Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

on

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

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

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

October 1, 2011

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EXECUTIVE SUMMARY

State law requires the Department of Health and Human Services (DHHS) to provide annual reports 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) 2010-2011, which covers the period July 1, 2010 through June 30, 2011.

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

In North Carolina, deaths are reported to DHHS by private licensed, private unlicensed, and state-operated facilities. The reporting requirements differ by type of facility. The data reported here include deaths required by state law to be reported: (a) occurred within seven days after the use of physical restraint, physical hold, or seclusion; or (b) resulted from violence, accident, suicide, or homicide. Table A, on page 5, provides a summary of the number of deaths reported, screened and investigated further pursuant to statute, and found to be related to the use of physical restraint, physical hold, or seclusion.

A total of 260 deaths were reported: 101 by private licensed facilities, 142 by private unlicensed facilities, and 17 by state-operated facilities. Of the 260 deaths reported, all were screened, 212 (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 staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed. A total of 3,943 licensure surveys, 1,509 follow-up visits, and 1,176 complaint investigations were conducted during the year. An exact number of facilities reviewed can not be readily determined as some facilities may have had more than one type of review. Table B, on page 7, provides a summary of the number of citations issued to private licensed, private unlicensed, and state-operated facilities and examples of the most frequent and least frequent citations issued to each type of facility.

A total of 230 facilities -- 225 private licensed facilities, five private unlicensed facilities, and no state-operated facility -- were issued a total of 319 citations for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. For those facilities that received one, 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” (150 or 47%) and “training in seclusion, physical restraint and isolation time-out” (93 or 29%). These citations accounted for three-quarters (76%) 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:

- Assisted Living Facilities
- Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day Treatment and Outpatient Treatment Programs
- Intermediate Care Facilities for Mental Retardation (ICF/MR)
- 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 Mental Retardation and Developmental Disabilities (CAP-MR/DD) providers

The state-operated facilities include:

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

This report covers **SFY 2010-2011**, the period **July 1, 2010 through June 30, 2011**. The report is organized into two sections (Parts A and B) and includes two Appendices (A and B).

- Part A provides summary data on deaths reported by these facilities and investigated by DHHS.
- Part B provides summary data on deficiencies related to the use of physical restraints, physical hold, and seclusion compiled from monitoring reports, surveys and investigations conducted by Department staff.
- The Appendices contain tables that provide the information from Parts A and B by licensure or facility type and by county and facility name.

PART A. DEATHS REPORTED AND INVESTIGATED

In the 2000, 2003 and 2009 legislative session, General Statutes 122C-31, 131D-10.6B and 131D-34.1 were amended to require certain facilities to notify the North Carolina Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

North Carolina Administrative Code 10A NCAC 26C .0300, 10A NCAC 13F .1207 and .1208, 10A NCAC 13G .1208 and .1209, and 10A NCAC 13H .1902 and .1903 implement the death reporting requirements of these laws and provide specific instructions for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5, **facilities licensed** under G.S. 131D, and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Health Services Regulation** (DHSR).
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services** (DMH/DD/SAS).

North Carolina Administrative Code 10A NCAC 27G .0600 and DHHS policies and procedures require some types of facilities to report other deaths. For example:

- State-operated facilities report **all deaths** that occur in the facility, 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 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 (occurring within seven days of the use of physical restraint, physical hold or seclusion, or due to violence, accident, suicide, or homicide) 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 an expanded summary of the number of deaths reported by county and facility name.

