	1	1	0
Pender	Coastal Horizons Center, Inc.	1	1	0
Person	Freedom House Recovery Center	1	1	0
Pitt	PORT	1	1	0
Randolph	Daymark Recovery Services, Inc.	2	2	0
Robeson	Monarch	1	1	0
	RHA	1	1	0
Rowan	Daymark Recovery Services, Inc.	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
Stanly	Daymark Recovery Services	1	1	0
Stanly	Monarch	1	1	0
Surry	Easterseals UCP	1	1	0
Transylvania	Meridian Behavioral Health Services	2	2	0
Union	Daymark Recovery Services	4	4	0
Vance	Daymark Recovery Services	3	3	0
Wake	A Small Miracle	2	2	0
	Carolina Outreach	1	1	0
	Coastal Horizons Center, Inc.	3	3	0
	Community Partnerships, Inc.	1	1	0
	Easterseals UCP	1	1	0
	FHR, INC	3	3	0
	Hope Services	1	1	0
	UNC Wake STEP Clinic	2	2	0
	Universal Mental Health Services, Inc.	2	2	0
	Youth Extensions, Inc.	1	1	0
Warren	Pinnacle Family Services	1	1	0
	Strategic Interventions, Inc.	2	2	0
Watauga	Daymark Recovery Services	2	2	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Wayne	ClientFirst Behavioral Health	1	1	0
	Coastal Horizons Center, Inc.	1	1	0
Wilkes	Daymark Recovery Services, Inc.	4	4	0
Wilson	Carolina Outreach	2	2	0
Yancey	RHA Health Services	1	1	0
Total	114 Facilities Reporting	**160**	**160**	**0**

NOTES:

1. The number of these facilities is unknown as they are not licensed or state-operated.
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. If the cause of death is not known, providers indicate unknown as cause of death. Since the timeframe for this report is July 2016-June 2017, providers have not received copies of death certificate or medical examiner's reports for some of reports submitted during this time period.
3. This is not an unduplicated count of number of deaths by suicide, accident, homicide or violence . Each agency providing a service to an individual is required to enter a report based upon the information that the provider has learned.
4. 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.
5. 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 145 beds as of June 30, 2017.
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[2]
	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 1,124 beds as of June 30, 2017.
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]
Buncombe	Black Mountain	1	1	0
Wilson	Longleaf	1	0	0
Total	2 Facilities Reporting	**2**	**1**	**0**

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 575 beds as of June 30, 2017, which includes 123 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	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 892 beds as of June 30, 2017.
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, 2017.
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, 2016 and ending June 30, 2017. 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 3,862 licensure surveys, 1,423 follow-up visits, and 1,588 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
Davidson	Grayson Creek of Welcome	1
Lee	Parkview Retirement Center	1
New Hanover	Cedar Cove Assisted Living	1
Robeson	Morningstar AL #3	1
Total	4 Facilities Cited	**4**

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, Inc.	1
Avery	Grandfather Home for Children - Campbell Cottage	1
Brunswick	A Helping Hand of Wilmington	1
	Alexander Youth Network-Bolivia Day Treatment	1
	Coastal Horizons Center, Inc.	1
	South Brunswick Counseling Service	2
Buncombe	Behavioral Health Group Asheville Treatment Center	1
	Montford Hall	1
	Mountain Health Solutions - Asheville	2
	STARS Program	1
	Western Carolina Treatment Center	1
Cabarrus	Ashlynn Group Home	1

