STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

October 1, 2020

SENT VIA ELECTRONIC MAIL

The Honorable Joyce Krawiec, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 308, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

North Carolina General Statutes 122C-5, 131D-2.13(e) and 131D-10.6(10) require the Department of Health and Human Services to report annually to the Joint Legislative Oversight Committee on Health and Human Services on the Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraints and Seclusion. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions, please contact Kody Kinsley, Deputy Secretary for Behavioral Health and Intellectual and Developmental Disabilities, at 984-236-5000.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

DocuSigned by:
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Kody H. Kinsley
Deputy Secretary for Behavioral Health & IDD
North Carolina Department of Health and Human Services

cc:

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

N.C.G.S. §§ 122C-5, 131D-2.13(e) and 131D-10.6(10)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By

North Carolina Department of Health and Human Services

October 1, 2020

Deaths Reported and Facility Compliance with Laws, Rules, and Regulations Governing Physical Restraint and Seclusion

Executive Summary

G.S. § 122C-31, *Report Required Upon Death of a Client*, requires a facility to notify the Secretary, Department of Health and Human Services (DHHS), upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and to notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. In turn, the Secretary is required to provide an annual report by October 1 on the following to the Joint Legislative Oversight Committee on Health and Human Services for the immediately preceding fiscal year:

1. the level of compliance of each adult care home with applicable State law and rules which govern the use of physical restraint and physical hold of residents which indicates the areas of highest and lowest levels of compliance; and the total number of adult care homes that reported client deaths pursuant to G.S. § 131D-34.1 reflecting the number of deaths reported by each facility, the number of deaths investigated, and the number of deaths found upon investigation to be related to the adult care home's use of physical restraint or physical hold. (G.S. § 131D-2.13)
2. the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities including the total number of facilities that reported deaths per this statute, the number of deaths reported by each facility, the number of deaths investigated, and the number found by investigation to be related to the use of physical restraint or time-out. (G.S. § 131D-10.6)
3. the level of facility compliance with applicable State law and federal laws, rules, and regulations governing the use of restraints and seclusion indicating the areas of highest and lowest levels of compliance; and the total number of facilities that reported deaths pursuant to G.S. § 122C-31, as well as the number found by investigation to be related to the use of restraint or seclusion. (G.S. § 122C-5)

The following DHHS Divisions contributed to the compilation of this report: Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Health Service Regulation (DHSR), and State-Operated Healthcare Facilities (DSOHF). In addition, data submitted by the Local Management Entities-Managed Care Organizations (LME-MCOs) and provider agencies through the Incident Response Improvement System (IRIS) are included in this report. The report reflects data for State Fiscal Year (SFY) 2019-2020, which covers the period of July 1, 2019 through June 30, 2020.

Part A of the report includes deaths reported to DHHS by private licensed, private unlicensed, and state- operated facilities. While the reporting requirements differ by type of facility, the data reported herein includes deaths which (a) occurred within seven days after the use of physical restraint, physical holds, or seclusion; or (b) resulted from violence, accident, suicide, or homicide. A total of 236 deaths were reported: 23 by adult care homes, 45 by private licensed facilities, 164 by private unlicensed facilities, 3 by private inpatient psychiatric units, and 1 by state-operated facilities. Of the 236 deaths reported, all were screened, 182 (77.1%) were investigated. None of the deaths was found to be related to the use of physical restraint, physical holds, or seclusion.

Part B of this report reflects information gathered related to facility compliance with laws, rules, and regulations governing the use of physical restraint, physical holds, and seclusion. The compliance data summarized herein was collected from facilities that received an on-site visit or an administrative desk review by DHHS or LME-MCO staff. Those interactions include initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed, but a total of 732 licensure surveys, 1,071 follow-up visits, 1,934 complaint investigations and 2,566 other reviews were conducted during the SFY. A total of 100 private licensed facilities were issued a total of 129 citations for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private unlicensed facilities or to any state-operated facilities during this reporting period.

Citations covered a wide range of deficiencies, including failure to provide training, obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, as well as improper or inappropriate use of physical restraints. The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (N=82 or 55.4%) and "training in seclusion, physical restraint and isolation time-out" (N=30 or 20.3%). These citations accounted for 75.7% of the total issued.

