STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

October 1, 2019

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 Development Disabilities, at 919-733-7011.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

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

cc: Matt Gross, Joyce Jones, Erin Matteson, Deborah Landry, Luke MacDonald, Hattie Gawande, Rob Kindsvatter, Marjorie Donaldson, Katherine Restrepo, Dave Richard, Lisa Wilks, Zack Wortman, Jessica Meed, Steve Owen, Theresa Matula, Mark Collins, reports@ncleg.net, Kody Kinsley, Susan G. Perry, Denise Thomas

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, 2019

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

Executive Summary

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

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

The following DHHS Divisions contributed to the compilation of this report: Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Health Service Regulation (DHSR), and State-Operated Healthcare Facilities (DSOHF). In addition, data submitted by the Local Management Entities-Managed Care Organizations (LME-MCOs) and provider agencies through the Incident Response Improvement System (IRIS) is included in this report. The report reflects data for State Fiscal Year (SFY) 2018-2019, which covers the period of July 1, 2018 through June 30, 2019.

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 185 deaths were reported: 25 by adult care homes, 21 by private licensed facilities, 135 by private unlicensed facilities, 2 by private inpatient psychiatric units, and 2 by state-operated facilities. Of the 185 deaths reported, all were screened, 167 (90.3%) 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 3,110 licensure surveys, 1,440 follow-up visits, and 2,137 complaint investigations were conducted during the SFY. A total of 139 private licensed facilities were issued a total of 204 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=119 or 58.3%) and "training in seclusion, physical restraint and isolation time-out" (N=71 or 34.8%). These citations accounted for 93.1% of the total issued.

Introduction

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

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

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

The private licensed facilities include:

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

The private unlicensed facilities include:

- Periodic Service Providers
- North Carolina Innovations

The state-operated facilities include:

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

This report covers SFY 2018-2019, which spans the period July 1, 2018 through June 30, 2019. 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-6 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 147 facilities –98 private unlicensed facilities, 25 adult care homes, 21 private licensed facilities, 2 state-operated facilities and 1 private inpatient psychiatric unit – reported a total of 185 deaths that were subject to these statutory reporting requirements.
2 Of the total 185 deaths reported, 135 deaths were reported by private unlicensed facilities, 25 were reported by adult care homes, 21 deaths were reported by private licensed facilities, 2 deaths were reported by state-operated facilities and 2 deaths by a private inpatient psychiatric unit.
3 All deaths that were reported were screened; a total of 167 deaths (90.3%) 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 2018-2019

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	1,225	41,247	25	25	16	0
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	1,851	10,575	21	21	16	
A-3	Psychiatric Hospitals, Units, & Hospital PRTFs	62	2,470	1	2	0	0
Subtotal		3,475	57,078	47	48	32	0
Private Unlicensed Facilities							
A-4	Private Unlicensed[5]			98	135	135	0
State-Operated Facilities							
A-5	Alcohol and Drug Treatment Centers	3	164	1	1	0	0
A-6	Psychiatric Hospitals	3	942	1	1	0	0
N/A[7]	Developmental Centers	3	1,101	0	0	0	0
N/A[7]	Neuro-Medical Treatment Centers[6]	3	SNF=405	0	0	0	0
			ICF=79	0	0	0	0
N/A[7]	Residential Programs for Children	2	38	0	0	0	0
Subtotal		14	2,729	2	2	0	0
Grand Total		**3,489**	**59,807**	**147**	**185**	**167**	**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, 2019).
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=79 ICF Beds) and as State-Operated Neuro-Medical Treatment Center (N=96 SNF 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, 2018 and ending June 30, 2019. 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 139 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to private unlicensed facilities or state-operated facilities during this reporting period.

2 Compliance data do not reflect all facilities. Rather, the data is limited to those facilities that required an on-site visit or a desk review by DHHS or LME-MCO staff. A total of 3,110 initial, renewal and change-of-ownership licensure surveys, 1,440 follow-up visits, and 2,137 complaint investigations were conducted during the year. Because of the potential for some facilities to have had more than one type of review, an exact unduplicated count of facilities reviewed is not available.

