STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

February 26, 2026

SENT VIA ELECTRONIC MAIL

The Honorable Carla Cunningham, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 403, Legislative Office Building
Raleigh, NC 27603

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

The Honorable Larry Potts, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B1, Legislative Office Building
Raleigh, NC 27603

The Honorable Jim Burgin, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 620, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

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

Should you have any questions regarding this report, please contact Karen Wade, Director of Policy, at Karen.Wade@dhhs.nc.gov.

Sincerely,

Signed by:
Debra Farrington for Secretary Devdutta Sangvai
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Devdutta Sangvai
Secretary

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

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

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By
North Carolina Department of Health and Human Services

February 26, 2026

Executive Summary

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

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

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

The private licensed facilities include:

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

The private unlicensed facilities include:

1. Periodic Service Providers
2. North Carolina Innovations

The state-operated facilities include:

1. Alcohol and Drug Abuse Treatment Centers (ADATCs)
2. Developmental Centers (ICF/IID)
3. Neuro-Medical Treatment Centers
4. Psychiatric Hospitals
5. Residential Programs for Children

Introduction

This report covers SFY 2024-2025, which spans the period July 1, 2024 through June 30, 2025. It is organized into two sections (Parts A and B) and includes two Appendices (A and B). Part A provides summary data on deaths reported by the facilities and investigated by DHHS. Part B provides summary data on deficiencies related to the use of physical restraints, physical holds, and seclusion compiled from monitoring reports, surveys and investigations conducted by DHHS and LME/MCO staff. The Appendices contain tables that provide information from Parts A and B of the report listed by licensure or facility type and by county and facility name.

The following DHHS Divisions contributed to the compilation of this report: Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS), Health Service Regulation (DHSR), and State-Operated Healthcare Facilities (DSOHF). In addition, data submitted by the Local Management Entities/Managed Care Organizations (LME/MCOs) and provider agencies through the Incident Response Improvement System (IRIS) are included in this report. The report reflects data for State Fiscal Year (SFY) 2024-2025, which covers the period of July 1, 2024 through June 30, 2025.

Part A of the report includes deaths reported to DHHS by private licensed, private unlicensed, and state-operated facilities. While the reporting requirements differ by type of facility, the data reported herein includes deaths which (a) occurred within seven days after the use of physical restraint, physical holds, or seclusion; or (b) resulted from violence, accident, suicide, or homicide. A total of 205 deaths were reported: 21 by adult care homes, 45 by private licensed facilities, and 106 by private unlicensed facilities. Of the 205 deaths reported, all were screened and 149 (72.7%) were investigated.

No deaths occurred in the community-based intermediate care facilities for individuals with intellectual and developmental disabilities (ICF-IID), in the psychiatric hospitals, hospitals with psychiatric units, hospital PRTFs, the mental health hospitals, the community-based PRTFs or in the state-operated alcohol and treatment centers (ADATC), developmental centers (ICF-IID), neuro-medical treatment centers, or in the residential programs for children.

Part B of this report reflects information gathered related to facility compliance with laws, rules, and regulations governing the use of physical restraint, physical holds, and seclusion. The compliance data summarized herein was collected from facilities that received an on-site visit or an administrative desk review by DHHS or LME/MCO staff. Those interactions include initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed; however, a total of 2,860 licensure surveys, 1,632 follow-up visits and 1,901 complaint investigations were conducted during the SFY.

A total of 129 private licensed facilities were issued a total of 164 citations for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations

were issued to community-based intermediate care facilities for individuals with ICF-IIDs, to private unlicensed facilities or to the state-operated ADATCs, ICF-IIDs, neuro-medical treatment centers, psychiatric hospitals or residential programs for children.