Introduction

G.S. § 122C-31, *Report Required Upon Death of a Client*, requires a facility to notify the Secretary, Department of Health and Human Services (DHHS), upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client and to notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. In turn, the Secretary is required to provide an annual report October 1 on the following to the Joint Legislative Oversight Committee on Health and Human Services for the immediately preceding fiscal year:

1. the level of compliance of each adult care home with applicable State law and rules which govern the use of physical restraint and physical holds of residents which indicates the areas of highest and lowest levels of compliance; and the total number of adult care homes that reported client deaths pursuant to G.S. § 131D-34.1 reflecting the number of deaths reported by each facility, the number of deaths investigated, and the number of deaths found upon investigation to be related to the adult care home's use of physical restraint or physical hold. (G.S. § 131D-2.13) G.S. § 131D-34.1 requires an adult care home to notify DHHS upon the death of any resident that occurs in the facility or that occurs within 24 hours of the resident's transfer to a hospital if the death occurred within seven days of the adult care home's use of physical restraint or physical hold of the resident; the statute also requires the adult care home to notify DHHS within three days of the death of any resident resulting from violence, accident, suicide, or homicide.
2. the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities including the total number of facilities that reported deaths per this statute, the number of deaths reported by each facility, the number of deaths investigated, and the number found by investigation to be related to the use of physical restraint or time-out. (G.S. § 131D-10.6)
3. the level of facility compliance with applicable State law and federal laws, rules, and regulations governing the use of restraints and seclusion indicating the areas of highest and lowest levels of compliance; and the total number of facilities that reported deaths pursuant to G.S. § 122C-31, as well as the number found by investigation to be related to the use of restraint or seclusion. (G.S. § 122C-5)

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

The private licensed facilities include:

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

The private unlicensed facilities include:

- Periodic Service Providers
- North Carolina Innovations

The state-operated facilities include:

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

This report covers SFY 2019-2020, which spans the period July 1, 2019 through June 30, 2020. It 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 the facilities and investigated by DHHS. Part B provides summary data on deficiencies related to the use of physical restraints, physical holds, and seclusion compiled from monitoring reports, surveys and investigations conducted by DHHS and LME-MCO staff. The Appendices contain tables that provide information from Parts A and B of the report listed by licensure or facility type and by county and facility name.

Part A: Deaths Reported and Investigated

Table A provides a summary of the number of deaths reported during the SFY by private licensed, private unlicensed, and state-operated facilities; the number of deaths investigated; and the number of deaths found by investigation to be related to the facility's use of physical restraint, physical holds, or seclusion. Tables A-1 through A-4 in Appendix A provide additional information on the number of deaths reported by county and facility name.

The data in Table A reflects the following:

1 A total of 184 facilities –114 private unlicensed facilities, 45 private licensed facilities, 22 adult care homes, 2 private inpatient psychiatric unit and 1 state-operated facility– reported a total of 236 deaths that were subject to these statutory reporting requirements.

2 Of the total 236 deaths reported, 164 deaths were reported by private unlicensed facilities, 45 deaths were reported by private licensed facilities, 23 were reported by adult care homes, 3 deaths by private inpatient psychiatric units and 1 death were reported by a state-operated facility.

3 All deaths that were reported were screened; a total of 182 deaths (77.1%) were investigated.

4 No deaths were determined to be related to the use of physical restraint, physical holds, or seclusion.

Table A: Summary Data on Consumer Deaths Reported During SFY 2019-2020

Table in Appendix	Type of Facility	Facilities Providing Services[1]	Beds at Facilities[1]	Facilities Reporting Deaths	Death Reports Received & Screened[2]	Deaths Reports Investigated[3]	Deaths Related to Restraints/ Seclusion[4]
Private Licensed Facilities							
A-1	Adult Care Homes	1,184	40,639	22	23	10	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	2,836	10,540	45	45	8	
A-3	Psychiatric Hospitals, Units, & Hospital PRTFs	60	2,378	2	3	0	0
N/A[7]	Community ICFs/IID	337	2,786	0	0	0	0
Subtotal		4,417	56,343	69	71	18	0
Private Unlicensed Facilities							
A-4	Private Unlicensed[5]			114	164	164	0
State-Operated Facilities							
N/A[7]	Alcohol and Drug Treatment Centers	3	180	0	0	0	0
N/A[7]	Developmental Centers	3	1,053	0	0	0	0
N/A[6,7]	Neuro-Medical Treatment Centers[6]	3	LTC=453	0	0	0	0
			ICF=39	0	0	0	0
N/A[7]	Psychiatric Hospitals	3	916	0	0	0	0
N/A[7]	Residential Programs for Children	2	42	0	0	0	0
Subtotal		14	2,683	0	0	0	0
Grand Total		**4,431**	**59,026**	**183**	**235**	**182**	**0**