Table A: Summary Data On Consumer Deaths Reported During SFY 2010-2011

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	Assisted Living Facilities	1,277	40,072	22	23	23	1
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,902	13,849	50	65	43	0
A-3	Community ICF-MRs	328	2,726	4	5	3	0
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	51	1,708	6	8	1	0
	Subtotal	5,558	58,355	82	101	70	1
PRIVATE UNLICENSED							
A-5	Private Unlicensed[6]			106	142	142	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	235	1	3	0	0
A-7	Developmental Center (ICF-MR)	3	1,258	0	0	0	0
A-8	Neuro-Medical Treatment Centers	3	667	0	0	0	0
A-9	Psychiatric Hospitals	3	911	3	14	0	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	3,113	4	17	0	0
	Grand Total	5,572	61,468	192	260	212	1

NOTES (referenced in Table A on page 5:

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, 2011).
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 one death reported in this column, the investigation was expanded to include review of the care provided to other residents as well. Multiple non-compliances were identified, and the facility received two Type A violations (defined as a condition or conditions that has resulted in death or serious physical harm to a resident or is likely to result in death or serious physical harm). DHSR initiated administrative action (provisional license and suspension of admissions) and provided the facility with a Directed Plan of Correction to immediately safeguard all residents involved and correct the non-compliances.

   The facility subsequently submitted and implemented a more comprehensive plan of correction to improve its systems and ensure corrections are sustained. A follow-up investigation was conducted two months later and verified that the violations had been corrected and corrective actions sustained. The Type A violations were abated and the administrative action that had been enforced was lifted.
5. The number of these facilities is unknown as they are not licensed or state-operated.

SUMMARY OF FINDINGS RELATED TO REPORTED DEATHS

As Table A shows:

- A total of 192 facilities -- 82 private licensed facilities, 106 private unlicensed facilities, and 4 state-operated facilities -- reported a total of 260 deaths that were subject to statutory reporting requirements.
- Of the total 260 deaths reported, 101 deaths were reported by private licensed facilities, 142 deaths were reported by private unlicensed facilities, and 17 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 212 deaths (82%) were investigated.
- A total of one death occurred within seven days of the use of physical restraint, physical hold, or seclusion. This death was determined to be related to the use of the restrictive intervention.
- Overall, of the 260 deaths reported, a total of one death 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 RESTRAINTS, PHYSICAL HOLD AND SECLUSION

The General Statutes also require DHHS to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical hold, and seclusion to include areas of highest and lowest levels of compliance.

The compliance data summarized in this section was collected from on-site visits by DHHS staff for licensure surveys, follow-up visits, and complaint and death investigations during the state fiscal year beginning July 1, 2010 and ending June 30, 2011. Please note that Department 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 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 an expanded summary of 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 2010-2011[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	Assisted Living Facilities	6	7	• Failure to obtain physician's order for use of restraint (2 citations) • Inadequate assessment and care planning for the use of a restraint (2 citations)	• Failure to obtain consent for use of a restraint (1 citation) • Inappropriate use of restraints (failure to obtain physician order, assessment, use least restrictive device, or no alternative attempted) (1 citation) • Failure to report a resident death that occurred within 7 days of, or that was related to, restraint/seclusion (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs,	217	302	• Training on alternatives to restrictive interventions (144 citations) • Training in seclusion, physical restraint and isolation time-out (93 citations)	• Abuse, Harm or Neglect where seclusion and restraint were a component (21 citations) • Least restrictive alternative (16 citations) • General policies (2 citations)

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				• Seclusion, physical restraint and isolation time-out (23 citations)	• Protective devices (2 citations) • Prohibited procedures (1 citation)
B-3	Community ICF-MRs	2	4	• A client placed in restaint must be checked at least every 30 minutes by staff trained in the use of restraint (2 citations)	• A record of these checks and usage must be kept (1 citation) • Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period when restraint is employed (1 citation)
B-4	Psychiatric Hospitals, Units, & Hospital PRTFs	0	0	• No citations were issued	• No citations were issued
	Subtotal	225	313		
	PRIVATE UNLICENSED				
B-5	Private Unlicensed	5	6	• Staff not trained in alternatives to restrictive intervention (6 citations)	• No citations in this category
	STATE OPERATED				
B-6	Alcohol and Drug Treatment Center	0	0	• No citations were issued	• No citations were issued
B-7	Developmental Center (ICF-MR)	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	**230**	**319**		

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. DHHS staff conducted a total of 3,943 licensure surveys, 1,509 follow-up visits, and 1,176 complaint investigations during the year.

