North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

October 1, 2013

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601-2808

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Attached is the *Legislative Report on Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraints and Seclusion.* This report is due annually on the first day of October to the Joint Legislative Oversight Committee on Health and Human Services as required by G.S. 122C-5. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

This report contains the number of deaths reported by each facility and the level of compliance of certain facilities with applicable state and federal laws, rules and regulations regarding the use of restraints and seclusion. During SFY12-13, none of the deaths reported was found to be related to the use of physical restraint, physical hold, or seclusion.

If you have questions or if further information is needed regarding the content of this report, please contact Dave Richard, Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Mr. Richard can be reached at (919) 733-7011.

Sincerely,

Aldona Wos, M.D.
Secretary

AW:mth

Attachment

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Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

on

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

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

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

October 2013

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

October 1, 2013

EXECUTIVE SUMMARY

State law requires the Department of Health and Human Services (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) 2012-2013, which covers the period July 1, 2012 through June 30, 2013.

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. Table A, on page 5, provides a summary of the number of deaths reported, screened and investigated further pursuant to statute, and the number found to be related to the use of physical restraint, physical hold, or seclusion.

A total of 243 deaths were reported: 74 reported by private licensed facilities, 162 reported by private unlicensed facilities, and 7 reported by state-operated facilities. Of the 243 deaths reported, all were screened, 237 (98%) 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 staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. A total of 3,222 licensure surveys, 1,490 follow-up visits, and 1,110 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, on page 7, provides a summary of the number of citations issued to private licensed, private unlicensed, and state-operated facilities and examples of the most frequent and least frequent citations issued to each type of facility.

A total of 194 facilities -- 194 private licensed facilities were issued a total of 280 citations for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. No private unlicensed facility or state operated facility was issued any citations during this period. Citations covered a wide range of deficiencies from inadequate documentation and training to improper or inappropriate use of physical restraints. The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (113 or 40%) and "training in seclusion, physical restraint and isolation time-out" (62 or 22%). These citations accounted for 62% of the total issued.

INTRODUCTION

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

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

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

The private licensed facilities include:

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

The private unlicensed facilities include:

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

The state-operated facilities include:

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

This report covers **SFY 2012-2013**, the period **July 1, 2012 through June 30, 2013**. 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 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 session, 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 Code 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 2012-2013

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	40,472	31	33	33	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,645	10,585	26	38	34	0
A-3	Community ICFs/IID	336	2,769	2	2	2	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	55	2,121	1	1	1	0
	Subtotal	5,283	55,947	60	74	70	0
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			121	162	162	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	240	0	0	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,280	1	1	1	0
A-8	Neuro-Medical Treatment Centers	3	NF= 483	2	2	2	0
			ICF= 174	1	1	1	0
A-9	Psychiatric Hospitals	3	873	3	3	1	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	3,092	6[6]	7	5	0
	Grand Total	5,297	59,039	187	243	237	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, 2013).
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 187 facilities -- 60 private licensed facilities, 121 private unlicensed facilities, and 6 state-operated facilities -- reported a total of 243 deaths that were subject to statutory reporting requirements.
- Of the total 243 deaths reported, 74 deaths were reported by private licensed facilities, 162 deaths were reported by private unlicensed facilities, and 7 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 237 deaths (98%) 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 staff for licensure surveys, follow-up visits, and complaint and death investigations during the state fiscal year beginning July 1, 2012 and ending June 30, 2013. The data summarized in this section is limited to those facilities that received an on-site visit by DHHS 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 2012-2013[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	19	20	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted) (17 citations) • Failure to obtain a physician's order for the use of restraints (2 citations)	• Inadequate assessment and care planning for the use of a restraint (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	174	259	• Training on alternatives to restrictive interventions (113 citations) • Training in seclusion, physical restraint and isolation time-out (62 citations) • Least restrictive alternative	• Prohibited Policies (1 citation) • Protective Devices (1 citation) • General Policies (1 citation)

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				(23 citations) • Seclusion, physical restraint and isolation time-out (21 citations)	
B-3	Community ICFs/IID	1	1	• Use of restraints not included in the Individual Program Plan (1 citation)	
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	0	0	• No citations were issued	• No citations were issued
	Subtotal	194	280		
	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	**194**	**280**		

NOTES:

1. The data is limited to those facilities that received an on-site visit by DHHS staff. DHHS staff conducted a total of 3,222 licensure surveys, 1,490 follow-up visits, and 1,110 complaint investigations during the year.