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

1. The number of facilities and beds can change during the year. The numbers shown reflect those existing at the end of the SFY (June 30, 2020).
2. Numbers reflect only deaths required to be reported by statute and/or rule. (i.e., those occurring within seven days of physical restraint, physical holds, or seclusion, or the result of violence, accident, suicide, or homicide). All death reports were screened. Due to reporting requirements, a death may be reported by more than one licensed and/or non-licensed provider if an individual is receiving services from more than one provider. Therefore, not all reports reflect unduplicated numbers. Each provider is required to report deaths to the appropriate oversight agency.

3. Deaths that occur within seven days of restraint/seclusion are required to be investigated. For other deaths, the decision to investigate and the level of investigation depends on the circumstances and information provided. Some investigations may be limited to confirming information or obtaining additional information.
4. Findings in this column indicate that restraint/seclusion either: (a) may have been a factor, but not necessarily the cause of death, or (b) may have resulted in the death.
5. The number of these facilities is unknown as they are not licensed or state-operated.
6. The data for O'Berry Facility is reflected in two categories, as State-Operated ICFs/IID Center (N=39 ICF Beds) and as State-Operated Neuro-Medical Treatment Center (N=144 LTC Beds), since this facility serves both populations.
7. N/A (not applicable) indicates that no tables are provided in Appendix A for facilities in which no deaths were reported.

Part B. Facility Compliance with Laws, Rules, and Regulations Governing the Use of Physical Restraints, Physical Holds, and Seclusion

As noted above, DHHS is also required to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical holds, and seclusion to include areas of highest and lowest levels of compliance. The compliance data summarized in this section was collected from on-site visits by DHHS and LME-MCO staff for licensure surveys, follow-up visits, and complaint and death investigations during the SFY beginning July 1, 2019 and ending June 30, 2020. DHHS and LME-MCO staff did not visit all facilities; therefore, the data summarized is limited to those facilities that received an on-site visit or an administrative desk review by DHHS and LME-MCO staff.

Table B provides a summary of the number of physical restraints, physical holds, and seclusion related citations that were issued to private licensed, private unlicensed, and state-operated facilities. The table shows the number of facilities that received a citation, the number of citations issued, and examples of the most frequent and least frequent citations issued.

Table B reflects the following:

1 A total of 114 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private unlicensed facilities or state-operated facilities during this reporting period.

2 Compliance data do not reflect all facilities. Rather, the data is limited to those facilities that required an on-site visit or a desk review by DHHS or LME-MCO staff. A total of 732 initial, renewal and change-of-ownership licensure surveys, 1,071 follow-up visits, 1,934 complaint investigations and 2,566 other reviews were conducted during the year. Because of the potential for some facilities to have had more than one type of review, an exact unduplicated count of facilities reviewed is not available.

3 A total of 148 citations were issued for non-compliance with rules governing the use of physical restraint, physical holds, or seclusion. All of these citations occurred in private licensed facilities. Citations covered a wide range of deficiencies including failure to obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, and improper or inappropriate use of physical restraints.

4 The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (N=82 or 55.4%) and "training in seclusion, physical restraint and isolation time-out" (N=30 or 20.3%); these accounted for 75.7% of

the total issued. The tables in Appendix B provide additional information on the number of citations issued by county and facility name.

