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 2012

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

October 1, 2012

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) 2011-2012, which covers the period July 1, 2011 through June 30, 2012.

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 the number found to be related to the use of physical restraint, physical hold, or seclusion.

A total of 231 deaths were reported: 58 by private licensed facilities, 162 by private unlicensed facilities, and 11 by state-operated facilities. Of the 231 deaths reported, all were screened, 223 (97%) were investigated, and **two** were found to be related to the use of physical restraint, physical hold, or seclusion.

PART B: FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION

The compliance data summarized here was collected from facilities that received an on-site visit by DHHS staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed. A total of 3,746 licensure surveys, 1,549 follow-up visits, and 1,123 complaint investigations were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review. Table B, on page 8, 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 175 facilities -- 174 private licensed facilities, one private unlicensed facility, and no state-operated facility -- were issued a total of 233 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" (128 or 55%) and "training in seclusion, physical restraint and isolation time-out" (78 or 33%). These citations accounted for 88% of the total issued.

INTRODUCTION

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

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

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

The private licensed facilities include:

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

The private unlicensed facilities include:

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

The state-operated facilities include:

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

This report covers **SFY 2011-2012**, the period **July 1, 2011 through June 30, 2012**. 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 Codes 10A NCAC 26C .0300, 10A NCAC 13F .1207 and .1208, 10A NCAC 13G .1208 and .1209, and 10A NCAC 13H .1902 and .1903 implement the death reporting requirements of these laws and provide specific instructions for reporting deaths.

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

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

- State-operated facilities report **all deaths** that occur in the facility, and if known, those that occur within 14 days of discharge, regardless of the manner of death. This includes deaths due to terminal illness, natural causes, and unknown causes.
- Private community-based providers report **deaths due to unknown causes** to DMH/DD/SAS. They also report deaths of individuals to whom they are providing services regardless of **whether or not the consumer was receiving services** when the death occurred.

Though not required, some providers voluntarily report all deaths of consumers to DHHS regardless of cause or where the death occurs.

All deaths reported to DHHS, regardless of whether or not reporting is required, are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to evaluate the cause of the death and any contributing factors, to determine if the death may have been preventable, and to ensure that the facility appropriately identifies and takes action to correct any deficiencies or to pursue opportunities for improvement that may exist in order to protect consumers and to prevent similar occurrences in the future. Deaths are also screened and investigated to determine if they were related to the use of physical restraint, physical hold, or seclusion.

As noted above, the number of deaths reported to DHHS, and the focus of screening and investigation activities go beyond what is required to be included in this report.

For the purposes of this report, only content specified by state law is included: (a) deaths occurring within seven days of the use of physical restraint, physical hold, or seclusion or

resulting from violence, accident, suicide or homicide, and (b) investigation findings that indicate whether the death was related to the use of physical restraint, physical hold, or seclusion.

Table A provides a summary of the number of deaths (referenced in (a) above) reported during the state fiscal year by private licensed, private unlicensed, and state-operated facilities, the number of deaths investigated, and the number found by the investigation to be related to the facility's use of physical restraint, physical hold, or seclusion.

Tables A-1 through A-10 in Appendix A provide additional information on the number of deaths reported by county and facility name.

Table A: Summary Data On Consumer Deaths Reported During SFY 2011-2012

Table in Appendix	Type of Facility	# Facilities Providing Services[1]	# Beds at Facilities[1]	# Facilities Reporting Deaths	# Death Reports Received & Screened[2]	# Death Reports Investigated[3]	# Deaths Related to Restraints / Seclusion[4]
PRIVATE LICENSED							
A-1	Adult Care Homes	1,248	40,170	26	29	29	1
A-2	Group Homes, Day & Outpatient Treatment, Community PRTFs	3,151	10,762	19	23	23	0
A-3	Community ICFs/IID	330	2,745	1	1	1	1
A-4	Psychiatric Hospitals, Units, & Hospital PRTFs	51	1,708	3	5	2	0
	Subtotal	4,780	55,385	49	58	55	2
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			105	162	162	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	240	1	1	0	0
A-7	Developmental Centers (ICFs/IID)	3	1,278	1	1	1	0
A-8	Neuro-Medical Treatment Centers	3	657	2	6	4	0
A-9	Psychiatric Hospitals	3	850	2	3	1	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	14	3,067	6	11	6	0
	Grand Total	4,794	58,452	160	231	223	2

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, 2012).
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 first death reported in this column, a resident with Alzheimer's Disease was found on the floor of her room with her neck and chin wedged between the hospital bed and half bed railing.