Summary Of Findings Related To Compliance With Laws, Rules, And Regulations

As Table B shows:

- A total of 194 facilities -- 194 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 or state operated facility was issued any citations during this period.
- The data is limited to those facilities that warranted an on-site visit by DHHS staff. A total of 3,221 initial, renewal and change-of-ownership licensure surveys, 1,490 follow-up visits, and 1,110 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 280 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 194 citations. No private unlicensed facilities 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" (113 or 40%) and "training in seclusion, physical restraint and isolation time-out" (62 or 22%). These citations accounted for 62% 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, 2012 and ending June 30, 2013 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 were 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	Alvarado's Family Care	1	1	0
Beaufort	Clara Manor	1	1	0
Bertie	United Services Health	1	1	0
Buncombe	Asheville Manor	1	1	0
	Avalon Hills	1	1	0
	Clare Bridge of Asheville	1	1	0
	Evergreen	1	1	0
Davidson	Mallard Ridge Assisted Living	1	1	0
Duplin	Wallace Gardens	1	1	0
Durham	Eno Pointe Assisted Living	1	1	0
Forsyth	Cornerstone Living Center of Winston-Salem	1	1	0
Gaston	Morningside of Gastonia	1	1	0
Guilford	Clare Bridge at High Point Place	1	1	0
	Greensboro Place on Lawndale	1	1	0
	Morningview in Greensboro	1	1	0
	Spring Arbor of Greensboro	1	1	0
Johnston	Autumn Wind Assisted Living	1	1	0
Macon	Grandview Manor Care Center	1	1	0
McDowell	Cedarbrook Residential Center	1	1	0
Mecklenburg	Carriage Club of Charlotte	1	1	0
	Legacy Heights Senior Living Community	1	1	0
	Regency Retirement Village	1	1	0
	Summitt Place of Southpark	1	1	0
Moore	Tara Plantation of Carthage	1	1	0
Rowan	Kannon Creek Assisted Living	1	1	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Transylvania	Kingsbridge House	1	1	0
Union	Hillcrest Church Rest Home	1	1	0
Wake	Elmcroft of North Ridge	1	1	0
	HeartFields at Cary	1	1	0
	Sunrise Assisted Living at North Hills	2	2	0
Yancey	Yancey House	2	2	0
Total	31 Facilities Reporting	**33**	**33**	**0**

NOTES:

1. There were 1,247 Licensed Adult Care Homes with a total of 40,472 beds as of June 30, 2013.
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]
Brunswick	Coastal Horizons Center	1	0	0
Buncombe	Crossroads Treatment Center of Asheville	1	1	0
	Mountain Area Recovery Center	1	1	0
Cabarrus	McLeod Addictive Disease Center - Concord	2	2	0
Catawba	McLeod Addictive Disease Center - Hickory	2	2	0
Craven	Port Human Services New Bern	1	1	0
Cumberland	Alternative Care Substance Abuse Services	1	0	0
	Carolina Treatment Center of Fayetteville	1	1	0
Durham	Inez's House	1	1	0
	BAART Community Healthcare	1	1	0
	Durham Treatment Center	3	3	0
Forsyth	Insight Human Services - Forsyth	1	1	0
Gaston	McLeod Addictive Disease Center	2	2	0
Guilford	Crossroads Treatment Center of Greensboro	6	6	0
Iredell	ARMS	1	1	0
	McLeod Addictive Disease Center	1	1	0
Johnston	Barbara's Whitley Group Home	1	0	0
Lee	Advance Behavioral Center, Inc.	1	0	0
Mecklenburg	Mecklenburg County Substance Abuse Services	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	McLeod Addictive Disease Center	1	1	0
New Hanover	Coastal Horizons Center	1	1	0
Pitt	Port Human Services - Paladin	2	2	0
	Greenville Recovery Center, LLC (GRC)	1	1	0
Union	McLeod Addictive Disease Center - Union	1	1	0
Wake	Meeks Group Home 1	2	2	0
Watauga	McLeod Addictive Disease Center - Watauga	1	1	0
Total	26 Facilities Reporting	**38**	**34**	**0**

