North Carolina Department of Health and Human Services

Pat McCrory
Governor

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

Adam Sholar
Legislative Counsel
Director of Government Affairs

September 24, 2014

SENT VIA ELECTRONIC MAIL

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

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

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, 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 North Carolina General Statute 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.

Please contact Courtney Cantrell, Ph.D., Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should you have any questions regarding this report. Dr. Cantrell can be reached at (919) 733-7011.

Sincerely,

Adam Sholar

cc:

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Jim Slate	Patricia Porter
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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

September 2014

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

October 1, 2014

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) 2013-2014, which covers the period July 1, 2013 through June 30, 2014.

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

In North Carolina, deaths are reported to DHHS by private facilities that have licensing requirements (private licensed), private facilities that do not have licensing requirements (private unlicensed), and state-operated facilities. The reporting requirements differ by type of facility. The data reported here include deaths meeting the following criteria: (a) occurred within seven days after the use of physical restraint, physical hold, or seclusion; or (b) resulted from violence, accident, suicide, or homicide.

A total of 249 deaths were reported: 96 by private licensed facilities, 148 by private unlicensed facilities, and 5 by state-operated facilities. Of the 249 deaths reported, all were screened, 205 (82%) were investigated, and one was 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 2,781 licensure surveys, 1,314 follow-up visits, and 2,286 complaint investigations were conducted during the year.

A total of 155 facilities -- 155 private licensed facilities were issued a total of 238 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" (82 or 34%) and "training in seclusion, physical restraint and isolation time-out" (69 or 29%). These citations accounted for 63% 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 2013-2014**, the period **July 1, 2013 through June 30, 2014**. 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 Code Sections 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 Section 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 2013-2014

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	1,236	40,690	32	36	26	1
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,520	10,499	40	57	27	0
A-3	Community ICFs/IID	336	2,769	3	3	1	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	56	2,171	0	0	0	0
	Subtotal	5,148	56,129	75	96	54	1
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			101	148	148	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	196	2	2	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,249	0	0	0	0
A-8	Neuro-Medical Treatment Centers	3	NF= 479	2	2	2	0
			ICF= 136	1	1	1	0
A-9	Psychiatric Hospitals	3	892	0	0	0	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	2,994	4[6]	5	3	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	5,162	59,123	180	249	205	1

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, 2014).
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.

   In the case of the death reported in this column, a resident with Spring Arbor of the Outer Banks was found in the resident's room with her head caught between the hospital bed and half bed railing. Investigation resulted in the facility being cited with one Type A1 violation. The Type A1 violation was for failure to assure the use of less restrictive methods of restraint, obtain current physician's orders for a hospital bed with bed rails, and no assessment for the use of bedrails as a restraint. The facility was required to immediately provide and implement a Plan of Protection to safeguard all residents and prevent further incidents. The incident occurred at the beginning of January 2014. After receipt of the formal investigation report, the facility submitted (in mid-March) a plan of correction. To evaluate the effectiveness of the corrective action, an follow-up inspection took place in mid-April. The Type A1 violation was abated.

   Adult Care Homes: 131D-34

   (1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

   a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

   a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect residents from further risk or additional harm.

   b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities licensed for six or fewer beds. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities licensed for seven or more beds. Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

Mental Health licensed Facilities 122C-24.1(a)(1)

(1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect clients from further risk or additional harm.

b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on a written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities or programs that serve six or fewer persons. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities or programs that serve seven or more persons. Where a facility has failed to correct a Type A1 Violation, the Department shall access the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction. The Department or its authorized representative shall determine whether the violation has been corrected.