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2019-2020[1]

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
Private Licensed Facilities					
B-1	Adult Care Homes	6	8	• Rule 10A NCAC 13G .1301(a) Failure to obtain physical order, assessment and to use least restrictive device or no alternative attempted (4 citations) • Rule 10A NCAC 13F.1501(e) Failure to document restraints (2 citations)	• Rule 10A NCAC 13G.1301(b) Failure to obtain consent from resident (1 citation) • Rule 10A NCAC 13F.1501(c) Failure to implement resident plan, care, doctor's order regarding checks and releasing restraints (1 citation)
B-2	Group Homes, Day Outpatient Treatment, Community Based PRTFs	100	129	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (82 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (30 citations) • Rule 10A NCAC 27E.0104 Seclusion, Physical Restraint and Isolation Time-Out (17 citations) • Rule 10A NCAC 27E.0101 Least Restrictive Alternative (10 citations)	• Rule 10A NCAC 27E.0103 General Policies (No citations) • 10A NCAC 27E.0105 Protective Devices (No citations) • NCAC 27E.0106 Intervention Advisory Committees (No citations)
N/A[2]	Community ICFs/IID	0	0	No Citations were issued.	No Citations were issued.

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-3	Psychiatric Hospitals, Units, and Hospital PRTFs	8	10	• A171: Order shall be used for management of violent or self-destructive behavior that jeopardizes the safety of the patient (3 citations) • A168: Use of restraints must be in accordance with order of a physician or other licensed independent practitioner (LIP) (2 citations)	• A188: When restraint or seclusion is used, there must be documentation of the patient's response to interventions used (1 citation) • A184: When restraint or seclusion is used, there must be documentation of the 1-hour face-to-face medical and behavioral evaluation if used to manage violent or self-destructive behavior (1 citation) • A179: The facility's staff failed to ensure the physician, LIP or trained registered nurse documented the one hour face-to-face evaluation within 1 hour after initiation or restraint or seclusion (1 citation) • A175: Patient must be monitored by physician, LIP, or trained staff (1 citation) • A169: Orders must be written and never standing orders (1 citation)
Subtotal		114	147		
Private Unlicensed Facilities					
N/A[2]	Private Unlicensed	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
State-Operated Facilities					
N/A[2]	Alcohol and Drug Treatment	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Center	0	0	No Citations were issued.	No Citations were issued.

B-4	Psychiatric Hospitals	1	1	A168: The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.	
N/A[2]	Residential Programs for Children	0	0	No Citations were issued.	No Citations were issued.
Subtotal		1	1		
Grand Total		**115**	**148**		

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

1. The citations summarized in this table do not reflect all facilities. The data is limited to those facilities that received an on-site visit or an administrative desk review by DHHS staff or LME-MCO staff. DHHS and LME-MCO staff conducted a total of 732 licensure surveys, 1,071 follow-up visits, 1,934 complaint investigations and 2,566 other reviews during the SFY.
2. N/A means not applicable and is used to indicate that no tables are provided in Appendix B for facilities for which no citations were issued.

Appendix A: Consumer Deaths Reported by County and Facility

Tables A-1 through A-4 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the SFY beginning July 1, 2019, and ending June 30, 2020, that were subject to the reporting requirements in G.S. §§ 122C-31, 131D-10.6 and 131D-34.1, namely deaths that occurred within seven days of physical restraint, physical holds, or seclusion, or that were the result of violence, accident, suicide or homicide.

These tables do not include deaths that were reported to DHHS for other reasons or that were the result of other causes. Each table represents a separate licensure category or type of facility. Each table lists by county, the name of the reporting facility, number of deaths reported, the number of death reports investigated, and the number investigated that were determined to be related to the use of physical restraint, physical holds, or seclusion.

All deaths that were reported were screened and investigated by DHHS when required by law. No deaths were found to be related to the use of physical restraints, physical holds, or seclusion.

Table A-1: Adult Care Homes[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Alamance	Alamance House	1	0	0
	Mebane Ridge Assisted Living	1	0	0
Buncombe	Heather Glen At Ardenwoods	1	1	0
Chowan	Edenton House	1	0	0
Clay	Hayesville House	1	0	0
Craven	The Gardens of Trent	1	1	0
Harnett	Senter's Rest Home	1	0	0
Henderson	Carolina Reserve of Hendersonville	1	1	0
Lenoir	Classic Care of Kinston	1	1	0
McDowell	Rose Hill Retirement Community	1	1	0
Mecklenburg	East Towne	1	1	0
	The Crossing at Steele Creek	1	0	0
Mitchell	Mitchell House	2	2	0
Moore	Elmcroft of Southern Pines	1	0	0
New Hanover	The Commons at Brightmore	1	0	0
Pasquotank	Brookdale Elizabeth City	1	0	0
Pender	Arbor Landing at Hampstead	1	1	0
Robeson	Lumberton Assisted Living	1	0	0
Wake	Elmcroft of Northridge	1	1	0
Wilkes	Rose Glen Manor	1	0	0
Wilson	Wilson House	1	0	0
Yancey	Yancy House	1	0	0
Total	**22 Facilities Reporting**	**23**	**10**	**0**