   Investigation resulted in the facility being cited with two Type A1 violations, one Type B violation, and one standard deficiency. The first Type A1 violation was for failure to assure that physical restraints (bedrails) were used only with a written order from a physician after appropriate assessment and care planning. The second Type A1 violation was for failure to provide supervision for residents who sustained repeated, unwitnessed falls with injuries resulting in death or requiring hospitalization or first aid. The Type B violation was for failure to assure that a hospital bed used for residents was assembled correctly. The standard deficiency was for failure to notify the resident's responsible person of the death. The facility was notified that a Type A1 penalty is being considered for each Type A1 violation cited.

   While investigators were still on-site, the facility was required to immediately provide and implement a Plan of Protection to safeguard all residents and prevent further incidents. The incident occurred at the end of June 2012. After receipt of the formal investigation report, the facility submitted (in early August) a long-term plan of correction. To evaluate the effectiveness of these corrections, an unannounced follow-up inspection will take place approximately 60 days after receipt of the plan of correction. At the time of this report, this has not yet occurred.

   In the case of the second death reported in this column, the death occurred during a behavior intervention using prone restraint. The prone restraint was part of the client's behavior support plan and was approved by the client's guardian, the team, and the facility's human rights committee.

   Investigators found that staff were trained on the behavior intervention as required and the intervention was conducted as written in the behavior plan and similar to prior prone restraint interventions with this client. The client was reported to be struggling, talking, and screaming at staff during the restraint and then suddenly stopped and became unresponsive. Staff immediately started CPR and called 911. EMS arrived a couple of minutes later and took over. The client was later pronounced dead at the hospital. No interviews or record reviews revealed any medical issues with the client prior to the intervention. An autopsy was requested, and the cause of death was not determined.

   The investigation found that the facility did not conduct a thorough investigation into the client's death causing it to be out of compliance with client protections requirements. The facility was required to submit a plan of correction, and a follow-up survey was conducted to ensure the facility's compliance.
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 160 facilities -- 49 private licensed facilities, 105 private unlicensed facilities, and 6 state-operated facilities -- reported a total of 231 deaths that were subject to statutory reporting requirements.
- Of the total 231 deaths reported, 58 deaths were reported by private licensed facilities, 162 deaths were reported by private unlicensed facilities, and 11 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 223 deaths (97%) were investigated.
- A total of **two** deaths were determined to be related to the use of physical restraint, physical hold, or seclusion.

PART B. FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINTS, PHYSICAL HOLD AND SECLUSION

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

The compliance data summarized in this section was collected from on-site visits by DHHS staff for licensure surveys, follow-up visits, and complaint and death investigations during the state fiscal year beginning July 1, 2011 and ending June 30, 2012. 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 additional information on the number of citations issued by county and facility name.

Table B: Summary Data On Citations Related To Physical Restraint, Physical Hold, and Seclusion Issued During SFY 2011-2012[1]

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE LICENSED					
B-1	Adult Care Homes	14	14	• Inappropriate use of restraints (failure to obtain assessment, physician order, and to use least restrictive device or no alternative attempted) (11 citations)	• Inadequate assessment and care planning for the use of a restraint (2 citations) • Failure to obtain a physician's order for the use of restraints (1 citation)
B-2	Group Homes, Day & Outpatient Treatment, Community PRTFs,	158	214	• Training on alternatives to restrictive interventions (128 citations) • Training in seclusion, physical restraint and isolation time-out (78 citations)	• Seclusion, physical restraint and isolation time-out (19 citations) • Least restrictive alternative (11 citations) • General policies (1 citation)
B-3	Community ICFs/IID	2	4	• Facility failed to ensure a record was kept of checks and usage of approved restraint (2 citations)	• Failure to check client at least every 30 minutes when restraint used. (1 citation) • Opportunity for motion and exercise must be provided for a period of not less than