Citations covered a wide range of deficiencies, including failure to provide training, to obtain the authorization required to implement a restrictive intervention, non-compliance with training requirements, failure to complete a proper assessment and care planning for the use of restraints, failure to ensure the individual is monitored by a medically trained professional at the required intervals and improper use of protective devices for behavioral control. The largest number of citations issued involved deficiencies related to training on alternatives to restrictive interventions (N=81 or 49.3%), failure to use least restrictive alternatives before implementing more restrictive interventions (N=34 or 20.7%) and training in seclusion, physical restraint and isolation time-out (N=30 or 18.3%). These citations accounted for 88.4% of the total issued.

Part A: Deaths Reported and Investigated

Table A provides a summary of the number of deaths reported during SFY 24-25 by private licensed, private unlicensed, and state-operated facilities; the number of deaths investigated; and the number of deaths found by investigation to be related to the facility's use of physical restraint, physical holds, or seclusion. Tables A-1 through A-3 in Appendix A provide additional information on the number of deaths reported by county and facility name.

The data in Table A reflects the following:

1. A total of 172 facilities reported a total of 205 deaths that were subject to these statutory reporting requirements. This included 106 private unlicensed facilities, 45 private licensed community-based facilities, and 21 adult care homes.
2. Of the total 205 deaths reported, 124 deaths occurred at private unlicensed facilities, 59 deaths occurred at private licensed community-based facilities and 22 occurred in adult care homes.
3. All deaths that were reported were screened; a total of 149 deaths (72.7%) were investigated.
4. Three deaths were found to be related to the use of physical restraint. In one death, it was determined that the use of physical restraint may have resulted in the death. The use of physical restraint in the other two deaths was determined to have been a factor, but not necessarily the cause of the deaths.

Table A: Summary Data on Consumer Deaths Reported During SFY 2024-2025

Table in Appendix	Type of Facility	Facilities Providing Services[1]	Beds at Facilities[1]	Facilities Reporting Deaths	Death Reports Received & Screened[2]	Deaths Reports Investigated[3]	Deaths Related to Restraints/ Seclusion[4]
Private Licensed Facilities							
A-1	Adult Care Homes	1,096	39,579	21	22	22	1
A-2	Group Homes, Day & Outpatient Treatment	3,057	10,625	45	59	3	0
N/A[6]	Psychiatric Hospitals (14), Hospitals with Psychiatric Units (42), & PRTFs (3)	59	2,995	0	0	0	0
N/A[6]	Community ICF-IID	338	2,799	0	0	0	0
Subtotal		4,550	55,998	66	81	25	1
Private Unlicensed Facilities							
A-3	Private Unlicensed[5]			106	124	124	0
State-Operated Facilities							
N/A[6]	Psychiatric Hospitals	3	901	0	0	0	0
N/A[6]	Alcohol and Drug Treatment Centers	3	102	0	0	0	0
N/A[6]	Developmental Centers (ICF-IID)	3	800	0	0	0	0
N/A[6]	Neuro-Medical Treatment Centers	3	92	0	0	0	0
N/A[6]	Residential Programs for Children	2	30	0	0	0	0
Subtotal		14	1,925	0	0	0	0
Grand Total		**4,564**	**57,923**	**172**	**205**	**149**	**1**

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

1. The number of facilities and beds can change during the year. The numbers shown reflect those existing at the end of the SFY (June 30, 2025).
2. Numbers reflect only deaths required to be reported by statute and/or rule. (i.e., those occurring within seven days of physical restraint, physical holds, or seclusion, or the result of violence, accident, suicide, or homicide). All death reports were screened. Due to reporting requirements, a death may be reported by more than one licensed and/or non-licensed provider if an individual is receiving services from more than one provider. Therefore, not all reports reflect unduplicated numbers. Each provider is required to report deaths to the appropriate oversight agency.
3. Deaths that occur within seven days of restraint/seclusion are required to be investigated. For other deaths, the decision to investigate and the level of investigation depends on the

circumstances and information provided. Some investigations may be limited to confirming information or obtaining additional information.