3 A total of 204 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=119 or 58.3%) and "training in seclusion, physical restraint and isolation time-out" (N=71 or 34.8%); these accounted for 93.1% 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 2018-2019[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	17	22	• Rules 10A NCAC 13F.1501(a) and 10A NCAC 13G .1301(a) Inappropriate use of restraints (failure to obtain physical order, assessment and to use least restrictive device or no alternative attempted) (16 citations)	• Rule 10A NCAC 13F.1501(d) Failure to assure a complete restraint order was obtained and updated every 3 months (3 citations) • Rule 19A NCAC 13F .0506(a) Failure to provide physical restraint training to staff (2 citations) • Rule 10A NCAC 13F.1501(c) Failure to assure assessment and care planning for use of restraints (1 citation)
B-2	Group Homes, Day Outpatient Treatment, Community Based PRTFs	118	176	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (119 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (69 citations) • Rule 10A NCAC 27E.0104 Seclusion, Physical Restraint and Isolation Time-Out (18 citations) • Rule 10A NCAC 27E.0101 Least Restrictive Alternative (12 citations)	• Rule 10A NCAC 27E.0102 Prohibited Procedures (1 citation)
B-3	Community ICFs/IID	2	3	• W306: Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed. (2 citations)	W303: A record of checks and usage of restraint must be kept. (1 citation)

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
B-4	Psychiatric Hospitals, Units, and Hospital PRTFs	2	3	• 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. (2 citations)	• A175: Condition of the patient who is restrained must be monitored by a physician, other licensed independent practitioner or trained staff. (1 citation)
Subtotal		139	204		
Private Unlicensed Facilities					
N/A[2]	Private Unlicensed	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
State-Operated Facilities					
N/A[2]	Alcohol and Drug Treatment	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Center	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Psychiatric Hospitals	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Residential Programs for Children	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
Grand Total		**139**	**204**		

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

1. The citations summarized in this table do not reflect all facilities. The data is limited to those facilities that received an on-site visit or an administrative desk review by DHHS staff or LME-MCO staff. DHHS and LME-MCO staff conducted a total of 3,110 licensure surveys, 1,440 follow-up visits, and 2,137 complaint investigations during the SFY.
2. N/A means not applicable and is used to indicate that no tables are provided in Appendix B for facilities for which no citations were issued.

Appendix A: Consumer Deaths Reported by County and Facility

Tables A-1 through A-6 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the SFY beginning July 1, 2018, and ending June 30, 2019, 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	LM&S Adult Care #2	1	0	0
Bertie	Pathways	1	1	0
Bladen	Oak Grove FCH #2	1	1	0
Brunswick	Leland House	1	0	0
Buncombe	Chunn's Cove AL	1	0	0
Burke	Clara's Cottage FCH #1	1	1	0
Caswell	Caswell House	1	1	0
Cleveland	Openview Retirement Home	1	1	0
Craven	Croatan Village	1	1	0
Davidson	Brookdale Lexington	1	0	0
Duplin	Autumn Village	1	1	0
Forsyth	Kerner Ridge AL	1	0	0
Guilford	Brookdale Lawndale Park	1	1	0
Lenoir	Lenoir Assisted Living	1	1	0
Mecklenburg	Brookdale South Park	1	1	0
	North Lake House	1	0	0
	The Little Flower AL	1	0	0
	Unlimited Possibilities	1	0	0
Northampton	Hampton Manor	1	1	0
Stanly	Woodhaven Court	1	1	0
Stokes	Priddy Manor AL	1	1	0
Wake	Brookdale Cary	1	0	0
	Phoenix Assisted Care	1	1	0
	Sunrise AL at North Hills	1	1	0
Wayne	Eagle's Pointe[4]	1	1	0
Total	**25 Facilities Reporting**	**25**	**16**	**0**