County	Facility	# Citations
Catawba	Hope Valley, Inc. Residential Services	1
Cleveland	New hope Group Home II	1
Columbus	Davis Avenue Group Home	1
	Rouse Counseling & Consulting Services	1
Craven	Hill Therapeutic Home	1
Cumberland	Carol's DDA Group Home	2
	Extended Reach Day Treatment	2
	Graceland Manor DDA #3	2
	Mother's Love Group Home	2
	Sunrise Residential Care	4
Davidson	Ambleside Adult Day Program	1
Durham	Adventure House	1
	Recovery Connections I	1
	Rose's Castle Residential Services, Inc.	2
Edgecombe	Kyseem's Unity Group Home #2	2
	Kyseem's Unity Group Home, LLC	2
Forsyth	Garvin Mental Management	1
	Group Homes of Forsyth, Inc. Brandywine Road	1
	Group Homes of Forsyth, Inc. Ebert Street Home	1
	Independent Living at Ransom Road	1
	Independent Living Group Home at Old Salisbury Road	1
	NOA Human Services #2	2
Gaston	A Child's Journey	2
	Buckingham	1
	Dorothy's Place	1
	Elizabeth Group Home	1
	Gastonia Treatment Center	2
	McLeod Addictive Disease Center - Gastonia	1
	Patriots	1
	Plyler Lake	1
	Postelle Home	1
	The Flynn Fellowship Home of Gastonia, Inc.	1
Guilford	A Brighter Day Group Home	1
	Successful Transitions LLC Residential Home Level III	2
	Youth Spring Residential Treatment	2
Harnett	Sierra's Residential Services, Inc.	2
Haywood	BHG Clyde Treatment Center	1
Henderson	Azalea Way	1
	Topic Home	1
Hoke	Grace House	1
	Jackson Springs Treatment Facility	1
	Serenity Therapeutic Services #7	1
Hyde	Mattamuskeet Opportunities Hyde ADAP	1
Johnston	Carolina Support Services Day Treatment	1
	Passionate Care Home #1	1
Lenoir	Larkspur House	2
	Oakwood Facility	1

County	Facility	# Citations
McDowell	Ruthie's Place	1
Mecklenburg	ACE Program	1
	Alphin Cottage	1
	Anuvia Prevention & Recovery	1
	Inner Vision	2
	Lifespan Linda Lake	2
	Linda Lake	1
	McLeod Addictive Disease Center - 3rd Floor	1
	New Place	1
	The Workshop	1
	Water Mill Home	1
Moore	Carolina Treatment Center	1
	Carolina Treatment Center of Pinehurst	1
Nash	South Rocky Mount Home	1
	T.Y.L Thank You Lord	1
New Hanover	Cape Fear Group Home Day Program	2
	Knox Counseling Services, Inc. dba Harvest of Wilmington	1
	New Hanover Treatment Center	1
	SCI Day Program	2
Pender	A Special Touch	1
Polk	Peniel #1	1
	Peniel #2	1
Randolph	E's House	2
Richmond	Samaritan Colony	1
Robeson	Lumberton Health Center Outpatient Services	1
	Nu-Image	1
Rowan	Gold Hill Drive	2
	Richard Street	2
Stanly	Loretta's Place	1
Surry	Hope Valley - Men's Division	1
	Hope Valley - Women's Division	1
	Peace Lily #1	1
	Peace Lily #2	2
Transylvania	Trails Carolina	1
Union	Agape Windsor	1
	McLeod Addictive Disease Center - Union	1
	Monroe Crisis Recovery Center	1
Wake	Absolute Home #4	1
	Absolute Home and Community Services 3	1
	Ann's Haven of Rest II	1
	Best Home Care Services	1
	Brost Court	1

County	Facility	# Citations
	Glen Forest Home	2
	New Beginnings Health Care	1
	New Beginnings Health Care Phase III	1
	Novella's Place, Inc.	1
	RHD Ranch Mill Circle	1
	Rose Home	2
	Russmed III	1
	Serenity Place	1
	SLHC Residential Program for Women and Children	1
	Southlight Healthcare-Garner Road	1
Warren	P.H.P. of N.C. Inc.	1
Watauga	Stepping Stones Wellness Center	1
Wayne	Belfast Group Home	4
	Daez of New Vision, Inc.	2
Wilkes	Foundation Strong Phase II	1
Wilson	Wilson Professional Services Treatment Center	1
Total	120 Facilities Cited	**155**

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
Cleveland	CH Cleveland	1
Columbus	Columbus County	2
Davidson	NV Thomasville	1
Guilford	High Point	1
Jackson	Harris Regional	2
Lenoir	Lenoir Memorial	4
Mecklenburg	Carolinas Medical Center Main	1
	CCC Pineville	2
	SBH Charlotte	1
	NV Presbyterian	1
Onslow	Byrnn Marr Hospital	2
Wake	SBH Garner	4
Total	12 Facilities Cited	**22**

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**