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

1. There were 1,184 Licensed Adult Care Homes with a total of 40,639 beds as of June 30, 2020.
2. For these facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DHSR and the County Department of Social Services by

the DHSR Complaint Intake Unit after screening for compliance issues.

3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

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

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Alamance	Morse Clinic of Albemarle	1	0	0
	New Dimensions Interventions, Inc.	1	0	0
	Pride Within	1	0	0
Buncombe	Mountain House	1	0	0
	Mountainview Recovery	1	0	0
	October Road, Inc.	1	0	0
Cabarrus	Facility Based Crisis of Cabarrus	1	0	0
Craven	Port Health Services-New Bern MMP	2	0	0
Cumberland	Carolina Outreach 1	1	0	0
	Carolina Treatment Center of Fayetteville	1	0	0
	Fayetteville Treatment Center	1	0	0
Davidson	Addiction Recovery Care Association (ARCA)	1	0	0
	Lexington Treatment Associates	1	1	0
	The Workshop of Davidson Group Home #1	1	1	0
Guilford	Alcohol and Drug Services-East	1	0	0
	Daymark Guilford Residential Treatment Facility	1	0	0
	Greensboro Treatment Center	2	2	0
	The Ringer Center	1	0	0
Halifax	RHA Roanoke Rapids Treatment Center	1	0	0
Harnett	Morse Clinic of Dunn	1	0	0
Haywood	Meridian Behavioral Health Services, Inc.	2	0	0
	Smoky Mountain House	1	0	0
Iredell	Daymark Recovery Services-Iredell	1	0	
Johnston	Johnston Recovery Services	1	0	0
Mecklenburg	Anuvia Prevention and Recovery Center	1	0	0
	Charlotte Treatment Center, Inc.	1	0	0
	Hopeway	1	1	0
	Villages of Hope Haven	1	1	
	VOCA-Wilson Avenue Group Home	1	1	0
Onslow	Jacksonville Treatment Center, LLC	1	0	0
Pitt	Greenville Recovery Center, LLC (GRC)	2	0	0
	Port Health Services-Adult Outpatient	1	0	0
	Port Health Services-Paladin	1	0	0
Polk	CooperRiis	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion [3]
Union	Monroe Crisis Recovery Center	1	0	0
Wake	Building Foundations	1	0	0
	Southlight Healthcare-Garner Road	1	0	0
	The Morse Clinic of North Raleigh	1	0	0
Wilson	Carolina Outreach III	1	0	0
	Stepping Stones Community Resources, Inc.	1	0	0
	Wilson Professional Services Treatment Center	1	0	0
Total	**45 Facilities Reporting**	**45**	**8**	**0**

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

1. There were 2,836 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,540 beds as of June 30, 2020.
2. This indicates the number of death reports that were investigated.
3. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-3: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Hospital-Based Psychiatric Residential Treatment Facilities[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion [2]
Guilford	Moses H. Cone	1	0	0
Moore	FirstHealth Moore Regional	2	0	0
Total	**2 Facilities Reporting**	**3**	**0**	**0**