NOTES:

1. There were 3,645 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,585 beds as of June 30, 2013.
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]
Guilford	RHA Howell Child Care Center - Gatewood	1	1	0
Scotland	Lee Forest Group Home	1	1	0
Total	2 Facilities Reporting	**2**	**2**	**0**

NOTES:

1. There were 336 Private ICFs/IID with a total of 2,769 beds as of June 30, 2013.
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]
Moore	FirstHealth Moore Regional Hospital	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 9 Private Psychiatric Hospitals, 44 Hospitals with Acute Care Psychiatric Units, and 2 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,121 beds as of June 30, 2013.
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 North Carolina and Virginia	1	1	0
	Psychotherapeutic Services Inc.	1	1	0
Alexander	RHA Health Services	1	1	0
Anson	DAYMARK Recovery Services Inc. Anson Center	2	2	0
	Partnership for Drug Free NC	1	1	0
Brunswick	NC Solutions	1	1	0
Buncombe	Family Preservation Services of NC, Inc.	1	1	0
	Heading in the Right Direction	2	2	0
	HOPE Advancement	1	1	0
	National Mentor Healthcare LLC dba NC MENTOR	1	1	0
	October Road Inc.	3	3	0
	Parkway Behavioral Health	1	1	0
	Ray of Light Homes, LLC	1	1	0
	Partnership for a Drug-Free NC, Inc.	1	1	0
	RHA Health Services	1	1	0
	The Arc of North Carolina	1	1	0
Cabarrus	Daymark Recovery Services, Inc.	1	1	0
	Partnership for Drug Free NC	1	1	0
	RHA Behavioral Health	1	1	0
Caldwell	RHA Behavioral Health	1	1	0
Catawba	Family NET of Catawba County	1	1	0
Chatham	Center for Behavioral Healthcare, PA	1	1	0
Columbus	Allied Behavioral Management	2	2	0
	AssistedCare, Inc.	1	1	0
Craven	Coastal Horizons Center, Inc.	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	PORT Human Services	2	2	0
Cumberland	Alternative Care Treatment Systems, Inc.	1	1	0
	Evergreen Behavioral Management, Inc.	2	2	0
	Johari Family Services, LLC	1	1	0
	Restart Behavioral Health	1	1	0
Dare	PORT Human Services	1	1	0
Davidson	Monarch	1	1	0
	Daymark Recovery Services Davidson Center	1	1	0
	Partnership for a Drug Free North Carolina	1	1	0
Davie	Triumph, LLC	1	1	0
Durham	Carolina Outreach	2	2	0
	ROJ Mental Health & Substance Abuse Services	2	2	0
	Telecare Mental Health Services of North Carolina	2	2	0
	Turning Point Family CARE	1	1	0
	Coastal Horizons Center, Inc.	1	1	0
Forsyth	Daymark Recovery Services	5	5	0
	Partnership for a Drug Free North Carolina	2	2	0
	Triumph, LLC	1	1	0
Gaston	BranMarc Inc. Family Services	1	1	0
	Phoenix Counseling Center	1	1	0
Guilford	Envisions of Life, LLC	1	1	0
	Alberta Professional Services, Inc.	1	1	0
	Monarch	4	4	0
	Lindley Habilitation Services	1	1	0
	Psychotherapeutic Services, Inc.	1	1	0
	RHA Behavioral Health	1	1	0
Harnett	Daymark Recovery Services, Inc.	1	1	0
	Sierra's Residential Services, Inc.	1	1	0
Haywood	Meridian Behavioral Health	1	1	0
	Jackson County Psychological Services	1	1	0
Iredell	Daymark Recovery Services	1	1	0
Jackson	Jackson County Psychological Services	1	1	0
Johnston	Johnston County Mental Health	3	3	0