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

As Table B shows:

- A total of 230 facilities -- 225 private licensed facilities, five private unlicensed facilities, and no state-operated facility -- were cited for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion.
- 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 staff. A total of 3,943 initial, renewal and change-of-ownership licensure surveys, 1,509 follow-up visits, and 1,176 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 319 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 313 citations, private unlicensed facilities received six citations, and state-operated facilities received no citations. 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" (150 or 47%) and "training in seclusion, physical restraint and isolation time-out" (93 or 29%). These citations accounted for three-quarters (76%) 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, 2010 and ending June 30, 2011 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 Assisted Living Facilities[1]

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alamance	Hearts of Gold II	1	1	0
Burke	High Country Home Care, Inc. dba Jonas Ridge	1	1	0
Carteret	Somerset Court of Shelby	1	1	0
Duplin	Moore Family Care Home #2	2	2	0
Forsyth	Clemmons Village II	1	1	**1**
Gaston	Country Time Inn	1	1	0
	Rosewood Assisted Living	1	1	0
Guilford	Loyalton of Greensboro	1	1	0
Harnett	Core Family Care Home, Inc.	1	1	0
	Pinecrest Gardens	1	1	0
Iredell	Olin Village	1	1	0
Johnston	Autumn Wind Assisted Living	1	1	0
Mecklenburg	Helton Manor West, Inc.	1	1	0
	The Haven in Highland Creek	1	1	0
	The Laurels in the Village at Carolina Place	1	1	0
Moore	Elmcroft of Southern Pines	1	1	0
Orange	Crescent Green of Carrboro	1	1	0
Rockingham	Beverly Rucker's Family Care Home #2	1	1	0
Rutherford	Southern Manor Retirement Home, Inc.	1	1	0
Transylvania	Cedar Mountain House	1	1	0
Wake	Ann's Ocean of Peace	1	1	0
	Aversboro Assisted Living of Garner, LLC	1	1	0
Total	22 Facilities Reporting	**23**	**23**	**1**

NOTES (referenced in Table A-1 on page 10):

1. There were 1,277 Licensed Assisted Living Facilities with a total of 40,072 beds as of June 30, 2011.
2. For licensed assisted living 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.

   In the case of the one death reported in this column, the investigation was expanded to include review of the care provided to other residents as well. Multiple non-compliances were identified, and the facility received two Type A violations (defined as a condition or conditions that has resulted in death or serious physical harm to a resident or is likely to result in death or serious physical harm). DHSR initiated administrative action (provisional license and suspension of admissions) and provided the facility with a Directed Plan of Correction to immediately safeguard all residents involved and correct the non-compliances.

   The facility subsequently submitted and implemented a more comprehensive plan of correction to improve its systems and ensure corrections are sustained. A follow-up investigation was conducted two months later and verified that the violations had been corrected and corrective actions sustained. The Type A violations were abated and the administrative action that had been enforced was lifted.