4. Findings in this column indicate that restraint/seclusion either: (a) may have been a factor, but not necessarily the cause of death, or (b) may have resulted in the death.
5. The number of these facilities is unknown as they are not licensed or state-operated.
6. N/A (not applicable) indicates that no tables are provided in Appendix A for facilities in which no deaths were reported.

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

As noted above, DHHS is also required to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical holds, and seclusion to include areas of highest and lowest levels of compliance. The compliance data summarized in this section was collected from on-site visits by DHHS and LME/MCO staff for licensure surveys, follow-up visits, and complaint and death investigations during the SFY beginning July 1, 2024, and ending June 30, 2025. DHHS and LME/MCO staff did not visit all facilities; therefore, the data summarized is limited to those facilities that received an on-site visit or an administrative desk review by DHHS and LME/MCO staff.

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

Table B reflects the following:

1 A total of 129 private licensed facilities were cited for non-compliance with one or more rules governing the use of physical restraint, physical holds, or seclusion. No citations were issued to community -based ICF-IIDs, to private unlicensed facilities or to the state-operated facilities.

2 Compliance data do not reflect all facilities. Rather, the data is limited to those facilities that required an on-site visit or a desk review by DHHS or LME/MCO staff.

3 A total of 2,860 initial, renewal and change-of-ownership licensure surveys, 1,632 follow-up visits and 1,901 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.

4 A total of 129 citations were issued for non-compliance with rules governing the use of physical restraint, physical holds, or seclusion. All of these citations occurred in private licensed facilities. Citations covered a wide range of deficiencies including failure to complete an assessment and care planning prior to implementing a restrictive intervention, non-compliance with training requirements, and failure to ensure the person had face-to-face contact with a physician or other licensed practitioner within one hour of the restraint being initiated.

5 The largest number of citations issued involved deficiencies related to training on alternatives to restrictive interventions (N=81 or 49.3%), failure to use a least restrictive alternative prior to implementing a restrictive intervention (N=34 or 20.7%) and training in seclusion, physical restraint and isolation time-out (N=30 or 18.3%). These citations accounted for 88.4% of the total issued. The tables in Appendix B provide additional information on the number of citations issued by county and facility name.

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2024-2025[1]

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE LICENSED FACILITIES					
B-1	Adult Care Homes	5	7	• Rule 10A NCAC 13F .1501(a) Failure to ensure was applied correctly, according to the manufacturer's instructions, and the physician's or the physician extender's order. (2 citations) • Rule 10A NCAC 13F .1501(c) & Rule 10A NCAC 13F .1301(c) Failure to ensure restraint was used only after an assessment and care planning process had been completed. (2 citations) • Rule 10A NCAC 13F ,1501(d) Failure to ensure orders for restraints were provided by the physician or physician extender and were completed in accordance with rules and regulations. (2 citations)	• Rule 10A NCAC 13F .1501(e) Failure to ensure restraint was used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning had been tried and documented as being unsuccessful. (1 citation)
B-2	Group Homes, Outpatient and Day Treatment Facilities	120	152	• Rule 10A NCAC 27E.0107 Training on Alternatives to Restraint Interventions (V536) (81 citations) • Rule 10A NCAC 27E .0101 Least Restrictive Alternative (V513) (34 citations) • Rule 10A NCAC 27E.0108 Training on Seclusion, Physical Restraint and Isolation Time-Out (V537) (30 citations) • Rule 10A NCAC 27E.0104(e)(9) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V521) (3 citations	• Rule 10A NCAC 27E .0104 (a) Protective Devices Used for Behavioral Control (V531) (2 citations) • Rule 10A NCAC 27E .0102 Prohibited Procedures (V514) (1 citation) • Rule 10A NCAC 27E .0104(e)(1-2) Seclusion, Physical Restraint and Isolation Time-Out (V518) (1 citation)
B-3	Psychiatric Hospitals, Hospitals with Psychiatric Units and PRTFs	4	5	The frequency of each citation was the same (N = 1). • A0154 All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. • A0178 When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention by a Physician or other licensed practitioner; or Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section.	