Lee	Advance Behavioral Center, Inc.	1	1	0
	Daymark Recovery Services, Inc.	2	2	0
Lenoir	Dixon Social Interactive Services	1	1	0
	PORT Human Service	2	2	0
Macon	Appalachian Community Services	1	1	0
McDowell	National Mentor Healthcare LLC dba NC MENTOR	1	1	0
Mecklenburg	Alexander Youth Network	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Lawson Support Services	1	1	0
	Mecklenburg County Provided Services Organization	2	2	0
	National Mentor Healthcare, LLC, dba NC Mentor	1	1	0
	McLeod Addictive Disease Center, Inc.	2	2	0
	SUNPATH, LLC	1	1	0
Mitchell	RHA Health Services	1	1	0
Montgomery	National Mentor Healthcare LLC dba NC Mentor	1	1	0
Moore	Daymark Recovery Services, Inc.	1	1	0
New Hanover	A Helping Hand of Wilmington, LLC	3	3	0
	Evergreen Behavioral Management	1	1	0
	NC Solutions	1	1	0
	Physician Alliance for Mental Health	1	1	0
	RHA Health Services, Inc.	3	3	0
Northampton	Integrated Family Services, PLLC	1	1	0
Onslow	Le'Chris Health Systems, Inc. of Jacksonville	1	1	0
Orange	Freedom House Recovery Center	1	1	0
Pasquotank	PORT Human Services	2	2	0
Pender	Coastal Horizons Center Inc.	1	1	0
Person	Freedom House Recovery Center	1	1	0
Pitt	Integrated Family Services, PLLC	1	1	0
	PORT Human Services	1	1	0
Polk	Partnership for a Drug-Free NC Inc.	1	1	0
Randolph	Daymark Recovery Services, Inc.	2	2	0
Robeson	Evergreen Behavioral Management, INC	1	1	0
	Positive Progress Services	1	1	0
	Primary Health Choice	1	1	0
Rockingham	Easter Seals UCP North Carolina and Virginia, Inc.	1	1	0
	Youth Haven Services, Inc.	1	1	0
Rowan	Monarch	1	1	0
Rutherford	Parkway Behavioral Health	2	2	0
	Universal Mental Health Services, Inc.	1	1	0
Sampson	Coastal Horizons Center, Inc.	1	1	0
Stanly	Daymark Recovery Services	2	2	0
Stokes	Triumph, LLC	1	1	0
Surry	Easter Seals UCP NC VA Inc.	1	1	0
	PQA Healthcare, Inc.	1	1	0
	Daymark Recovery Services - Surry Center	1	1	0
Swain	Meridian Behavioral Health	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Services			
Union	Daymark Recovery Services	1	1	0
	Turning Point Services, Inc.	1	1	0
	Monarch	1	1	0
Vance	Daymark Recovery Services	4	4	0
	Holly Hill Mobile Crisis Team	2	2	0
	The HOPE Centre for Advancement, LLC	1	1	0
Wake	Cottage Health Care Services Inc.	1	1	0
	Wake Behavioral Health	2	2	0
	Wake MH/DD/SA	1	1	0
	Wellness Supports	1	1	0
Wayne	Coastal Horizons Center Inc.	1	1	0
	Waynesboro Family Clinic, P.A.	2	2	0
Wilkes	Daymark Recovery Services	2	2	0
Wilson	Bridges of Hope Inc.	1	1	0
	Coastal Horizons Center Inc.	1	1	0
Yadkin	Daymark Recovery Services	2	2	0
	The Arc of NC	1	1	0
Yancey	RHA Health Services	2	2	0
Total	121 Facilities Reporting	**162**	**162**	**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 investigated by the responsible Local Management Entity (LME) providing oversight, and the findings are discussed with the Division of MH/DD/SAS. If problems are identified, the LME requires the facility to develop a plan for correcting these problems then monitors the implementation of the plan.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)[1]