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	Guidance House	1	0	0
	UNC Horizons	1	1	0
Bertie	Rachel's House Day Treatment	1	0	0
Brunswick	New Hanover Treatment Center	1	1	0
Cabarrus	McLeod Addictive Disease Center-Concord	4	3	0
Catawba	McLeod Addictive Disease Center-Hickory	1	0	0
Columbus	Columbus House	1	1	0
Craven	Port Human Services	1	0	0
	RHA/Howell's Child Care Center-Riverbend	1	1	0
Cumberland	Elite Care Services, Inc. SAIOP Program	1	0	0
	Fayetteville Treatment Center	2	1	0
Davidson	Addiction Recovery Care Association (ARCA)	1	0	0
Durham	Durham Treatment Center	3	2	0
Guilford	Alcohol and Drug Services-East	1	1	0
	Brentwood Homes	1	1	0
	Greensboro Treatment Center	3	2	0
	Hillcrest House	1	1	0
	Mercy Home Services II	1	1	0
	Morris Manor	1	1	0
	Righteous Path	1	1	0
Halifax	Life Inc. Georgia Avenue	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Haywood	The Balsam Center Adult Recovery Unit	1	0	0
Iredell	McLeod Addictive Disease Center	2	1	0
Johnston	Johnston Recovery Services	1	1	0
Lenoir	Country Pines #1	1	1	0
Lincoln	Crescent Court II	1	1	0
Martin	Shadow Support Center	1	1	0
Mecklenburg	Anuvia Prevention and Recovery Center	1	0	0
	McLeod Addictive Disease Center	2	0	0
	Mecklenburg County Substance Abuse Service	2	2	0
	Simplicity Care, Inc. #2	1	1	0
	VOCA-Woodbridge Road Group Home	1	0	0
Moore	Carolina Treatment Center of Pinehurst	1	0	0
New Hanover	Coastal Horizons Center, Inc.	1	1	0
	New Hanover Treatment Center	1	1	0
Orange	Club Nova	1	0	0
Pitt	Divine Guidance Integrative Services #3	1	1	0
	RHA/Howell Care Centers/ Tar River	2	1	0
Randolph	Daymark Recovery Services	1	1	0
Sampson	Skill Creations of Clinton	1	0	0
Stanly	Daymark Recovery Services, Inc.	1	0	0
Wake	Avalon #4	1	1	0
	Biltmore Center	3	3	0
	Garner Road	2	2	0
	Mary's Manor #3	1	1	0
	Raleigh Methadone Treatment Center	1	0	0
Warren	Warren County Group Home	1	1	0
Wayne	Carolina Treatment Center of Goldsboro	1	1	0
Wilkes	Synergy Recovery At The Bundy Center	1	1	0
	VOCA-Apple Valley (ICF)	1	1	0
Total	50 Facilities Reporting	**65**	**43**	**0**

NOTES:

1. There were 3,902 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 13,849 beds as of June 30, 2011.
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 the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Craven	RHA/Howells CCC/Riverbend	1	1	0
Pitt	RHA Howells CCC/Tar River	2	1	0
Sampson	Skills Creation of Clinton	1	0	0
Wilkes	Voca-Apple Valley	1	1	0
Total	4 Facilities Reporting	**5**	**3**	**0**

NOTES:

1. There were 328 Private ICF-MR's with a total of 2,726 beds as of June 30, 2011.
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]
Buncombe	Memorial Mission Hospital	1	0	0
Durham	Durham Regional Hospital	1	0	0
Guilford	Moses Cone Hospital	1	0	0
Johnston	Johnston Memorial Hospital	1	1	0
Moore	FirstHealth Moore Regional	3	0	0
Orange	UNC Hospitals	1	0	0
Total	6 Facilities Reporting	**8**	**1**	**0**

NOTES:

1. There were 6 Private Psychiatric Hospitals, 43 Hospitals with Acute Care Psychiatric Units, and 2 Hospital-Based Psychiatric Residential Treatment Facilities (PRTFs) with a total of 1,708 beds as of June 30, 2011.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-5: Private Unlicensed Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alamance	Triumph	2	2	0
Allegheny	Mid-day Counseling	1	1	0
	New River Behavioral Healthcare	1	1	0
Anson	Daymark Recovery Services-Anson Center	1	1	0
Ashe	New River Behavioral Healthcare	1	1	0
Bladen	Assisted Care - Elizabethtown	1	1	0
Brunswick	Coastal Horizons Center, Inc.	1	1	0
	NC Solutions	1	1	0
Buncombe	October Road Inc	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Buncombe	Parkway Behavioral Health	1	1	0
	Partnership for a Drug Free NC	1	1	0
	Strategic Interventions, Inc.	1	1	0
Burke	A Caring Alternative	1	1	0
Cabarrus	Daymark Recovery Services, Inc.	1	1	0
Caldwell	New River Behavioral Healthcare	2	2	0
Carteret	Recovery Innovations	1	1	0
Chatham	Chatham Outpatient	1	1	0
Cleveland	True Behavioral Healthcare	1	1	0
Columbus	Allied Behavioral Management	1	1	0
	Community Innovations Inc.	1	1	0
Craven	PORT Human Services - New Bern Clinic	2	2	0
Cumberland	Coastal Horizons Center, Inc	1	1	0
	Elite Care Service Inc	1	1	0
	Peterkin & Associates, Inc.	1	1	0
	The Arc of North Carolina	1	1	0
Dare	ResCare	1	1	0
Durham	B & D Behavioral Health	2	2	0
	Pathways to Life, Inc	1	1	0
	Triumph - Durham	1	1	0
Edgecombe	Coastal Horizons Center, Inc	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
	Region 3 Treatment Accountability for Safer Communities (TASC)	1	1	0
Gaston	Outreach Management Services	1	1	0
Guilford	NC MENTOR	1	1	0
	Psychotherapeutic Services	1	1	0
	Region 3 Treatment Accountability for Safer Communities (TASC)	1	1	0
	United Quest Care Services, LLC	1	1	0
	Wrights Home	1	1	0
Harnett	Daymark Recovery Services	3	3	0
Haywood	Appalachian Community Services	1	1	0
Henderson	Crossroads	1	1	0
Jackson	Jackson County Psychological Services	1	1	0
	Region 4 Treatment Accountability for Safer Communities (TASC)	1	1	0
Johnston	Johnston County Mental Health	5	5	0
Lee	Daymark Recovery Services-Lee Center	1	1	0
Lenoir	Coastal Horizons Center, Inc	1	1	0
McDowell	New River Behavioral Healthcare	2	2	0
Mecklenburg	Family Preservation Services of NC, Inc	1	1	0
	McLeod Addictive Disease Center	1	1	0
	Mecklenburg ACTT	1	1	0
	Mecklenburg Substance Abuse Services Center	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Mecklenburg	Miracle Houses, Inc.	1	1	0
	Person Centered Partnerships	3	3	0
	Simplicity Care	1	1	0
	Superior Healthcare Services, Inc.	1	1	0
Mitchell	RHA	1	1	0
Montgomery	Daymark Recovery Services Montgomery Center	1	1	0
Moore	PRI Counseling Services	1	1	0
Nash	Easter Seals, UCP NC and VA	1	1	0
New Hanover	A Helping Hand of Wilmington	1	1	0
	Coastal Horizons Center	2	2	0
	Physicians Mental Health	1	1	0
	RHA - The Harbor	1	1	0
	RHA Mobile Crisis Management	2	2	0
Northampton	Integrated Family Services, PLLC	1	1	0
Orange	Freedom House CHOC	1	1	0
	Triumph	2	2	0
Person	Freedom House Recovery Center	2	2	0
	Therapeutic Alternatives Hospital Transition Team	1	1	0
Pitt	Bridges of Hope, Inc.	1	1	0
	Le'Chris Health Systems	1	1	0
	PORT Human Services	3	3	0
	ReStart, Inc.	1	1	0
	Youth Villages, Inc.	1	1	0
Polk	Polk Wellness Center	1	1	0
Randolph	Advanced Health Resources	1	1	0
	Daymark Recovery Services Randolph Center	3	3	0
	Randolph County Day Reporting Center	1	1	0
	Triad Therapy Mental Health Center, LLC - CST Program	1	1	0
Richmond	Daymark Recovery Services	1	1	0
Robeson	Advantage Behavioral HealthCare, Inc	1	1	0
	Community Innovations	1	1	0
Rockingham	Daymark Recovery Services	1	1	0
Rowan	Daymark-Rowan Center	2	2	0
Rutherford	RHA	1	1	0
Sampson	Coastal Horizons Center, Inc	1	1	0
Scotland	Evergreen Behavioral Management	1	1	0
Stanly	Stanly Outpatient	2	2	0
Stokes	Triumph	2	2	0
Surry	Easter Seals United Cerebral Palsy	2	2	0
	New River Behavioral Healthcare	4	4	0
Transylvania	Brevard REC	1	1	0
	Plans For Life	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Tyrrell	Coastal Horizons Center, Inc	1	1	0
Union	Daymark Recovery Services	1	1	0
Vance	Triumph	2	2	0
Wake	Easter Seals United Cerebral Palsy	1	1	0
	Faithworks	1	1	0
	Fellowship Health Resources	1	1	0
	Psych Support Inc.	1	1	0
	Triangle Family Services	2	2	0
	Triumph - Wake	1	1	0
	Wake County Human Services	5	5	0
Watauga	New River Behavioral Healthcare	1	1	0
Wilkes	New River Behavioral Healthcare	2	2	0
Yadkin	New River Behavioral Healthcare	1	1	0
Total	106 Facilities Reporting	**142**	**142**	**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]
Pitt	Walter B. Jones	3	0	0
Total	1 Facility Reporting	**3**	**0**	**0**