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

1. There were 12 Private Psychiatric Hospitals, 44 Hospitals with Acute Care Psychiatric Units, and 4 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,378 beds as of June 30, 2020.
2. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-4: Private Unlicensed Facilities[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Alamance	Albertacare	1	1	0
	B & D Integrated Health Services	1	1	0
	Coastal Horizons Center	1	1	0
	RHA Health Services	3	3	0
	United Quest Care Services	1	1	0
	Universal Mental Health Services, Inc.	1	1	0
Ashe	Daymark Recovery Services	1	1	0
Beaufort	Dream Provider Care Services, Inc.	1	1	0
Bladen	RHA Health Services	1	1	0
Brunswick	Coastal Horizons Center	1	1	0
Buncombe	Buncombe BH	1	1	0
	Carolina Pediatric Therapy	1	1	0
	Family Preservation Services of NC, Inc.	1	1	0
	October Road, Inc.	2	2	0
	RHA Health Services	8	8	0
	Universal Mental Health Services-Asheville	1	1	0
Burke	A Caring Alternative	1	1	0
	Catawba Valley Behavioral Healthcare	2	2	0
Cabarrus	Cabarrus Center	1	1	0
Caldwell	Lenoir BHS	3	3	0
Carteret	Coastal Horizons Center Region 1 TASC	1	1	0
	PORT Health	1	1	0
	RHA Health Services	1	1	0
Caswell	Coastal Horizons Center Region 2 TASC	1	1	0
Catawba	Catawba Valley Behavioral Healthcare	4	4	0
Chatham	Daymark Recovery Services	1	1	0
Cherokee	Appalachian Community Services	1	1	0
	Meridian Behavioral Health Services	1	1	0
Craven	PORT Health Services	1	1	0
Cumberland	Carolina Outreach, LLC	3	3	0
Dare	PORT Health	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion [3]
Davidson	Daymark Recovery Center Davidson Center	1	1	0
	DHH Statewide	1	1	0
Durham	Carolina Outreach	4	4	0
	Freedom House Recovery Center	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
	DHH Statewide	1	1	0
	Monarch BH-Forsyth	2	2	0
Franklin	Coastal Horizons Center Region 2 TASC	1	1	0
	Women Children and Family Counseling	1	1	0
Gaston	Outreach Management Services	1	1	0
Guilford	Adolescent and Family Therapy Services	1	1	0
	Bellemeade	1	1	0
	BH-Guilford ACTT	1	1	0
	Family Service of the Piedmont, Inc.	2	2	0
	RHA Health Services	1	1	0
	Strategic Interventions	2	2	0
	Youth Focus	1	1	0
Harnett	Coastal Horizons Center Region 2 TASC	2	2	0
	Daymark Recovery Services Harnett Center	2	2	0
Haywood	Appalachian Community Services	1	1	0
	Haywood Recovery Education Center	2	2	0
	Meridian Behavioral Health Services	2	2	0
Henderson	Family Preservation Services of NC	2	2	0
	Frost AFL	1	1	0
Hoke	Coastal Horizons Center Region 2 TASC	1	1	0
Iredell	Polar Junction	1	1	0
Jackson	Meridian Behavioral Health	1	1	0
Johnston	Johnston Public Health Behavioral Health Division	1	1	0
Lee	Coastal Horizons Center Region 2 TASC	1	1	0
Lenoir	Carolina Outreach Kinston	1	1	0
	Waynesboro Family Clinic, P.A.	1	1	0

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion [3]
Macon	Meridian Behavioral Health Services	2	2	0
McDowell	RHA Health Services Marion	3	3	0
Mecklenburg	Anuvia Prevention Recovery, Inc.	1	1	0
	Family Preservation Services of NC, Inc.	1	1	0
	McLeod Addictive Disease Center	1	1	0
	Monarch	2	2	0
	Pinnacle Family Services LLC	1	1	0
	Samuel Billings Center	1	1	0
	The Arc of North Carolina	1	1	0
	The Kids Workshop	1	1	0
	The Robinson Home	1	1	0
	Therapeutic Services Group	1	1	0
New Hanover	Easter Seals UCO of NC & VA	1	1	0
	PAMH - AMI	1	1	0
	RHA Health Services	1	1	0
Orange	Freedom House Recovery Center	2	2	0
	UNC CECMH	1	1	0
Pasquotank	Albemarle Regional Health Services	1	1	0
	PORT Elizabeth City	1	1	0
Pender	CHC Pender Office	1	1	0
	Coastal Horizons Center Region 1 TASC	2	2	0
	Coastal Horizons Pender County	2	2	0
Person	Coastal Horizons Region 2 TASC	1	1	0
Pitt	Coastal Horizons Center Region 1 TASC	1	1	0
	PORT Health	1	1	0
Richmond	Daymark Recovery Services, Inc. Richmond Center	1	1	0
Robseon	Coastal Horizons Center Region 2 TASC	1	1	0
	Coastal Horizons, Inc.	1	1	0
	Coastal Southeastern United Care	1	1	0
	Stephens Outreach Center, Inc.	1	1	0
Rockingham	Ariel Community Care	1	1	0
	Daymark Recovery Services	1	1	0
Rowan	Daymark-Rowan Center	3	3	0