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2024-2025[1] – continued

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE LICENSED FACILITIES					
B-3	Psychiatric Hospitals, Hospitals with Psychiatric Units and PRTFs			• A0179 The patient must be seen face-to-face within 1 hour after the initiation of the intervention to evaluate the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. • A0213 Hospitals must report deaths associated with the use of seclusion or restraint. The hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death: each death that occurs while a patient is in restraint or seclusion; each death that occurs within 24 hours after the patient has been removed from restraint or seclusion; each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, The staff must document in the patient's medical record the date and time the death was reported to CMS. • A0214 Hospitals must report deaths associated with the use of seclusion or restraint. When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information: Any death that occurs while a patient is in such restraints; and any death that occurs within 24 hours after a patient has been removed from such restraints. The staff must document in the patient's medical record the date and time the death was: recorded in the internal log or other system for deaths. Entries into the log or other system must be documented as follows: each entry must be made not later than seven days after the date of death of the patient; each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient medical record number, and primary diagnosis(es). The information must be made available to CMS immediately upon request.	
N/A[2]	Community ICF/IID	0	0	No citations were issued.	No citations were issued.
Subtotal		129	164		

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE UNLICENSED FACILITIES					
N/A[2]	Private Unlicensed	0	0	No Citations were issued.	No Citations were issued.
	Subtotal	0	0		

Table B: Summary Data on Citations Related to Physical Restraint, Physical Holds, and Seclusion Issued During SFY 2024-2025[1] – continued

Table in Appendix	Type of Facility	Facilities Issued a Citation	Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
STATE-OPERATED FACILITIES					
N/A[2]	Alcohol and Drug Treatment Centers (ADATC)	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Developmental Centers (ICF-IID)	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Neuro-Medical Treatment Centers	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Psychiatric Hospitals	0	0	No Citations were issued.	No Citations were issued.
N/A[2]	Residential Programs for Children	0	0	No Citations were issued.	No Citations were issued.
Subtotal		0	0		
Grand Total		**129**	**164**		

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

1. The citations summarized in this table do not reflect all facilities. The data is limited to those facilities that received an on-site visit or an administrative desk review by DHHS staff or LME/MCO staff. DHHS and LME/MCO staff conducted a total of 2,860 licensure surveys, 1,632 follow-up visits, and 1,901 complaint investigations during the SFY.
2. N/A means not applicable and is used to indicate that no tables are provided in Appendix B for facilities for which no citations were issued.

Appendix A: Consumer Deaths Reported by County and Facility

Tables A-1 through A-6 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the SFY beginning July 1, 2024 and ending June 30, 2025, that were subject to the reporting requirements in G.S. §§ 122C-31, 131D-10.6 and 131D-34.1, namely deaths that occurred within seven days of physical restraint, physical holds, or seclusion, or that were the result of violence, accident, suicide or homicide.

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

All deaths that were reported were screened and investigated by DHHS when required by law. Of the three deaths that were found to be related to the use of physical restraints, physical holds, or seclusion, in only one case, it was concluded that restraint/seclusion may have resulted in the death. In the other two instances, there were indications that restraint/seclusion may have been a factor, but not necessarily the cause of the death.

Table A-1: Adult Care Homes[1]

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Brunswick	Ocean Isle Operations – Arbor Landing at Ocean Isle	1	1	0
	The Bluefields	1	1	0
Carteret	Carteret Landing	1	1	0
Davidson	Grayson Creek of Welcome	1	1	0
Durham	Brookdale Chapel Hill	1	1	0
	Brookdale Durham	1	1	0
Forsyth	Grand Villa Assisted Living	1	1	0
Franklin	Franklin Manor Assisted Living	1	1	0
Halifax	The Landings of Lake Gaston	1	1	0
Hertford	Ahoskie AL	1	1	1
Macon	Franklin House	2	1	0
Mecklenburg	Legacy Heights Senior Living	1	1	0
	Summit Place of South Park	1	1	0
	The Laurels of Highland Creek	1	1	0
Pasquotank	Waterbrook of Elizabeth City	1	1	1
Rockingham	Brookdale Eden	1	1	0
Rowan	TerraBella Salisbury	1	1	0
Stokes	Rose Tara Senior Living	1	1	0
Wake	Calyx Living of Fuquay Varina	1	1	2
Wilkes	Rose Glen Manor	1	1	0
Yadkin	Pinebrook Residential Center	1	1	0
Total	**21 Facilities Reporting**	**22**	**22**	**3**