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

1. There were 1,225 Licensed Adult Care Homes with a total of 41,247 beds as of June 30, 2019.
2. For these facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DHSR and the County Department of Social Services by the DHSR Complaint Intake Unit after screening for compliance issues.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.
4. This facility self-reported the death of a resident to the DHSR Complaint Intake Unit. The resident had diagnoses of acute chronic respiratory failure with hypoxia, acute pulmonary edema, and idiopathic gout. The resident had recently been hospitalized due to heart failure and began receiving hemodialysis treatment. The patient returned from the hospital with hospice services. After readmission, the resident suffered a fall, increased ammonia levels and severe mental status changes, resulting in a cervical fracture. Half bed rails were ordered for the resident for safety due to the cervical fracture. The resident was ultimately transferred to an inpatient hospice facility and died three days later. Upon investigation by the Wayne County Department of Social Services from 2/25/2019-4/25/2019, use of the half bed rails did not contribute to the resident's death and there was no non-compliance identified related to the resident's 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 Zebulon	1	1	0
Brunswick	New Hanover Treatment Center	1	1	0
Buncombe	Crossroads Treatment Center of Asheville	1	1	0
	Zillicoa	1	1	0
Cabarrus	Daymark Recovery Services-Cabarrus Center	1	0	0
	McLeod Addictive Disease Center-Concord	1	1	0
Davidson	Lexington Treatment Associates	1	1	0
	Daymark Recovery Services-Davidson Center	1	0	0
Durham	Triangle Residential Option for Substance	1	1	0
Forsyth	Insight Human Services-Forsyth	1	1	0
Gaston	McLeod Addictive Disease Center	1	0	0
Guilford	Alcohol and Drug Services-East	1	1	0
	Durham Treatment Center	1	1	0
Iredell	Daymark Recovery CRC Statesville	1	1	0
	ARMS	1	1	0
Johnston	Johnston Recovery Services	1	1	0
McDowell	McLeod Addictive Disease Center	1	1	0
Mecklenburg	McLeod Addictive Disease Center	1	0	0
	Water Mill Home	1	1	0
Watauga	McLeod Addictive Disease Center-Watauga	1	0	0
Wayne	Carolina Treatment Center of Goldsboro	1	1	0
Total	**21 Facilities Reporting**	**21**	**16**	**0**

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

1. There were 1,851 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,575 beds as of June 30, 2019.
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]
Moore	Firsthealth Moore Regional	2	0	0
Total	**1 Facility Reporting**	**2**	**0**	**0**

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

1. There were 13 Private Psychiatric Hospitals, 44 Hospitals with Acute Care Psychiatric Units, and 5 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 2,470 beds as of June 30, 2019.
2. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-4: Private Unlicensed Facilities