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Rutherford	RHA Health Services	2	2	0
Sampson	Coastal Horizons Center Region 1 TASC	1	1	0
Stanly	Stanly Behavioral Health	2	2	0
	Stanly Outpatient	1	1	0
Transylvania	Meridian Behavioral Health Services	1	1	0
Union	Daymark Recovery Services	1	1	0
Vance	Coastal Horizons Center Region 2 TASC	1	1	0
Wake	BH Wake (Ashville Ave)	1	1	0
	Carolina Outreach	3	3	0
	Community Partnerships	1	1	0
	Fellowship Health Resources	2	2	0
	Monarch-Wake BH Navaho	1	1	0
	North Carolina Recovery Support Services	1	1	0
	Southlight Healthcare	4	4	0
	UNC Hospitals at Wakebrook	1	1	0
Wayne	Waynesboro Family Clinic, P.A.	4	4	0
Wilkes	Daymark Recovery Services	1	1	0
Wilson	Pride in NC	1	1	0
Yadkin	Daymark Yadkin Center	1	1	0
Total	**114 Facilities Reporting**	**164**	**164**	**0**

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

1. This report includes private facilities not required to be licensed by G.S. § 122C. The number of unlicensed facilities in the state is unknown as they are not licensed or state-operated. Rule 10A NCAC 27G .0604 requires each provider agency to report an incident based on the information learned if an individual was receiving services in the last 90 days before the death occurred. Since one individual may receive services from more than one provider, the total count may not be an unduplicated count of the number of deaths by suicide, accident, homicide or violence. During SFY20, for example, 164 deaths met the reporting requirement for this report.
2. Information regarding the actual cause of death for many cases is obtained from Death Certificates and/or Medical Examination reports. This information generally takes over 12 months to obtain. Providers use the term “unknown” to report deaths the cause of which is not known. Since the timeframe for this report is July 2019-June 2020, providers have not received copies of the death certificate or medical examiner's reports for some of the deaths submitted during this time period.

3. All deaths reported by unlicensed facilities are reviewed by the responsible LME-MCO providing oversight, and the findings are discussed with DMH/DD/SAS. If problems are identified, the LME-MCO can investigate and/or require the facility to develop a plan for correcting these problems. The LME-MCO then monitors implementation of the plan of correction.
4. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Appendix B: Number of Citations Related to Physical Restraint, Physical Holds, and Seclusion by County and Facility

Tables B-1 through B-4 provide data regarding the number of physical restraints, physical holds, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2019 and ending June 30, 2020. Each table represents a separate licensure category or type of facility, shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits and administrative desk reviews conducted by DHHS and LME-MCO staff for initial, renewal and change-of- ownership licensure surveys, follow-up visits and complaint investigations. A total of 732 licensure surveys, 1,071 follow-up visits, 1,934 complaint investigations and 2,566 other reviews were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility Cited	Citations
Cumberland	The Arc of Hope Hill	2
Henderson	Tore's Home #22	2
Mecklenburg	Kestral Ridge Family Care Home	1
Mecklenburg	Up at 13931 Thompson	1
Wake	Allcare Assisted Living	1
Wayne	Eagle's Pointe	1
Total	**6 Facilities Cited**	**8**