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

1. There were 1,096 Licensed Adult Care Homes with a total of 39,579 beds as of June 30, 2025.

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. No findings in this column (0) indicate that there were no deaths related to restraint/ seclusion; 1 indicates that restraint/seclusion may have been a factor, but not necessarily the cause of death; 2 indicates that restraint/seclusion may have resulted in the death.

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

County	Facility	Deaths Reported and Screened	Death Reports Investigated[2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Buncombe	Asheville Academy	2	2	0
	BHG Asheville Treatment Center	1	0	0
	First Step Farm - Men	1	0	0
	God's Special People	1	0	0
	October Road, Inc.	2	0	0
Caldwell	Foothills Regional Treatment Center	1	0	0
	The Center for Spiritual Emergence &	2	0	0
Catawba	Hickory Metro Treatment Center	2	0	0
Chatham	Carolina House	1	1	0
Davidson	Daymark Recovery Services-Davidson	1	0	0
Forsyth	Addiction Recovery Care Association,	1	0	0
	Insight Human Services-Forsyth	1	0	0
Gaston	McLeod Centers for Wellbeing	1	0	0
	Phoenix Counseling Center-Outpatient	2	0	0
Guilford	Crossroads Treatment Center of	1	0	0
Harnett	Morse Clinic of Dunn	1	0	0
Haywood	Meridian Behavioral Health Services, Inc.	1	0	0
	Pisgah Recovery Services	1	0	0
Lenoir	Hardee Road Group Home	1	0	0
Mecklenburg	Adult Homeless and Substance Abuse Treatment	1	0	0
	Anuvia Prevention and Recovery Center	1	0	0
	High Focus Center	1	0	0
	McLeod Centers for Wellbeing	1	0	0
	October Road, Inc.	1	0	0
	Queen City Treatment Center	2	0	0
Moore	Carolina Treatment Center of Pinehurst	1	0	0
Nash	Carolina Blue Waters	1	0	0
New Hanover	Coastal Horizons Center, Inc	3	0	0

	Reflections of Hope, LLP	1	0	0

Table A-2: Private Group Homes, Day and Outpatient Treatment Facilities[1] continued

County	Facility	Deaths Reported and Screened	Death Reports Investigated [2]	Deaths Related to Restraints/ Physical Holds/ Seclusion[3]
Onslow	Jacksonville Treatment Center, LLC	3	0	0
Orange	Hillsborough Comprehensive Treatment Center	1	0	0
Pender	Coastal Horizons Center-Pender	1	0	0
Pitt	Pathways to Life	1	0	0
	Greenville Treatment Center	1	0	0
Robeson	Stephens Outreach Center, Inc.	1	0	0
	Tanglewood Arbor	1	0	0
Rutherford	Clarvida-Rutherford	1	0	0
Stanly	Stanly Behavioral Health	1	0	0
Union	McLeod Centers for Wellbeing	2	0	0
Wake	First Step Services, PLLC	1	0	0
	Morse Clinic of North Raleigh	1	0	0
	Southlight Healthcare-Garner Road	1	0	0
	Western Wake Treatment Center, LLC	1	0	0
Wayne	Goldsboro Comprehensive Treatment	2	0	0
Wilkes	Mountain Health Solutions-North	1	0	0
Wilson	Wilson Professional Treatment Center,	1	0	0
Wilson	Dixon Interactive Services, Inc.	1	0	0
	Wilson Professional Services Treatment Center	3	0	0
Total	**45 Facilities Reporting**	**59**	**3**	**0**