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 180 facilities -- 75 private licensed facilities, 101 private unlicensed facilities, and 4 state-operated facilities -- reported a total of 249 deaths that were subject to statutory reporting requirements.
- Of the total 249 deaths reported, 96 deaths were reported by private licensed facilities, 148 deaths were reported by private unlicensed facilities, and 5 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 249 deaths (82%) were investigated.
- There was **one** death 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, 2013 and ending June 30, 2014. 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 2013-2014[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	8	9	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted (7 citations)	• Inadequate assessment and care planning for the use of a restraint (2 citations)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	137	204	• Training on alternatives to restrictive interventions (82 citations) • Training in seclusion, physical restraint and isolation time-out (69 citations) • General Policies (28 citations)	• Least Restrictive Alternatives (13 citations) • Seclusion, physical restraint and isolation time-out (11 citations)

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-3	Community ICFs/IID	0	0	• No citations were issued	• No citations were issued
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	10	25	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted (7 citations)	• Training in seclusion, physical restraint and isolation time-out (2 citations) • Training on alternatives to restrictive interventions (2 citations) • Least Restrictive Alternatives (1 citation)
	Subtotal	155	238		
	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	**155**	**238**		

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 2,781 licensure surveys, 1,314 follow-up visits, and 2,286 complaint investigations during the year.

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

As Table B shows:

- A total of 155 facilities -- 155 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.
- 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 2,781 initial, renewal and change-of-ownership licensure surveys, 1,314 follow-up visits, and 2,286 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 238 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 155 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" (82 or 34%) and "training in seclusion, physical restraint and isolation time-out" (69 or 29%). These citations accounted for 63% 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, 2013 and ending June 30, 2014 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, **one** 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	Lane Street Retirement Home	1	1	0
Bladen	A & C Family Care	1	0	0
Buncombe	Angel House I	1	1	0
Catawba	Austin Adult Care	1	1	0
Cleveland	Shelby Manor	1	1	0
Cumberland	Cumberland Village Assisted Living	2	2	0
Currituck	Currituck House	1	1	0
Dare	Spring Arbor of the Outer Banks	1	1	1
Davidson	Brookstone Retirement Center	1	1	0
Duplin	Dayspring of Wallace	1	1	0
Durham	Croasdaile Village	1	1	0
	Elsie-Doris Family Care Home	1	1	0
Edgecombe	Exceeding Limitations	1	0	0
Forsyth	Kerner Ridge Assisted Living	1	1	0
Gaston	Country Time Inn	2	1	0
Guilford	Westchester Harbour	2	2	0
Harnett	Johnson Better Care	1	0	0
	Pinecrest Gardens	1	1	0
Hertford	Ahoskie House	1	1	0
Iredell	The Gardens of Statesville	1	1	0
Madison	Hot Springs Family Care Home #1	1	0	0
McDowell	Cedarbrook Residential Center	1	1	0
Mecklenburg	The Laurels in the Village at Carolina Place	1	1	0
	Hunter Village	1	1	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	The Parc at Sharon Amity	1	0	0
	Emeritus at Eastover	1	0	0
New Hanover	Hermitage House	1	1	0
	The Commons at Brightmore	1	0	0
Robeson	Lumberton Assisted Living	2	2	0
Rowan	Deal Care Inn	1	0	0
Wayne	Waylin Life Care Center	1	1	0
Yancey	Yancey House	1	0	0
Total	32 Facilities Reporting	**36**	**26**	**1**

NOTES:

1. There were 1,236 Licensed Adult Care Homes with a total of 40,690 beds as of June 30, 2014.
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.

   In the case of the death reported in this column, a resident with Spring Arbor of the Outer Banks was found in the resident's room with her head caught between the hospital bed and half bed railing.

   Investigation resulted in the facility being cited with one Type A1 violation. The Type A1 violation was for failure to assure the use of less restrictive methods of restraint, obtain current physician's orders for a hospital bed with bed rails, and no assessment for the use of bedrails as a restraint.

   The facility was required to immediately provide and implement a Plan of Protection to safeguard all residents and prevent further incidents. The incident occurred at the beginning of January 2014. After receipt of the formal investigation report, the facility submitted (in mid-March) a plan of correction. To evaluate the effectiveness of the corrective action, an follow-up inspection took place in mid-April. The Type A1 violation was abated.