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
					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	174	232		
	PRIVATE UNLICENSED				
B-5	Private Unlicensed	1	1	• Seclusion room did not have an electronic lock integrated with the fire alarm system to automatically unlock in the event of a fire (1 citation)[2]	• 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 Centers (ICFs/IID)	0	0	• No citations were issued	• No citations were issued
B-8	Neuro-Medical Treatment Center	0	0	• No citations were issued	• No citations were issued
B-9	Psychiatric Hospitals	0	0	• No citations were issued	• No citations were issued
B-10	Residential Programs for Children	0	0	• No citations were issued	• No citations were issued
	Subtotal	0	0		
	Grand Total	**175**	**233**		

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 3,746 licensure surveys, 1,549 follow-up visits, and 1,123 complaint investigations during the year.
2. The facility was an out-of-state PRTF serving a NC consumer that was investigated as a result of a complaint. **As an out of state facility, it is not subject to NC rules.** The facility is licensed under SC rules, which do not require seclusion rooms to have an electronic lock integrated with the fire alarm system. Because of this, feedback was provided to the facility as a "recommendation" rather than as a "citation". Although not required by local rule, the facility voluntarily complied with the recommendation and installed an integrated lock.

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

As Table B shows:

- A total of 175 facilities -- 174 private licensed facilities, one private unlicensed facility, 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 3,746 initial, renewal and change-of-ownership licensure surveys, 1,549 follow-up visits, and 1,123 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 233 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 232 citations, private unlicensed facilities received one citation, 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" (128 or 55%) and "training in seclusion, physical restraint and isolation time-out" (78 or 33%). These citations accounted for 88% 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, 2011 and ending June 30, 2012 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, **two** of the deaths that were reported and investigated were found to be related to the use of physical restraints, physical hold, or seclusion.

Table A-1: Private Licensed Adult Care Homes[1]

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Caldwell	Carolina Oaks Enhanced Care Center	1	1	0
Chowan	Edenton House	1	1	0
Currituck	Currituck House	1	1	0
Forsyth	Magnolia Creek Assisted Living	2	2	0
Gaston	Terrace Ridge	1	1	0
Greene	Snow Hill Assisted Living	1	1	0
Guilford	Greensboro Manor	1	1	0
	High Point Place	2	2	0
Harnett	Alzheimer's Related Care	1	1	0
Iredell	Aurora of Statesville	1	1	0
Macon	Grandview Manor Care	1	1	0
McDowell	Rose Hill Retirement Community	1	1	0
Mecklenburg	The Haven in Highland Creek	1	1	0
Mitchell	Mitchell House	2	2	0
Moore	Tara Plantation of Carthage	1	1	0
New Hanover	The Commons at Brightmore	1	1	**1**
Onslow	Pearl's Family Care Home #4	1	1	0
Pasquotank	House of Love	1	1	0
Rowan	The Meadows of Rockwell Retirement Center	1	1	0
Stanly	Albemarle House	1	1	0
Stokes	Rose Tara Plantation, Inc.	1	1	0
Wake	Ann's Ocean of Peace	1	1	0
	Brighton Gardens of Raleigh	1	1	0
	Spring Arbor of Apex	1	1	0
	Wake Forest Care Center	1	1	0
Wayne	Goldsboro Assisted Living &	1	1	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Alzheimer's Care			
Total	26 Facilities Reporting	**29**	**29**	**1**

NOTES (referenced in Table A-1 on page 11):

1. There were 1,248 Licensed Adult Care Homes with a total of 40,170 beds as of June 30, 2012.
2. For licensed adult care homes, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DHSR and the County Department of Social Services by the DHSR Complaint Intake Unit after screening for compliance issues.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

   In the case of the one death reported in this column, a resident with Alzheimer's Disease was found on the floor of her room with her neck and chin wedged between the hospital bed and half bed railing.

   Investigation resulted in the facility being cited with two Type A1 violations, one Type B violation, and one standard deficiency. The first Type A1 violation was for failure to assure that physical restraints (bedrails) were used only with a written order from a physician after appropriate assessment and care planning. The second Type A1 violation was for failure to provide supervision for residents who sustained repeated, unwitnessed falls with injuries resulting in death or requiring hospitalization or first aid. The Type B violation was for failure to assure that a hospital bed used for residents was assembled correctly. The standard deficiency was for failure to notify the resident's responsible person of the death. The facility was notified that a Type A1 penalty is being considered for each Type A1 violation cited.