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

County	Facility Cited	Citations
Alamance	A Mother's Love	1
	A Solid Foundation	1
	Alamance Homes	1
	Crestview Group Home	1
	Crestview Group Home #2	1
	Motivational Residential Care	1
	R & S Independent Health Services, Inc.	1
	Total Access Care Woodland	1
	Trinity Behavioral Healthcare PC	2
	Union Avenue Group Home	2
Alexander	Luca's Hope	2
Avery	Campbell Cottage	2
Buncombe	Mountain View Recovery, Inc.	1
	The Center for Spiritual Emergence	1
	The Willows at Red Oak Recovery, LLC	1
Burke	The Cognitive Connection - Burke	1
Clay	MedMark Treatment Center of Murphy	1
Cleveland	Crossroads Treatment Center of Cleveland, P.C.	1
Columbus	Washington House	1
Cumberland	Adrienne's House	1
	Carol's DDS Group Home	2
	New Horizons Group Home #3	2
	Serenity Therapeutic Services #2	1
	The Loving Home, Inc. #6	1
Dare	Changing Tides	1
Davidson	Davidson #3	1
Duplin	Sampson Group Home	1
	Warsaw Group Home	1
Durham	Baart Community Healthcare	1
	Community House - Durham	1
	Destiny Home, Inc.	1
	Melody House	1
	PP&V Health Care Solutions	1
	Watts Street Group Home	1
Forsyth	Disability Management Services	2
	Garvins Mental Management	2
	The Fellowship Home	1
	Winston-Salem Comprehensive Treatment Center	1
Gaston	A Better Concept	2
	Brighter Dayz, LLC #2	1
	New Hope Home III	2
	Serenity House	2
	VOCA Dellinger	1

County	Facility Cited	Citations
Guilford	Agape Home Living, LLC	1
	Blackwell House, Inc.	1
	Creative Management Service, Inc.	1
	Majestic Solutions, LLC	2
	Mercy Home Services II	2
	Our Home	1
	The Ringer Center	2
Henderson	Azalea Way	4
	Pieridae	1
Hertford	Rehoboth Counseling Services	2
Iredell	Helms House	2
	RAPHA Healthcare Services - Mooresville	1
	Stickney House	2
Johnston	Cornerstone Residential Services #2	2
	RBC Healthcare Solutions, Inc.	2
	The Lighthouse II of Clayton	1
Jones	Quality-Care Behavioral Health II	1
	Quality-Care Behavioral Health Services	1
Lee	I Innovations, Inc. – 2105 Live Oak Drive	1
Lenoir	Maplewood Facility	1
Mecklenburg	Echelon 3	3
	Harris Home	1
	Jasper's House Day Treatment	1
	One Step Forward Outreach	1
Moore	Jackson Springs Treatment Center	1
Nash	AFL Home-Roliman	1
	MACTA, LLC	1
	South Rocky Mount Home	2
	Steve Avent	1
	Stutz AFL Home	1
Pitt	Camelot Supervised Living	1
	Emmanuel Residential Facility	4
Randolph	Russell House, LLC	1
Rowan	ACE Program	1
	TGH Phase 2 Residential Services	2
	Timber Ridge Treatment Center	1
Rutherford	Kelly's Care II	1
Stanly	Loretta's Place	1
Union	McLeod Addictive Disease Center	1
	Union Diversified Industries	2
Vance	Beyond Challenges Community Services, LLC	1
	House of Blessings II	1
Wake	Absolute Home-Marcony Way	1
	Ann's Country Manor II	1
	Best Home Care Services	1
	Blessed Home, Inc.	1
	GH	1
	Meredith Autism Program	1
	Western Wake Treatment Center, LLC	1

County	Facility Cited	Citations
Wayne	ASA Living I	1
	Carolina Treatment Center of Goldsboro	1
	Country Pines #1	1
	Country Pines #2	1
	Magnolia Group Home	1
Total	**100 Facilities Cited**	**129**

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

County	Facility	Citations
Cumberland	Cape Fear Valley	1
Granville	Maria Parham	3
Harnett	Good Hope	1
McDowell	Mission	1
Mecklenburg	Carolinas Medical	1
Moore	FirstHealth	1
Orange	UNC Hospitals	1
Rutherford	Rutherford	1
Total	**8 Facilities Cited**	**10**

Table B-4: State-Operated Psychiatric Hospitals

County	Facility	Citations
Granville	Central Regional	1
Total	**1 Facility Cited**	**1**

No citations were issued for the following types of facilities: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities; Private Unlicensed Facilities; State Alcohol and Drug Abuse Treatment Centers; State Intermediate Care Facilities for Individuals with Intellectual Disabilities; State Neuro-Medical Treatment Centers; or State Residential Programs for Children.