   Adult Care Homes: 131D-34

   (1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

   a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

   a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect residents from further risk or additional harm.

   b. Within 15 working days of the investigation, send a report of the findings to the facility.

   c. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

   The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities licensed for six or fewer beds. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities licensed for seven or more beds. Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

Mental Health licensed Facilities 122C-24.1(a)(1)

(1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect clients from further risk or additional harm.

b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on a written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities or programs that serve six or fewer persons. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities or programs that serve seven or more persons. Where a facility has failed to correct a Type A1 Violation, the Department shall access the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction. The Department or its authorized representative shall determine whether the violation has been corrected.

Table A-2: Private Group Homes, Community-Based Psychiatric Residential Treatment Facilities, Day and Outpatient Treatment Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Alamance	Sisterly Love LLC II	1	1	0
Avery	Grandfather Home for Children	1	1	0
Beaufort	Plant Street	1	1	0
Buncombe	Crossroads Treatment Center	2	1	0
	Western Carolina Treatment	1	0	0
	Mountain Area Recovery Center	1	0	0
	First Step Farm - Men	1	0	0
Cabarrus	McLeod Addictive Disease Center	3	2	0
	Crisis Recovery Center	1	0	0
Carteret	The Beach House	1	0	0
Catawba	McLeod Addictive Disease Center	2	1	0
Cleveland	Phoenix Counseling Center	1	0	0
Cumberland	Carolina Treatment Center of Fayetteville	3	2	0
	Agape Unit Care Services, Inc.	1	1	0
Davidson	Addiction Recovery Care	1	0	0
	Lexington Treatment Associates	1	0	0
Forsyth	Insight Human Services - Forsyth	3	1	0
Gaston	McLeod Addictive Disease Center	1	1	0
Guilford	Alcohol and Drug Services	1	1	0
	Crossroads Treatment Center of Greensboro	2	1	0
	Greensboro Treatment Center	1	0	0
Haywood	Smoky Mountain House	1	0	
Henderson	Sixth Avenue West	1	0	
Iredell	Spring Academy	1	0	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Johnston	Johnston Recovery Services	1	0	0
	The Lighthouse	1	1	
McDowell	McDowell Psychosocial Rehabilitation	1	0	0
	McLeod Addictive Disease Center	1	0	
Mecklenburg	Queen City Treatment Center	3	2	0
	Mecklenburg County SAS	1	0	0
New Hanover	Coastal Horizons Center, Inc.	2	1	0
Onslow	Jacksonville Treatment Center, LLC	1	0	
Polk	CooperRiis	2	2	0
Rowan	Rowan Treatment Associates	4	3	
Union	Monroe Crisis and Recovery Center	1	0	0
Wake	Garner Road	1	1	0
	SouthLight Healthcare	2	1	0
Watauga	McLeod Addictive Disease Center	1	1	0
Wayne	Carolina Treatment Center of Goldsboro	1	0	0
Wilkes	Mountain Health Solutions	1	1	
Total	40 Facilities Reporting	**57**	**27**	**0**

NOTES:

1. There were 3,520 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,499 beds as of June 30, 2014.
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]
Durham	Voca Gentry	1	1	0
Pitt	RHA/Howells-Tar River	1	0	0
Lenoir	RHA/ Howells Care Centers - Bear Creek	1	0	0
Total	3 Facilities Reporting	**3**	**1**	**0**

NOTES:

1. There were 336 Private ICFs/IID with a total of 2,769 beds as of June 30, 2014.
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]
		0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 10 Private Psychiatric Hospitals, 44 Hospitals with Acute Care Psychiatric Units, and 2 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,171 beds as of June 30, 2014.
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]
Alleghany	DAYMARK Recovery Services, Inc. - Alleghany County	2	2	0
Brunswick	A Helping Hand of Wilmington, LLC	1	1	0
	Brunswick County TASC	1	1	0
	A Helping Hand of Wilmington, LLC	1	1	0
	Coastal Horizons Center Brunswick	2	2	0
	Coastal Southeastern United Care - Asheville	1	1	0
Buncombe	Universal Mental Health Services, Inc.	1	1	0
	Ray of Light Homes, LLC	1	1	0
	WNC Ray of Hope	1	1	0
Burke	A Caring Alternative	2	2	0
	Catawba Valley Behavioral Healthcare	1	1	0
Cabarrus	DAYMARK Recovery Services, Inc.	5	5	0
	Crisis Recovery Center	1	1	0
Caldwell	RHA Lenoir	1	1	0
Carteret	Le'Chris Health Systems	1	1	0
Chatham	Center for Behavioral Healthcare, PA	1	1	0
Clay	Balsam Center for Hope and Recovery	1	1	0
Cleveland	Phoenix Counseling Center	1	1	0
Craven	Easter Seals UCP	1	1	0
Cumberland	Evergreen Behavioral Management, Inc.	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Yelverton's Enrichment Services, Inc.	2	2	0
	Cumberland County TASC	1	1	0
Davidson	Davidson Outpatient	1	1	0
	DAYMARK Recovery Services, Inc. Davidson Center	1	1	0
	Davidson ACTT	1	1	0
Durham	Carolina Outreach	2	2	0
Forsyth	DAYMARK Recovery Services, Inc.	3	3	0
	RHA	1	1	0
	People Helping People of NC	1	1	0
Gaston	Phoenix Counseling Center	1	1	0
	Outreach Management Services, LLC	1	1	0
Graham	Appalachian Community Services	3	3	0
Guilford	RHA Behavioral Health Services	1	1	0
	Caring Services, Inc.	1	1	0
	Bellemeade	1	1	0
Harnett	DAYMARK Recovery Services, Inc. - Harnett Center	1	1	0
	Specialized Services & Personnel, Inc.	1	1	0
	Harnett County TASC Program	1	1	0
Haywood	Meridian Behavioral Health	1	1	0
	Balsam Center for Hope and Recovery	1	1	0
Hertford	PORT Human Services	3	3	0
Iredell	Easter Seals UCP	1	1	0
Jackson	Jackson County Psychological Services Therapy	1	1	0
Lenoir	PORT Human Service	1	1	0
McDowell	Strategic Interventions, Inc.	1	1	0
Mecklenburg	Healthcore Resource Inc.	1	1	0
	Mecklenburg County Provided Services Organization - YFS-QSAP	1	1	0
	Person Centered Partnerships, Inc.	1	1	0
	YFSCT	1	1	0
	Another Level Counseling	1	1	0
	Anuvia Prevention & Recovery Center	1	1	0
Montgomery	DAYMARK Recovery Services, Montgomery Center	2	2	0
Moore	Life Opportunities Therapeutic Home Services	1	1	0
New Hanover	AssistedCare, Inc.	3	3	0
	Physician Alliance for Mental Health - AMI	2	2	0
	Coastal Horizons Center, Inc.	5	5	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	A Helping Hand of Wilmington, LLC	2	2	0
	CoastalCare	1	1	0
Onslow	CoastalCare	1	1	0
	Precision Health Care	1	1	0
	Le'Chris Counseling Services	1	1	0
	Wrights Care Services, LLC	1	1	0
Orange	UNC CECMH	1	1	0
	B & D Behavioral Health Services	1	1	0
Pender	Coastal Horizons Center Inc.	1	1	0
Person	Freedom House Recovery Center	2	2	0
Pitt	PORT Human Services – Greenville Adult Outpatient	2	2	0
	Integrated Family Services, PLLC	1	1	0
	Le'Chris Health Systems of Greenville, Inc.	1	1	0
	Pathways to Life, Inc.	1	1	0
Randolph	DAYMARK Recovery Services, Inc.	1	1	0
Richmond	Sandhills Alternative Academy, LLC	1	1	0
Robeson	Primary Health Choice	1	1	0
Rockingham	Faith In Families, Inc.	3	3	0
	DAYMARK Recovery Services, Inc.	5	5	0
Rowan	DAYMARK Recovery Services, Inc.	1	1	0
Rutherford	Family Preservation Services, NC	1	1	0
Stanly	Stanly ACTT	1	1	0
	DAYMARK Recovery Services, Inc.	4	4	0
	Stanly Outpatient	2	2	0
Surry	PQA Healthcare, Inc.	1	1	0
Union	DAYMARK Recovery Services, Inc.	5	5	0
Vance	DAYMARK Recovery Services, Inc.	3	3	0
	Freedom House Recovery Center	1	1	0
	Holly Hill Mobile Crisis	1	1	0
	Recovery Innovations	1	1	0
	Family Preservation Services	1	1	0
Wake	Behavioral Health - Wake	2	2	0
	Fellowship Health Resources, Inc.	2	2	0
	Continuum Care Services, Inc.	1	1	0
	Turning Point Family CARE	1	1	0
	Carolina Outreach, LLC	1	1	0
	Carolina Community Mental Health Center	1	1	0
	Wake County TASC Program	1	1	0
Watauga	DAYMARK Recovery Services, Inc. – Watauga Unit	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Wilkes	Region III Treatment Accountability for Safer Community	1	1	0
	DAYMARK Recovery Services, Inc.	3	3	0
Wilson	Bridges of Hope Inc.	1	1	0
	Wilson Behavioral Health	1	1	0
Yadkin	DAYMARK Recovery Services, Inc.	2	2	0
	Pathways Transitional Supportive Housing Program	1	1	0
Total	101 Facilities Reporting	**148**	**148**	**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]
Buncombe	Julian F. Keith	1	0	0
Pitt	Walter B. Jones	1	0	0
Total	2 Facilities Reporting	**2**	**0**	**0**