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 235 beds as of June 30, 2011.
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 the Mentally Retarded (ICF-MR)[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 Facility Reporting	**0**	**0**	**0**

NOTES:

1. There were 3 State-Operated ICF-MR's with a total of 1,258 beds as of June 30, 2011.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-8: State Neuro-Medical Treatment Center[1]

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

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 667 beds as of June 30, 2011.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-9: State Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Burke	Broughton	4	0	0
Granville	Central Regional	5	0	0
Wayne	Cherry	5	0	0
Total	3 Facilities Reporting	**14**	**0**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 911 beds as of June 30, 2011.
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, 2011.
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, 2010 and ending June 30, 2011. Each table represents a separate licensure category or type of facility. Each table shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits conducted by DHHS staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits and complaint investigations. Please note that DHHS 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 staff. A total of 3,943 licensure surveys, 1,509 follow-up visits, and 1,176 complaint investigations were conducted during the year. An exact number of facilities reviewed can not be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Assisted Living Facilities

County	Facility	# Citations
Cabarrus	St. Andrew's Living Center, Inc.	1
Forsyth	Clemmons Village II	2
Greene	Glencare of Snow Hill	1
Lincoln	Boger City Rest Home	1
Rockingham	Turner's Family Care Home	1
Rutherford	Southern Manor Retirement Home	1
Total	6 Facilities Cited	**7**

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

County	Facility	# Citations
Alamance	A Solid Foundation	2
	Cozie's Supervised Living	1
	H Group Ventures, Inc.	3
	Hilford	1
	New Dimensions Interventions, Inc. - 001-164	2
	New Dimensions Interventions, Inc. - 001-165	2
	Restorations	1
	Sisterly Love, LLC	1
	Sixth Avenue Group Home	1
	Union Avenue Group Home	1
	United Care Facility	2
	Vision II	2
Alexander	Alexander Group Home	1
Avery	Avery County Group Home	1
	Grandfather Home For Children	1
Beaufort	Beaufort County Group Home #2	1
	Ray G. Silverthorne Crisis Center	1
Bladen	Bladen County Group Home I	1