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

1. There were 3,057 Group Homes, Community-Based Psychiatric Residential Treatment Facilities (PRTFs), Day and Outpatient Treatment Facilities with a total of 10,625 beds as of June 30, 2025.
2. This indicates the number of death reports that were investigated.
3. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

Table A-3: Private Unlicensed Facilities[1]

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Alamance	Coastal Horizons Center – Region 2 TASC - Alamance	1	1	0
	RHA Health Services	1	1	0
Avery	Daymark Recovery Services, Inc.	1	1	0
Bladen	Coastal Horizons Center – Region 2 TASC - Bladen	1	1	0
	Coastal Horizons Mobile Clinic	1	1	0
Brunswick	Coastal Horizons Center Brunswick	1	1	0
	Coastal Southeastern United Care by Broadstep	1	1	0
	RHA Health Services	1	1	0
Buncombe	Helping You Heal	4	4	0
	Insight Human Services	1	1	0
	October Road Inc.	2	2	0
	RHA Health Services	1	1	0
	Swann AFL Home	1	1	0
Burke	A Caring Alternative LLC	1	1	0
	Skill Creations, Inc.	1	1	0
Cabarrus	Daymark Recovery Services, Inc.	1	1	0
Carteret	Coastal Horizons Center – Region 1 TASC - Carteret	1	1	0
	Easter Seals PORT Health	1	1	0
Catawba	Catawba Valley Behavioral Healthcare	5	5	0
	Support Incorporated	1	1	0
	Taylorsville Behavioral Health Services	1	1	0
Chowan	Carolina House	1	1	0
Clay	Appalachian Community Services	1	1	0
Cleveland	BH Cleveland	1	1	0
Columbus	Easterseals PORT Health	1	1	0
	Primary Health Choice	1	1	0
	RHA Health Services	1	1	0
	Southeastern Integrated Care, LLC	1	1	0
Cumberland	ACI Dungarvin	1	1	0
	Carolina Outreach	1	1	0
	Carolina Outreach, Fayetteville Site	1	1	0
	Coastal Horizons Center – Region 2 TASC - Cumberland	1	1	0
	Yelverton's Enrichment Services	1	1	0
Currituck	Pinnacle Home Care	1	1	0
Davidson	Daymark Recovery Services, Inc.	2	2	0
Duplin	Coastal Horizons Center – Region 1 TASC - Duplin	1	1	0
Durham	Coastal Horizons Center – Region 2 TASC - Durham	1	1	0

Table A-3: Private Unlicensed Facilities[1] - continued

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Edgecombe	Coastal Horizons Center – Region 1 TASC - Edgecombe	1	1	0
	Monarch	1	1	0
Forsyth	Daymark Recovery Services	2	2	0
	PQA Healthcare, Inc.	1	1	0
Gaston	Partners	1	1	0
	Partners Health Management	1	1	0
	Support Incorporated	1	1	0
Granville	Coastal Horizons Center – Region 2 TASC - Granville	1	1	0
Guilford	Akachi Solution	1	1	0
	Community Support Service	1	1	0
	Insight Human Services	2	2	0
	Monarch	1	1	0
	Psychotherapeutic Services	1	1	0
	Stephens Outreach Center, Inc.	1	1	0
	Strategic Interventions, LLC	1	1	0
Haywood	Appalachian Community Services	1	1	0
	Blue Ridge Health Services	1	1	0
Hertford	Coastal Horizons Center – Region 1 TASC - Hertford	1	1	0
Johnston	Coastal Horizons Center – Region 2 TASC - Johnston	2	2	0
Lee	Coastal Horizons Center – Region 2 TASC - Lee	1	1	0
Lincoln	Support Incorporated	1	1	0
Macon	Blue Ridge Health	1	1	0
Madison	RHA Behavioral Health	1	1	0
McDowell	Cedarbrook Assisted Living	1	1	0
Mecklenburg	Amara Wellness Services	1	1	0
	Carolina Outreach	1	1	0
	Colonial Care Home, Inc.	1	1	0
	Teaching Love and Care Counseling	1	1	0
	The SPARC Network	1	1	0
Moore	Moore Center	1	1	0
Nash	Educare Living dba Community	1	1	0
	Straight Walk Family Services	1	1	0
New Hanover	PAMH - AMI	1	1	0
	Coastal Horizons Center	2	2	0
	Bayada Home Health Care	1	1	0
Onslow	Coastal Horizons Center – Region 1 TASC - Onslow	1	1	0
	Easterseals PORT Health Jacksonville	1	1	0
	Trillium Health Resources	1	1	0