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

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 240 beds as of June 30, 2013.
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]
Granville	Murdoch	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 3 State-Operated ICFs/IID with a total of 1,280 beds as of June 30, 2013.
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[3]
Buncombe	Black Mountain	1	1	0
Wayne[2]	O'Berry (NF)	1	1	0
Wayne[2]	O'Berry (ICF)	1	1	0
Total	2 Facilities Reporting	**3**	**3**	**0**

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 657 beds as of June 30, 2013 which includes 174 ICFs/IID beds at O'Berry Facility.
2. The data for O'Berry Facility is separated to indicate deaths in the ICF and the Neuro-Medical Treatment Center as the O'Berry Facility serves both populations.
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-9: State Psychiatric Hospitals[1]

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

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 873 beds as of June 30, 2013.
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, 2013.
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, 2012 and ending June 30, 2013. 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 staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits and complaint investigations. The data summarized in this section is limited to those facilities that received an on-site visit by DHHS staff. A total of 3,221 licensure surveys, 1,490 follow-up visits, and 1,110 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	2
Burke	Morganton Long Term Care - Southview Facility	1
Cumberland	Cumberland Village Assisted Living	1
Forsyth	Kindred Hearts Adult Care Home	1
	Forest Heights Senior Living Community	1
Franklin	Autumn Wind Assisted Living of Louisburg	1
Granville	Granville House	1
Jones	Magnolia Cottage Care BLG #3	1
Moore	Tara Plantation of Carthage	1
New Hanover	Cedar Cove Assisted Living	1
Northampton	Rich Square Manor	1
Orange	Livewell Assisted Living	1
Robeson	Lumberton Assisted Living	1
Scotland	Willow Place	1
Transylvania	Tore's Home #3	1
Union	Monroe Manor Assisted Living Building I	1
Wake	Lee's Long Term Care Facility	1
Wayne	Sutton's Retirement Center	1
Wilson	Wilson Assisted Living	1
Total	19 Facilities Cited	**20**

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

County	Facility	# Citations
Alamance	A Solid Foundation	2
	Alamance House	1
	Angelic Heartz Care Facility	1
	AT&B Residential Adult Group Services	1

County	Facility	# Citations
	Ceesons of Change	2
	Dee & G Enrichment Center #3	1
	Dee & G Enrichment Center #2	1
	Enoch Group Home	2
	Green Valley Haven	1
	Hall Avenue Facility	1
	L&J Home	1
	New Beginning Group Home	1
	Righteous Path	1
	Wildwood Lane Group Home	1
	Youth Builders, LLC	4
Alexander	Grandfather Home for Children	1
Beaufort	Beaufort County Group Home #1	1
	Beaufort County Group Home #2	1
	Wooded Acres #1	2
	Wooded Acres #3	1
	Wooded Acres #4	1
	Wooded Acres Guest Home #5	1
Brunswick	Benya AFL	1
Buncombe	Ellenwood	1
	Women and Children First	1
Burke	Hand in Hand Burke County Day Treatment	1
	Northwood Group Home	1
	Regal Pointe	1
	SCI Enola	1
Cabarrus	Rose of Sharon	3
Catawba	Luca's Hope	1
Chatham	Carolina House	2
	Griffin House	1
	Perkins	1
Cherokee	Pleasant Hill	1
	Pleasant Valley	1
Cleveland	Caring Way 114	1
	Caring Way 118	1
	Cleveland Crisis & Recovery	1
Cumberland	Genesis: A New Beginning	1
	Graceland Manor DDA #1	1
	Graceland Manor DDA #3	1
	Segura Home	3
	Stepping Stones Group Home #2	2
	Stepping Stones Group Home #8	2
	Willowbrook Treatment Center	2
Duplin	Atkinson Care Home #4	1
Durham	Adventure House	2
	BAART Community Services .	3
	Durham Men's Halfway House	1
	Great Bend Group Home	1
	Melody House	1
	Peaceful House	1
	The Durham family Group Home - Wilkerson	2
Edgecombe	Blazing Women of God Adult Group Home	1