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 196 beds as of June 30, 2014.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-7: State Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)[1]

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

NOTES:

1. There were 3 State-Operated ICFs/IID with a total of 1,249 beds as of June 30, 2014.
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 615 beds as of June 30, 2014 which includes 136 ICFs/IID beds at O'Berry Facility.
2. The data for O'Berry Facility is separated to indicate a death in the ICF Center as the O'Berry Facility serves ICF and the Neuro-Medical Treatment 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]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 892 beds as of June 30, 2014.
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, 2014.
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, 2013 and ending June 30, 2014. 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 2,781 licensure surveys, 1,314 follow-up visits, and 2,286 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
Buncombe	Evergreen Living Home #3	1
Craven	The Courtyards at Berne Village Memory Care	1
Davie	The Heritage of Cedar Rock	1
Duplin	Rosemary Rest Home	1
Granville	Summit Communities	2
Henderson	Cardinal Care Center	1
Hoke	Open Arms Retirement Center	1
Robeson	Dial's Family Care Home #1	1
Total	8 Facilities Cited	**9**

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

County	Facility	# Citations
Alamance	A New Beginning Group Home	1
	A Solid Foundation	4
	Angelic Heartz Care Facility	1
	Dee & G Enrichment #2	1
	Enoch Group Home	2
	Ethel's Footprints	1
	Green Valley Haven	1
	Helping Hands	1
	Righteous Path, LLC	1
	Sisterly Love, LLC II	1
	Wicker Street Group Home	1
Anson	Cornerstone Treatment Center	1
Ashe	Summit Support Services of Ashe - Lighthouse	1

County	Facility	# Citations
Buncombe	Dos Portico en el Sol	1
	Marne	1
Caswell	Ruth's Cove	1
Catawba	Hickory Metro Treatment Center	1
Chatham	Griffin's House	1
	Perkins Place	1
Cherokee	The Risin'	3
Cleveland	Cleveland Crisis and Recovery	1
Cumberland	Hearts of Hope	1
	Improving Life Inc.	2
	New Horizons Group Home	2
	Pelham Group Home #1	2
	Pelham Group Home #2	2
	Stanberry Place	1
	Sunny Acres Group Home	2
	The Loving Home #2	1
Davidson	Oak Hill	2
Durham	Adventure House	2
	DHD	2
	Faith Homes and Habilitation	1
	Great Bend Group Home	2
	Melody House	1
	Melody House #1 LLC	1
	Recovery Connections I	2
	Recovery Connections II	2
	Vision Quest - Stuart	1
Edgecombe	Edwards Residential Care	1
Forsyth	Friendly People that Care 2	1
	The Cottages at Independent Living- Katlas Trail	1
Gaston	Buckingham Home	1
	New Hope Group Home	1
	The Essential Home	1
Greene	Dogwood	2
	Indianhead	2
Guilford	A 2nd Chance for Life, Inc.	2
	A Place of Their Own, LLC	3
	Alcohol and Drug Services - East	1
	Chisholm Home 1	1
	Chisholm Home II	1
	Chisholm Home III	1
	Crossroads Treatment Center of Greensboro	1
	Deborah's Hope House	2
	GHH Northridge Group Home	1
	Good Shepard Family Care Home, LLC	1
	Mercy Home Services, Inc.	2
	Milton's Manor	1
	Murphy's Group Home, LLC	3
	Omega Treatment Center	5
	Successful Transitions, LLC	2
	Union Group Home II	2