Table A-3: Private Unlicensed Facilities[1] - continued

County	Facility	Deaths Reported and Screened[2]	Death Reports Investigated[3]	Deaths Related to Restraints/ Physical Holds/ Seclusion[4]
Orange	UNC STEP	1	1	0
Pender	Coastal Horizons Center	1	1	0
Pitt	Coastal Horizons Center – Region 1 TASC - Pitt	1	1	0
	Pathways to Life, Inc.	1	1	0
Randolph	Amethyst Consulting & Treatment Solutions, PLLC	1	1	0
Richmond	Daymark Recovery Services	1	1	0
Robeson	Cape Fear Valley Hospital	1	1	0
	Southeastern Integrated Care	1	1	0
	Stephens Outreach Center	2	2	0
Rowan	Daymark Recovery Services, Inc.	1	1	0
Rutherford	Family Preservation Services of NC, Inc.	1	1	0
	SPARC Services and Programs	1	1	0
Scotland	Coastal Horizons Center – Region 2 TASC - Scotland	1	1	0
	Stephens Outreach Center	1	1	0
Stanly	Daymark Stanly Center	1	1	0
Surry	Easter Seals PORT Health ACTT	1	1	0
Transylvania	Helping You Heal	1	1	0
Wake	Carolina Outreach	1	1	0
	Coastal Horizons Center – Region 2 TASC – Wake	1	1	0
	Easterseals PORT Health	1	1	0
	Fernandez Community Center	1	1	0
	Monarch	2	2	0
Wake	North Carolina Recovery Support	1	1	0
	Southlight Healthcare	2	2	0
Wayne	Client First Behavioral Health	1	1	0
	Moment of Change Counseling Services, PLLC	1	1	0
	Monarch	1	1	0
	Waynesboro Family Clinic, P.A.	1	1	0
Wilkes	Daymark – Rowan Center	1	1	0
Wilson	PRIDE NC - Wilson	1	1	0
Yadkin	Daymark Recovery Services	1	1	0
Total	**106 Facilities Reporting**	**124**	**124**	**0**

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

1. This report includes private facilities not required to be licensed by G.S. § 122C. The number of unlicensed facilities in the state is unknown as they are not licensed or state-operated. Rule 10A NCAC 27G .0604 requires each provider agency to self-report an incident based on the information learned if an individual was receiving services in the last 90 days before the death occurred. Since one individual may receive services from more

than one provider, the total count may not be an unduplicated count of the number of deaths by suicide, accident, homicide or violence. The total number of deaths that occurred in unlicensed facilities during SFY25 that met the reporting requirement for this report is 124.

2. Information regarding the actual cause of death for many cases is obtained from Death Certificates and/or Medical Examination reports. This information generally takes over 12 months to obtain. Providers use the term “unknown” to report deaths the cause of which is not known. Since the timeframe for this report is July 2024-June 2025, providers have not received copies of the death certificates or medical examiner's reports for some of the deaths submitted during this time period.
3. All deaths reported by unlicensed facilities are reviewed by the responsible LME/MCO providing oversight, and the findings are discussed with DMH/DD/SUS. If problems are identified, the LME/MCO (now Tailored Plan) can investigate and/or require the facility to develop a plan for correcting these problems. The Tailored Plan (TP) then monitors implementation of the plan of correction.
4. No findings in this column indicate that there were no deaths related to the use of restraint/seclusion.