County	Facility	# Citations
	Someone Does Care	1
Forsyth	A Sure House, Inc.	2
	Faithful Companion	1
	Garvin's Mental Management	2
	Life's New Beginnings	1
	The Fellowship Home	1
Gaston	McLeod Addiction Center	1
	Plyler Lake	1
	The Flynn Fellowship House of Gastonia	1
	The Phoenix Counseling Center	1
Greene	Ambleside	4
	Barbara's Love and Care #5	2
	Carrie's Loving Hands	1
	Hamilton	2
Guilford	A Brighter Tomorrow Group Home	1
	A New Progression	1
	A Place of Their Own	2
	Agape Homes, Inc.	3
	Blackwell House	2
	Brushwood home	1
	Carter Group Home	1
	Chavis Manor, LLC	1
	Chisholm Homes I	1
	Chisholm Homes II	1
	Chisholm Homes III	1
	Classic Care Family Services	1
	Garden Lakes	1
	Hazel's House at Fellowship Hall	1
	Lizzy's Family Care and Services, Inc.	1
	Mercy Home Services, Inc.	2
	Milton's Manor	2
	Positive Connections Care DD Home	2
	Youth Focus Residential Treatment	2
	Zander's Place at Fellowship Hall	1
Harnett	Duncan Residential	2
	Sierra Residential Services	1
Haywood	Dogwood Acres	1
Henderson	Hillpark Group Home	1
Hertford	Port Human Services	1
Hoke	Forever Young Secured Community	1
	M&T Enhancement Residential Care	1
	Your New Beginning	2
Iredell	Barium Springs Home for Children - Nelson Home	1
Iredell	Scott's Creek	3
	Stickney House	1
Jackson	Pointer Road Home	1
Johnston	The Lighthouse	1
	The Lighthouse of Clayton II	1
	Trinity Independent Home Care	2
	Ultimate Family Care	1
Lenoir	Advance Behavioral Health Center	1

County	Facility	# Citations
	Barbara's Love and Care Home	1
	Barbara's Love and Care Home #4	1
	Kristi's Home Inc.	2
	Maplewood	17
	Pinewood Facility	2
Martin	McLawhorne Home	1
McDowell	SUWS of Carolinas, Inc.	2
Mecklenburg	Alexander Youth Network	1
	Alexander Youth Network - Nisbet Unit	1
	LIMS	1
	Lone Tree AFL	1
	Mr. Bill's Place	1
	The Keys of Carolina	1
	Thompson Child and Family Focus - Christ Church Cottage	3
	Thompson Child and Family Focus - Kenan Cottage	3
	Thompson Child and Family Focus - Merancas Cottage	3
	Thompson Child and Family Focus - Peace Cottage	3
	Thompson Child and Family Focus - Yorke Cottage	3
	Thompson Child and Family Focus- Alpin Cottage	3
	Thompson Child and Family Focus - Williamson Cottage	3
Moore	Jackson Springs Treatment Center	1
	The Bethany House	1
Nash	BTW Home Care Services II	2
	BTW Home Care Services III	1
New Hanover	Port Human Services - Stepping Stone Manor	1
	Yahweh's Children Center PRTF	1
Northampton	Family Advantage LLC	1
	Residential Loving Care	2
Onslow	FACT Day Treatment	1
	Simon's Home	1
Orange	Maggie Alvis Women's Halfway House	1
Pasquotank	Christian Medical Center	1
	River City Achievement Center	1
Pitt	Emmanuel Residential Facility	1
	Evans Home	2
	Mitchell and Crandell	1
Randolph	Hopes Care Home	1
Robeson	Hope House	1
	New Haven Treatment Center	1
	Tanglewood Arbor	2
Rockingham	Empowered Girls	1
Rowan	Rowan Treatment Associates	2
Rutherford	Joyful Too	1
Sampson	Harvest House	1
Union	Friendship Home	1

County	Facility	# Citations
Vance	Divine Prodigy	2
Wake	A+ Residential Care	2
	Absolute Care Services	1
	Avalon #3	1
	Brooklyn's House	1
	E.W. Stone Adult Care Center	1
	Eagle Home #1	1
	Eagle Home #5	1
	Eagle Home 1	1
	Learning Services River Ridge	1
	Meeks Group Home 1	2
	New Beginnings Health Care Phase III	1
	Novella's Place	1
	Omega Independent Living Site III	1
	Residential Loving Care	2
	United Family Network at Fuquay- Varina	1
	United Family Network at Willow Springs	1
Warren	The Davis Home	1
Wayne	Country Pines #1	1
	Daez of New Vision	4
	Graham New Horizon #1	2
	Main Street House	1
Wilson	Virginia Dare Home	1
Total	174 Facilities Cited	**259**

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

County	Facility	# Citations
Halifax	Life, Inc.- Lakeview	1
Total	1 Facility Cited	**1**

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

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

Table B-5: Private Unlicensed Facilities:

County	Facility	# Citations
	No citations were issued	
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**