County	Facility	# Citations
	Virpark Residential Facility, Inc.	1
	Youth Focus	1
Halifax	Timothy Dean's House	2
Harnett	Harmony Home 1	1
Haywood	MARC-West	1
Henderson	Hopeful	2
Hoke	Essence	2
	Ravenwood	1
Iredell	Barium Springs - Howard Home	1
	Harbor Point	1
	Realistic Change by Choice, Inc. (RCBC)	1
Johnston	Barbara Whitley's Group Home	1
	United Family Network at Ridge Road	1
Lenoir	Barbara's Love and Care Home	2
	Larkspur House	2
Lincoln	Crescent Court	1
Madison	Mountain Opportunity Center - Madison	1
	Riverview	1
McDowell	SUWS	1
Mecklenburg	Access Academy	2
	Alexander Youth Network - Charlotte Day Treatment	1
	Echelon 5	3
	Hillcrest	1
	Kenan Cottage	1
	Merancus	2
	Peace Cottage	1
	Strategic Behavioral Health	2
	Total Care and Concern - South Campus	2
	Williamson Cottage	2
Montgomery	D&S Country Manor	2
Nash	My Guardian Angel #2	1
New Hanover	New Hanover Treatment Center	1
	Yahweh Center Children's Center	3
Onslow	Harris Home	2
Orange	Horizon's Daybreak	1
	Sunrise Casaworks	2
Pitt	Evans Home	2
Randolph	A Touch from the Heart	2
	New Beginnings Youth Facility	2
Robeson	A Better Way Residential Services	1
	Crossroads Treatment Center	2
	New Haven Treatment Center	3
	Our House	1
	Tanglewood Arbor	1
Rockingham	Gunn Street Home	1
Rowan	Fresh Start Boundary Home	1
	Timber Ridge	1
Rutherford	Chase Place	3
Transylvania	Trails Carolina	1
Union	Friendship Home	1
Vance	Divine Prodigy	1

County	Facility	# Citations
Wake	Absolute Care Services	2
	Avalon 3	1
	Bradley Home Extension - PKEDS House	1
	Brost Court	3
	Cascade Home	2
	Eagle Home 7	2
	Eagle Home III	1
	Eason Court	2
	Garner Road	1
	Gloryland Homecare Services	2
	Great Bend Home	2
	Mary's Manor III	1
	New Bailey Home	2
	Novella's Place	1
	Raleigh Methadone Treatment Center	1
	Serenity Place	1
	United Family at Fuqua Varina	1
Wayne	Country Pines #1	1
	Country Pines #2	1
	Harbor House #5	2
Wilkes	Mountain Health Solutions	1
Wilson	Bailey's Respite Care	1
	Bailey's Respite Care #2	1
Total	137 Facilities Cited	**204**

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
Catawba	Catawba Memorial	2
Catawba	Frye Regional	2
Craven	Lenoir Memorial	1
Cumberland	Cape Fear Valley	1
Guilford	High Point	1
Johnston	Johnston Memorial	5
Mecklenburg	Presbyterian Mathews	1
Nash	Nash Regional	1
Rutherford	Rutherford	7
Wake	Strategic - Garner	4
Total	10 Facilities Cited	**25**

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