County	Facility	# Citations
	Bladen County Group Home II	1
Brunswick	Strategic Behavioral Center	4
Buncombe	Clearview Terrace	1
	Crossroads Treatment Center	1
	Cummings Cottage	1
	First Step Farm Women	1
	Goodwill Industries of NWNC/Asheville	1
	Judy Ray Home	1
	Mary Benson House	1
	Mountain Health Solutions	1
	Neil Dobbins	1
	Reynolds Cottage	2
Burke	Flynn Christian Fellowship Home	1
	Phoenix Home for Boys	1
	Phoenix Home for Girls	1
	Regal Pointe	2
Cabarrus	Devereaux Home	2
	Lakewood Home	2
	Youth Care 8	2
Carteret	The Rouse House	1
Catawba	Hickory House	1
Chatham	Gray Alternative	2
Cherokee	Rising Sun	1
	The Crossing	1
Cleveland	East Pointe Children's Home	1
	Mill Creek	1
	One on One Metcalf 2	1
	Stony Point Group Home	1
Cumberland	Ashton Lilly Home	1
	Carol's DDA Group Home	1
	Educational Unlimited 1	1
	Fayetteville Treatment Center	1
	Fresh Start Res. Facility	1
	Mahogany	1
	Myrover-Reese Fellowship	1
	New Horizons Group Home	1
	Pat Reese Fellowship Home	1
	Roxie Avenue Center	1
	Stepping Stones GH #2	2
	Sunny Acres	1
	The Loving Home #2	1
	Tyrek's Heavenly Angels	1
	Unity Home Care II	1
Davidson	Path of Hope - 029-006	1
	Path of Hope - 029-007	1
	Path of Hope - 029-114	1
Duplin	Atkinson Care Home #2	2
Durham	A New Way Home	1
	BAART	2
	Big Brother At Lancaster	2
	Care Health Services I	2
Durham	Faith Homes Inc	1

County	Facility	# Citations
	Frances St. Women's Half	1
	Our Daily Living	1
	Outreach home #3	1
	TLC Adult Group Home	1
	Trinity-Cheviot House	2
Edgecombe	New Day New Beginning	1
Forsyth	Friendly People That Care #3	1
	Friendly People That Care 2	1
	Insight Human Services	2
	Linville Place	2
	Sharpe & Williams Family Home Care	1
	The Fellowship Home	1
Franklin	E.W. Stone Adult Care Center	1
	Kingdom Health Care	1
	St. Paul Residential Care	1
Gaston	A.C.P.P., Inc Restorative Justice Center	1
	Plyler Lake	2
	The Essential Home #1	1
Guilford	A Place of Their Own, LLC	2
	All About you Residential Home	2
	Bingham Street Home	2
	Broadview House	1
	CC&A Family Services, Inc. #2	2
	Center for Progressive Strides	2
	Classic Care Family Services	1
	Creekbrook Court Home	1
	Fresh Start Home for Children	1
	Gentlehands Adult Home	1
	Gentlehands AFL Adult	1
	Gentlehands AFL Children's Home	1
	Gentlehands Home	1
	Greensboro Treatment Center	1
	James El Parrish	2
	Jane Street Group Home	2
	Lydia's House, LLC Phase 1	1
	Max and Friends Day Program	1
	Morris Manor	4
	NC Absolute Care Services, Inc. Greensboro	4
	Our House	1
	Precious Pearls	1
	Quail Cove Home	2
	Special K Services	1
	The Anderson Home	1
	The McDowell House	1
	Victory House	2
Haywood	Smokey Mountain House	1
Henderson	Laurel Park Group Home	1
	Sixth Avenue West	1
	Smith Avenue West	1
Hoke	Cissel's Residential Facility	1
	Lend a Helping Hand	4
Hoke	Niven's Avenue	1