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Alamance	Easterseals UCP NC & VA Burlington ACTT	1	1	0
	RHA Health Services	3	3	0
Beaufort	Dream Provider Care Services, INC	1	1	0
Brunswick	Coastal Horizons Center, Region 2 TASC	1	1	0
	Coastal Southeastern United Care	1	1	0
	Physician Alliance for MH	1	1	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Buncombe	Family Preservation Services of NC, Inc.	1	1	0
	October Road Inc.	1	1	0
	Region 4 Justice Services	1	1	0
	RHA Behavioral Health	3	3	0
Burke	A Caring Alternative	2	2	0
Cabarrus	Daymark Recovery Services Cabarrus Center	1	1	0
Caldwell	Lenoir	1	1	0
Carteret	Integrated Family Services, PLLC Morehead City Office	1	1	0
	PORT Health Services	1	1	0
Catawba	Catawba Valley Behavioral Healthcare	4	4	0
Chatham	Coastal Horizons Center, Inc.	1	1	0
Cherokee	Appalachian Community Services	2	2	0
Cleveland	Support Incorporated	1	1	0
Craven	Coastal Horizons Center	1	1	0
	Port Health Services	1	1	0
	RHA Health Services	1	1	0
Cumberland	Carolina Outreach	2	2	0
	Coastal Horizons Center, Inc.	1	1	0
	Youth Villages	1	1	0
Dare	Coastal Horizons	1	1	0
Davidson	ABC of NC Child Development Center	1	1	0
	Daymark Recovery Center Davidson Center	2	2	0
Duplin	Touchstone Residential Services	1	1	0
Durham	B&D Integrated Health Services	3	3	0
	Carolina Outreach Durham	1	1	0
	Resources for Human Development ESH	1	1	0
Forsyth	Monarch BH-Forsyth	1	1	0
	Top Priority Care Services	1	1	0
Franklin	At-Home Counseling Services, Inc.	1	1	0
	Coastal Horizons Center, Inc.	1	1	0
	First Step Community Services	1	1	0
Gaston	BH Gaston ACTT			0
	Region 4 Justice Services	2	2	0
Guilford	Bellemeade	2	2	0
	BH-Guilford	1	1	0
	Family Services of the Piedmont High Point	1	1	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Guilford	LIFESPAN Creative Campus Guilford	1	1	0
	RHA Health Services	3	3	0
Haywood	Appalachian Community Services	3	3	0
	Meridian Behavioral Health	2	2	0
Henderson	Family Preservation Services	1	1	0
	RHA Behavioral Health	1	1	0
Hertford	Ahoskie Office	1	1	0
Hoke	Daymark Recovery Services-Hoke Center	1	1	0
	ESUCP Lillington ACT Team	1	1	0
Johnston	Johnston Public Health Behavioral Health Division	1	1	0
Lee	Coastal Horizons Center	1	1	0
Madison	RHA Health Services	1	1	0
McDowell	Marion BHS	1	1	0
Mecklenburg	Monarch Behavioral Health	2	2	0
	Samuel Billings Center	1	1	0
Montgomery	Daymark Recovery Services Montgomery Center	1	1	0
Moore	Daymark Recovery Moore Center	2	2	0
Nash	Monarch Nash BH	1	1	0
New Hanover	A Helping Hand of Wilmington	1	1	0
	Coastal Horizons Center, Inc.	2	2	0
	Coastal Southeastern United Center	1	1	0
	Integrated Family Services, PLLC	1	1	0
Orange	Carolina Outreach ACT	1	1	0
	Lutheran Family Services ACTT	1	1	0
	UNC STEP Clinic	1	1	0
Pasquotank	PORT Health Services	1	1	0
	Pride in North Carolina	1	1	0
Pender	Coastal Horizon Center	1	1	0
Person	Coastal Horizons Center, INC.	1	1	0
Pitt	PORT Health Services	4	4	0
	RHA Behavioral Health for the DHH	1	1	0
Richmond	Daymark Recovery Services, Inc. Richmond Center	1	1	0
Robeson	Monarch BH-Robeson	1	1	0
Rockingham	Daymark Recovery Services	3	3	0
Rowan	S&H Youth and Adult Services	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
Scotland	Monarch BH-Scotland	1	1	0
Stanly	Monarch BH-Stanly	3	3	0

County	Facility[1]	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Stanly	Daymark Recovery Services-Stanly	1	1	0
Surry	Daymark Recovery Services-Mt. Airy	1	1	0
Union	Daymark Recovery Services	1	1	0
Vance	Daymark Recovery Services	1	1	0
Wake	B&D Integrated Health Services	2	2	0
	Carolina Outreach LLC	4	4	0
	Easterseals UCP NC & VA	1	1	0
	Fellowship Health Resources	1	1	0
	North Carolina Recovery Support Services	1	1	0
	Southlight Healthcare	2	2	0
	UNC Wake STEP Community Clinic	1	1	0
Watauga	Daymark Recovery Services	2	2	0
	Region 4 Justice Services	2	2	0
Wayne	One on One with Youth, Inc.	1	1	0
Wilkes	Daymark Recovery Services Wilkes	2	2	0
Wilson	Carolina Outreach, LLC	1	1	0
	One on One with Youth, Inc.	1	1	0
Yadkin	Strategic Interventions	1	1	0
Total	**98 Facilities Reporting**	**135**	**135**	**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 SFY19, for example, 135 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 2018-June 2019, providers have not received copies of the death certificate or medical examiner's reports for some of the deaths submitted during this time period.
3. All deaths reported by unlicensed facilities are reviewed by the responsible LME-MCO providing oversight, and the findings are discussed with DMH/DD/SAS. If problems are identified, the LME-MCO can investigate and/or require the facility to develop a plan for correcting these problems. The LME-MCO then monitors implementation of the plan of correction.
4. Findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-5: State Alcohol and Drug Abuse Treatment Centers (ADATC)[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated	Deaths Related to Restraints/ Physical Holds/ Seclusion[2]
Buncombe	Julian F. Keith	1	0	0
Total	**1 Facility Reporting**	**1**	**0**	**0**