   While investigators were still on-site, the facility was required to immediately provide and implement a Plan of Protection to safeguard all residents and prevent further incidents. The incident occurred at the end of June 2012. After receipt of the formal investigation report, the facility submitted (in early August) a long-term plan of correction. To evaluate the effectiveness of these corrections, an unannounced follow-up inspection will take place approximately 60 days after receipt of the plan of correction. At the time of this report, this has not yet occurred.

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	1	0
Cabarrus	McLeod Addictive Disease	1	1	0
Carteret	Newport	1	1	0
Catawba	Building Future	1	1	0
	McLeod Addictive Disease	1	1	0
Cumberland	Fayetteville Treatment Center	1	1	0
	Serenity Therapeutic Services	1	1	0
Guilford	Greensboro Treatment Center	3	3	0
	Alcohol and Drug Treatment	1	1	0
Iredell	McLeod Addictive Disease	2	2	0
Mecklenburg	Villages Of Hope Haven	1	1	0
	Queen City Treatment	1	1	0
New Hanover	Cape Fear Respite Home	1	1	0
Surry	SYRS Day Service	1	1	0
Wake	Avalon #3	1	1	0
	Life Skills Independent Care #1	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	Mary's Manor II	1	1	0
	The Emmanuel Home IV	1	1	0
Wayne	Carolina Treatment Center of Goldsboro	2	2	0
Total	19 Facilities Reporting	**23**	**23**	**0**

NOTES:

1. There were 3,151 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,762 beds as of June 30, 2012.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-3: Private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Buncombe	Blue Ridge Homes-Swannanoa	1	1	**1**
Total	1 Facility Reporting	**1**	**1**	**1**

NOTES:

1. There were 330 Private ICFs/IID with a total of 2,745 beds as of June 30, 2012.
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.

   In the case of the one death reported in this column, the death occurred during a behavior intervention using prone restraint. The prone restraint was part of the client's behavior support plan and was approved by the client's guardian, the team, and the facility's human rights committee.

   Investigators found that staff were trained on the behavior intervention as required and the intervention was conducted as written in the behavior plan and similar to previous prone restraint interventions with this client. The client was reported to be struggling, talking, and screaming at staff during the restraint and then suddenly stopped and became unresponsive. Staff immediately started CPR and called 911. EMS arrived a couple of minutes later and took over. The client was later pronounced dead at the hospital. No interviews or record reviews revealed any medical issues with the client prior to the intervention. An autopsy was requested, and the cause of death was not determined.

   The investigation found that the facility did not conduct a thorough investigation into the client's death causing it to be out of compliance with client protections requirements. The facility was required to submit a plan of correction, and a follow-up survey was conducted to ensure the facility's compliance.