County	Facility	# Citations
Iredell	Barium Springs Home for Children	1
	Chestnut Grove	1
Johnston	Cornerstone Residential Service #2	2
	Rose of Sharon Adolescent II	1
	Southeastern Adult Day Center	2
	The Lighthouse	2
	The Lighthouse II of Clayton	2
	Trinity Independent Home Care	1
	Unity Residential Services	2
Lenoir	Baltimore	1
	Kristi's Home Inc	2
Macon	Barium Springs Mental Health Pro's	1
Madison	Morning Song Farm	1
Martin	Shadow Support Services	2
McDowell	Hands Up Home - The Landing	1
	SUWS of Carolina	1
Mecklenburg	Alexander Youth Network - Elm unit	2
	Alexander Youth Network - Lions Den	1
	Alexander Youth Network - Nisbet	3
	Alexander Youth Network - Oak Unit	1
	Brown Residential Support Services	1
	Commonwealth Group Home	1
	Dorothy Hardison Home	1
	Echelon 1	1
	Echelon 3	4
	Echelon 4	2
	Goldenblush Group Home	2
	Nevins, Inc.	1
	New Horizons	2
	The Keys of Carolina	3
	The School at Thompson	1
	Turnaround	2
New Hanover	Faith House	2
	Yahweh Center Children's Village	1
	Yahweh Center PPD-PRTF	2
Onslow	Jacksonville Treatment Ctr.	1
Orange	Chapel Hill Men's Halfway House	1
	Maggie Avis Women's Halfway House	1
	RSI Ephesus Church Road	2
	Sunrise CASAWORKS at Horizon	1
Pasquotank	Christian Medical Center	4
Pitt	Divine Integrative Services #2	1
	Divine Integrative Services #3	1
	Evan's Home	1
	Greenville Recovery Center LLC	1
Randolph	Youth Unlimited Millis Home	1
Robeson	New Life Svc. Group Home #3	2
	Peace of Mind Residential Services #2	2
Rowan	ACE Program	1
	House of Sharon	1
	Jack	2
Rowan	Rowan Treatment Associates	1

County	Facility	# Citations
	Sedgefield home	1
	Timber Ridge Treatment Center	2
	Youth Care 4	2
Rutherford	Chevy Place	1
	Commonwood	1
	Joyful Too!	1
	Kelly's Care 6	1
	Magnolia House	1
	New Alternative #3	1
	New Alternatives II	1
Sampson	Parker House	1
Scotland	Scotchfair Group Home	1
	Scotchfair Group Home #2	1
Stanly	Lincoln Street Group Home	1
Transylvania	Tapestry Eating Disorder Program	1
	Trails Carolina	1
Union	Quest Activity Center	3
Vance	Advantage Care	1
Wake	Ann's Haven of Rest	2
	Ann's Spring of Life	3
	Coleman Health Facility	1
	Creech Road Family Care	1
	Gibson Home	1
	Havering Place	1
	Judith's House	1
	Kirby Falls	2
	Learning Services River Ridge	1
	Life Skills Ind. Care 1	1
	McNeil's Home #2	3
	New Beginnings Healthcare	1
	Omega Independent Living Services Site I	2
	Omega Independent Living Services Site IV	1
	Omega Independent Living Services Site V	1
	Taylor Made for Caring	2
	The Emmanuel Home IV	1
	Townes Family Care	2
	Wake Enterprises Inc	1
Wayne	Country Pines #1	1
	Country Pines #2	1
Wilson	Annie's House of Love	1
	Hinton’s Residential Services II	1
	MADIP - Shannon woods	2
	Wellman Center #3	1
Total	217 Facilities Cited	**302**

Table B-3: Private Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
Wake	Blanche Drive	2
	Lockley Road	2
Total	2 Facilities Cited	**4**

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

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

Table B-5: Private Unlicensed Facilities:

County	Facility	# Citations
Durham	Turning Point Family Care PLLC	1
Franklin	Family Intervention & Prevention Services	1
New Hanover	Youth and Family Alliance	1
Norfolk (VA)	Pines Residential Treatment	2
Robeson	Premier Behavioral Services, Inc	1
Total	5 Facilities Cited	**6**

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 the Mentally Retarded (ICF-MR)

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 Facility Cited	**0**

Table B-10: State Residential Program For Children

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