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

1. There were three State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 164 beds as of June 30, 2019. These facilities report all deaths that occur in the facility and, if known, those that occur within 14 days of discharge regardless of the manner of death including those resulting from natural causes, terminal illness, and unknown causes.
2. Findings indicate there were no deaths related to the use of restraint/seclusion.

Table A-6: State Psychiatric Hospitals

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

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

1. There were three State-Operated Psychiatric Hospitals with a total of 942 beds as of June 30, 2019. These facilities report all deaths that occur in the facility and, if known, those that occur within 14 days of discharge regardless of the manner of death including those resulting from natural causes, terminal illness, and unknown causes.
2. Findings indicate there were no deaths related to the use of restraint/seclusion.

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 restraint, physical holds, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2018 and ending June 30, 2019. Each table represents a separate licensure category or type of facility, shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits and administrative desk reviews conducted by DHHS and LME-MCO staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits and complaint investigations. A total of 3,110 licensure surveys, 1,440 follow-up visits, and 2,137 complaint investigations were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility Cited	Citations
Catawba	Austin Adult Care Home	1
Chatham	Liselotte Care Home	1
Davidson	Grayson Creek of Welcome	1
Forsyth	Carillon Assisted Living of Clemmons	1
Gaston	Woodlawn Haven	2
Granville	Pine Gardens Adult Care	1
Haywood	McCracken Rest Home	1
	Spicewood Cottage Oaks	1
Hoke	Open Arms Retirement Center	2
Jones	Magnolia Cottage Care Bldg. #2	1
Lincoln	Lakewood Care Center	2
Mecklenburg	The Sanctuary at Stonehaven	1
Randolph	North Pointe Assisted Living of Archdale	1
Robeson	Cromartie Spring Village Rest Home	1
Rowan	Angels at Heart Assisted Living	3
Wake	Renaissance Care Home at Traditions	1
Warren	Alpha Magnolia Garden	1
Total	**17 Facilities Cited**	**22**

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

County	Facility Cited	Citations
Alamance	A Solid Foundation	1
	Ethel's Footprints II	2
	Garner's House of Grace	2
	L & J Homes-Apple Street	2
	Motivational Residential Care	1
	R & S Independent Health Services, Inc.	1
	Total Access Care Woodland	1
Alexander	Changing Lives Now #1	3
Anson	F&J Community Services	1
Avery	Daymark C.A.R.E.S.	1
Brunswick	Strategic Behavioral - Leland	1
	Wallbrown Home Inc.	3
Buncombe	BHG Asheville	1
	Davis House	1
Burke	126 Air Park Drive Apt. C	1
Cabarrus	Smith House	1
Carteret	Morehead City Treatment Center	1
Caswell	Levan Place	1
Catawba	VOCA 8th Avenue	1
	VOCA-Forest Ridge	2
Chatham	Carolina House	1
Clay	MedMark Treatment Center Murphy	1
Columbus	Burkhead Group Home	3
Cumberland	Ashton W. Lilly Home	2
	Myrover-Reese Fellowship Home	2
	Rainbow of Sunshine 1	2
	Summerhill	2
	Sunrise Residential Care	2
	The Loving Home #3	1
	The Loving Home #5	2
Davidson	Davidson Crisis Center	2
	Daymark Recovery Services-Davidson Center	1
	The Workshop of Davidson	2
Durham	Morse Clinic of Hillsboro	1
Edgecombe	Open Hearts	1
Forsyth	Daymark Recovery Services-Forsyth County	1
	Garvins Mental Management	1
	Home Care Solutions	1
	Home Care Solutions at Kaymoore Drive	1
	Independent Living Group Home at Old Salisbury	1
	The Center for Creating Opportunities, LLC	1
	Winston-Salem Comprehensive Treatment	2
Gastonia	VOCA Dellinger	1
Greene	Hopewell	1