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]
Forsyth	Old Vineyard	1	1	0
Moore	Firsthealth Moore Regional	2	0	0
Orange	UNC Hospital	2	1	0
Total	3 Facilities Reporting	**5**	**2**	**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, 2012.
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	1	1	0
Alexander	RHA Health Services, Inc.	1	1	0
Ashe	New River Behavioral Healthcare	1	1	0
Beaufort	Monarch	1	1	0
	Lifequest, Inc.	1	1	0
	PORT Human Services	1	1	0
	RHA Health Services, Inc.	1	1	0
Bladen	Community Innovations	1	1	0
Brunswick	NC Solutions	2	2	0
Buncombe	Families Together, Inc.	1	1	0
	Partnership For A Drug-Free NC, Inc.	1	1	0
	Crossroads treatment center of Asheville	1	1	0
Burke	A Caring Alternative	1	1	0
	Partnership For A Drug-Free NC, Inc.	1	1	0
Cabarrus	Davidson ACTT	1	1	0
Caldwell	RHA Health Services, Inc.	3	3	0
Carteret	Le Chris Counseling Services	1	1	0
Chatham	Therapeutic Alternatives Inc.	1	1	0
	The Arc of NC	1	1	0
Cherokee	Appalachian Community Services	2	2	0
	Meridian Behavioral Health Services	1	1	0
Columbus	Evergreen Behavioral Management	2	2	0
Craven	Coastal Horizons Center	1	1	0
	PORT Human Services	1	1	0
Cumberland	Alternative Care Treatment	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	System			
Davidson	Davidson ACTT	1	1	0
Durham	Carolina Outreach, LLC	1	1	0
	Durham Center Access	1	1	0
	Fidelity Community Support Group	1	1	0
Forsyth	Daymark Recovery Services	9	9	0
	H&W Enterprises of NC, LLC	1	1	0
	NuDay Case Management	1	1	0
	Partnership For A Drug-Free NC, Inc.	1	1	0
	Triumph	1	1	0
Gaston	Carolina Center for Counseling	1	1	0
	Outreach Management Services	1	1	0
	Support, Incorporated	1	1	0
	True Behavior Health Care	2	2	0
Guilford	Family Empowerment, LLC	1	1	0
	Alberta Professional Services	3	3	0
	Alcohol and Drug Services - East	1	1	0
	Fairhands Services	1	1	0
	LIFESPAN	2	2	0
	TriSupport Services DBA CM Services	1	1	0
	Psychotherapeutic Services Inc.	2	2	0
	Partnership For A Drug-Free NC, Inc.	1	1	0
Halifax	Coastal Horizons Center	1	1	0
	Triumph	1	1	0
Harnett	Daymark Recovery Services	1	1	0
Haywood	Appalachian Community Services	1	1	0
	Haywood Center	1	1	0
Iredell	Partnership For A Drug-Free NC, Inc.	1	1	0
Johnston	Johnston County Mental Health	3	3	0
Lee	Daymark Recovery Services	4	4	0
Lenoir	PORT Human Services	2	2	0
Lincoln	True Behavior Health Care	1	1	0
McDowell	RHA Health Services, Inc.	1	1	0
Mecklenburg	Anuvia Prevention & Recovery Center	1	1	0
	McLeod Addictive Disease Center	4	4	0
	Person Centered Partnerships	2	2	0
	The Arc of NC	1	1	0
Montgomery	Partnership For A Drug-Free NC, Inc.	1	1	0
Moore	Daymark Recovery Services	1	1	0
	Daymark Recovery Services	2	2	0
New Hanover	Coastal Horizons Center	1	1	0
	Easter Seals	1	1	0
	Evergreen Behavioral Management	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	NC Solutions	2	2	0
	Physician Alliance for Mental Health	2	2	0
	RHA Health Services, Inc.	1	1	0
Orange	Freedom House CHOC	2	2	0
	Triumph	2	2	0
Pasquotank	Intensive Mental Care	1	1	0
Pender	Coastal Horizons Center	2	2	0
Person	Person County Clinic	1	1	0
Pitt	PORT Human Services	4	4	0
Polk	Family Preservation Services	1	1	0
Randolph	Advanced Health Resources	1	1	0
	Daymark Recovery Services	2	2	0
	Therapeutic Alternatives Inc.	1	1	0
Richmond	Partnership For A Drug-Free NC, Inc.	1	1	0
Robeson	Continuum Care Services	1	1	0
	Primary Health Choice	2	2	0
	Robeson Health Care Corporation	1	1	0
Rockingham	Daymark Recovery Services	7	7	0
Rowan	Partnership For A Drug-Free NC, Inc.	2	2	0
Rutherford	Partnership For A Drug-Free NC, Inc.	1	1	0
Sampson	Coordinated Health Services	1	1	0
Stanly	Daymark Recovery Services	2	2	0
Surry	New River Behavioral Healthcare	1	1	0
Union	Daymark Recovery Services	3	3	0
Vance	Family Preservation Services	1	1	0
	Holly Hill Mobile Crisis	1	1	0
Wake	Bradley Home Extension	1	1	0
	Easter Seals	1	1	0
	Fellowship Health Resources	1	1	0
	Maxim Healthcare Services	1	1	0
	NC Recovery Support Services	1	1	0
	Wake County Human Services	4	4	0
	Wellness Supports	2	2	0
Watauga	Daymark Recovery Services	1	1	0
Wayne	Easter Seals	1	1	0
	Waynesboro Family Clinic, P.A.	3	3	0
Wilkes	Daymark Recovery Services	3	3	0
Yadkin	New River Behavioral Healthcare	1	1	0
Total	105 Facilities Reporting	**162**	**162**	**0**

NOTES:

1. The number of these facilities is unknown as they are not licensed or state-operated.
2. All deaths reported by unlicensed facilities are investigated by the responsible Local Management Entity (LME) providing oversight, and the findings are discussed with the Division of MH/DD/SAS. If problems are identified, the LME requires the facility to develop a plan for correcting these problems then monitors the implementation of the plan.

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

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

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

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 240 beds as of June 30, 2012.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

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

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Lenoir	Caswell Developmental Center	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 3 State-Operated ICFs/IID with a total of 1,278 beds as of June 30, 2012.
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]
Buncombe	Black Mountain	4	3	0
Wilson	Longleaf	2	1	0
Total	2 Facilities Reporting	**6**	**4**	**0**

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 657 beds as of June 30, 2012.
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	1	0	0
Granville	Central Regional	2	1	0
Total	2 Facilities Reporting	**3**	**1**	**0**

NOTES:

1. There were 3 State-Operated Psychiatric Hospitals with a total of 850 beds as of June 30, 2012.
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, 2012.
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, 2011 and ending June 30, 2012. 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 3,746 licensure surveys, 1,549 follow-up visits, and 1,123 complaint investigations were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility	# Citations
Buncombe	Becky's Rest Home #2	1
Burke	Glenda's Plantation	1
Cleveland	Nellie's Family Care Home, Inc.	1
Davidson	Choice Care Family Care Home	1
Forsyth	The Bradford Village of Kernersville, West	1
Harnett	Alzheimer's Related Care	1
Lincoln	Boger City Rest Home	1
New Hanover	The Commons at Brightmore	1
Rockingham	Pine Forrest Home for the Aged	1
Rutherford	Hillcrest Rest Home	1
Surry	Central Care, Inc.	1
Transylvania	Tore's Home, Inc. #7	1
Wake	Lee's Long Term Care Facility	1
	Wake Forest Care Center	1
Total	14 Facilities Cited	**14**

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

County	Facility	# Citations
Alamance	Ethel's Footprints	2
	Righteous Path	2
	New Dimensions Interventions, Inc.	5
	AT&B Residential Group Home	2
	Cozie's Supervised Living	2
	Hazel's Residential Care	1
	Union Avenue Group Home	2
	United Care Center	1
	A Solid Foundation	1
	McPherson Group Home	1

County	Facility	# Citations
Avery	Grandfather Home for Children	1
Beaufort	Wooded Acres #1	1
Bertie	Cherry's Group Home #1	1
Buncombe	Western Carolina Treatment Center	1
	First Step Farm - Women	1
	Ellenwood	1
	Crossroads Treatment Center - Weaverville	1
	Marne	1
Burke	Caring for Children - Phoenix Home for Girls	2
	SCI - Enola	1
	SCI - Crestwood	1
	Presnell Home	1
	McPherson Home	1
	Regal Pointe	3
	Flynn Christian Fellowship Home of Burke County	1
Cabarrus	Cabarrus County Group Home #10	1
	Watch Place	1
Caldwell	VOCA - Elm	1
Catawba	Hickory House	1
	Corner House I @ Stanton	1
Cherokee	Rising Sun	1
	Pleasant Hill Group Home	1
	Pleasant Valley Group Home	1
Cleveland	Shelby Day Habilitation	2
	Golden Years A	1
	Eastpointe Children's Home	2
Cumberland	Chestnut Hills Group Home	1
	Fresh Start Residential Facility	2
	Majestic Alternative Supervised Living Facility	1
	Myrover-Reese Fellowship Home	1
	Rainbow of Sunshine 2	2
	S&S Spoonridge #2	1
	Stepping Stones Group Home #1	2
	Stepping Stones Group Home #5	2
	Stepping Stones Group Home #6	2
	Willowbrook Treatment Center	1
Currituck	Two Dreams - Outer Banks, LLC	1
Duplin	Atkinson's Care Home #2	2
	Wilson Home	2
Durham	Devereux Residential Services Kincaid Court	1
	Durham Center Access	2
	Great Bend Group Home	2
	Makin' Choices, Inc.	1
	Meadows Place	2
	Melody House	1
	Our Daily Living	2
	Outreach Home 3	2
	Roshaun's House of Care	1
	WeCare Residential Facility	1
Edgecombe	Better Days Ahead of Rocky Mount, Inc.	1
	Edwards Residential Care	1