County	Facility Cited	Citations
Guilford	De-Borah's Hope House	2
	Envisions of Life Gateway House	2
	Loving Hearts Home	2
	Mercy Home Services, Inc.	1
	Our Home-Aunt Zola's	1
	Person Centered Care	1
	Successful Transitions, LLC-Residential Care Level II	2
	Successful Transitions, LLC-Residential Home Level III	2
	Successful Visions, LLC	1
Haywood	BHG-Clyde Treatment Center	1
Henderson	Equinox RTC	1
Hoke	Canyon Hills Treatment Center	3
Iredell	Barium Springs Home for Children-King Home	1
	Helms House	1
	Stickney House	2
	Whalen House	2
Lee	I Innovation, Inc	2
	I Innovation, Inc-Sean Lane	1
	I Innovation, Inc-Valley View	2
Lenoir	Essex	1
	Neuse Enterprises, Inc.	1
McDowell	Clear Sky Group Home	3
	West Marion Group Home	1
Mecklenburg		
	Carolina Center for Recovery	1
	Fairstone Home	1
	Merancas Cottage	1
	Midwood Addiction	1
	New Vision Home	1
	The Blanchard Institute	1
Nash	BTW Home Care Services II LLC	1
	House of Hope	1
	Loving Care #3	1
	My Brother's Keeper II	2
New Hanover	Coastal Horizons	1
	Reflections of Hope, LLP	1
Onslow	Shadowridge Retreat	1
Orange	Serenity Crest	1
Pender	A Special Touch	3
Pitt	Emmanuel Residential Facility	4
	Greenville Recovery Center	1
	WeCare Residential	2
	WeCare Residential #2	2
Robeson	RHCC Recovery Home	2
	Robeson Group Home 2	1
Rowan	ACE Program	2
Rutherford	DirectCare Group Home	5
	Peace in the City	2
Sampson	Garland Group Home	2
Stanley	Loretta's Place	2
Transylvania	Tapestry Eating Disorder Program	1

County	Facility Cited	Citations
Wake	Ann's Haven of Rest II	1
	Best Home Care Services	1
	Divine Supportive Homes	1
	Easter Seals UCP of North Carolina	1
	Johnson's House of Hope Family Care	1
	Life Skills Independent Care #1	2
	McNeil Home	1
	Montreal Court Home	2
	Peace Healthcare	1
	Pine Forrest II	2
	Raleigh Methadone Treatment Center	1
	Southlight Healthcare-Garner Road	1
	St. Marks Manor	2
Wayne	Angel Wings Group Home 1	1
	Daez of New Vision, Inc.	2
	Howell & Howell's	1
	Main St. Universal Home	2
	Winston	1
Wilkes	Daymark Recovery Services-Wilkes	1
	Wilkes Day Treatment-Mulberry Elementary	2
	Wilkes Day Treatment-CC Wright Elementary	1
Wilson	Kyseem's Unity Group Home #3	1
	Miss Daisy's Gentlemen of the Future	2
	Sunshine	2
Total	**118 Facilities Cited**	**176**

Table B-3: Private Community-Based Intermediate Care Facilities for Individuals with Intellectual Disabilities

County	Facility	Citations
Wake	Helmsdale	2
Wake	Riverbend	1
Total	**2 Facilities Cited**	**3**

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

County	Facility	Citations
Granville	Granville	1
Mecklenburg	CMC Main	2
Total	**2 Facilities Cited**	**3**

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