County	Facility	# Citations
Forsyth	Insight Human Services	1
	North Williams	2
	Linville Place	2
Franklin	St Paul Residential Care	2
	The Ainuddin's Home	1
Gaston	Ohio Street II	1
	Gardner Park Group Home	1
	Phoenix Counseling Center	1
	Flynn Christian Fellowship Home	1
	VOCA - Dellinger	1
Granville	Oxford Group Home	2
Greene	Atkinson's Care Home #4	2
	Carrie's Loving Hands	2
	Hopewell	1
Guilford	CC&A Family Services, Inc.	1
	The Anderson Home	1
	The McDowell Home	1
	Fresh Start Home for Children	1
	Precious Pearls	2
	Mag's House II	1
	All About You Residential Services, LLC.	1
	Crossroads Treatment Center of Greensboro	1
	A Brighter Tomorrow	2
	Wynmere Place	1
	Mercy Home Services II	1
	Hick's House of Care	1
	A Place of Their Own	2
	GHH Northridge Home	1
	Lanier Home	1
	Garden Lakes	1
Harnett	Continuum Care Services, Inc.	1
	Robin Hill Residential	1
	Summerville Residential	1
Henderson	Hour House	1
	King Creek Blvd.	1
	Capps Home	1
Hoke	Hope Gardens	1
Iredell	Brookdale	1
	Barium Springs	1
	ARMS	1
	Daymark Recovery CRC Statesville	2
Jackson	Painter Road Home	1
Johnston	Angel's Group Home. LLC	2
	House of Care, Inc.	1
	RHCC Cambridge Place Casaworks & Perinatal	1
	The Lighthouse II	1
Lenoir	Barbara's Love & Care Home	1
Lincoln	State Street	2
Martin	McLawhorne Home	1
McDowell	SUWS of the Carolinas	1
Mecklenburg	The Taylor Home	1

County	Facility	# Citations
	Outreached Arms	1
	Villages of Hope Haven	1
	Highland Mist Home	1
	One Step Forward Outreach	1
	The Keys of Carolina	2
Nash	BTW Home Care Services	1
	BTW Home Care Services II, LLC	1
	Peace of Mind Adult Group Home	1
New Hanover	Faith House	1
	Yahweh Center Children's Village	1
Northampton	Residential Loving Care	1
Pasquotank	Church Street	3
	Our Home Is Your Home	2
Pender	Richard House	4
Pitt	PORT Human Services-Paladin Site	1
Polk	CooperRiis	1
Richmond	Samaritan Colony	1
Robeson	Crossroads Treatment Center	1
	Future Innovations	3
Rockingham	Life Turn	1
	Empowered Girls	4
Rowan	Rowan Treatment Associates	1
Rutherford	LaDale Home	1
	Hardin House	1
Stokes	Pinnacle Homes #1	1
	Pinnacle Homes #2	1
Transylvania	Transylvania Association for Disabled Citizens	1
Union	Hampton Meadow Home	2
Wake	Avalon #5	2
	Life Skills Independent Care #1	2
	Omega Independent Living Services-Site V	1
	Residential Services Wake County-Millbrook Road	1
	RHD Ranch Mill Circle	1
	The Right Trax	1
	Townes Family Care Home	1
Warren	Wortham's Group Home	2
Watauga	Three Forks Home	1
Wayne	The Vaughn-Family Home	2
	Universal	2
Wilkes	Synergy Recovery at the Bundy Center	1
Wilson	Community House - Wilson	1
	Gentle Hands	1
	Wilson County Group Home #2	1
	Wilson County Group Home #3	1
	Wilson County Group Home #4	1
Yancey	Warren Home	1
Total	158 Facilities Cited	**214**

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

County	Facility	# Citations
Moore	TLC	3
Wake	Tammy Lynn	1
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[1]
Greenville (SC)	SpringBrook Behavioral Health	1
Total	1 Facility Cited	**1**

1. The facility was an out-of-state PRTF serving a NC consumer that was investigated as a result of a complaint. **As an out of state facility, it is not subject to NC rules.** The facility is licensed under SC rules, which do not require seclusion rooms to have an electronic lock integrated with the fire alarm system. Because of this, feedback was provided to the facility as a "recommendation" rather than as a "citation". Although not required by local rule, the facility voluntarily complied with the recommendation and installed an integrated lock.

Table B-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)

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

Table B-7: State Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

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

Table B-8: State Neuro-Medical Treatment Center

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

Table B-9: State Psychiatric Hospitals

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

Table B-10: State Residential Program For Children

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