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

Tables B-1 through B-4 provide data regarding the number of physical restraints, physical holds, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2024 and ending June 30, 2025. Each table represents a separate licensure category or type of facility, shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits and administrative desk reviews conducted by DHHS and LME/MCO staff for initial, renewal and change-of- ownership licensure surveys, follow-up visits and complaint investigations. A total of 2,860 licensure surveys, 1,632 follow-up visits and 1,901 complaint investigations were conducted during the year. An exact number of facilities reviewed cannot be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Adult Care Homes

County	Facility Cited	Citations
Burke	Morganton Long Term Care	1
Cleveland	Kings Mountain Memory Care Center	1
Durham	Seasons at Sout Point	1
	The Enclave at Shelburn	1
Onslow	Light House Village	3
Total	**5 Facilities Cited**	**7**

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities

County	Facility Cited	Citations
Alamance	Just In Time Youth Services II	2
	Lillie's Place	1
	McPherson Group Home	1
	New Beginnings Group Home	1
Alexander	Luca's Hope III	1
Buncombe	Asheville Academy	1
	Caiyalynn Burrell Crisis Center	1
	Radiance	1
	Riverview Group Home	1
	Western Carolina Treatment Center	1
Cabarrus	Adrienne's House	2
	APOMO-Patterson Road	1
	Brookwood	1
	Cabarrus Group Home	1
	Cabarrus Group Home #2	1
	Harmony House	2
	Transcending Heights, LLC	1

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities - continued

County	Facility Cited	Citations
Chatham	Carolina House	1
	Chatham County Group Home #3	1
Cleveland	Adventure House	1
	Lakeview House	2
Columbus	Whiteville Group Home	1
Cumberland	C.R.E.S.T. Group Home #2	1
	C.R.E.S.T. Group Home #3	1
	C.R.E.S.T. Group Home #5	1
	Elite Care Services at Middle Road	2
	Myrover-Reese Fellowship Home	1
	The Loving Home, Inc.	4
	The Loving Home, Inc. #4	2
Durham	BAART Community Healthcare	1
	Dedove Homes, Inc.	1
	Liasions Community Care, LLC	1
	The Sherman House	1
	TLC Adult Group Home	1
Edgecombe	Dorothy's Place	1
	Open Arms Family Services, Inc.	1
Forsyth	Johnson & Johnson Health Care Group	1
	NOA Human Services II, Inc.	1
	NOA Human Services III, Inc.	1
	NOA Human Services, Inc.	3
	YWCA-Hawley House	1
Franklin	Americares Health Services (dba) House of Blessings	1
Gaston	Freedom	1
	Monarch dba UMAR-Hoffman	1
	New Home NC 1, Inc.	1
	New Hope Home	1
	Positive Point	1
	Saving Others Until Life Stops LLC	1
	The Flynn Fellowship Home of Gastonia, Inc.	1
Graham	The Twin Oaks	1
Granville	Learning Services Corporation-Transitional Living Center	1
	Learning Services Neurobehavioral Institute 2	1
Greene	Edwards Group Home #2	1
Guilford	Adolescent Alternatives	2
	Agape Home Living Care, LLC	2
	Bears Creek Home	1
	McCrary Home	1
	Person Centered Care	1
	Sedrick's Place	2
	Servant's Heart	1
Harnett	Freedom Care Services, LLC #6	2
Haywood	The Balsam Center Adult Recovery Unit	1
Iredell	James Farm Home	1
Johnston	Freedom Care Services, LLC-King Mill	2
Lee	Lee County Group Home II	1
Lenoir	Larkspur House	2
Lincoln	VIRTUE, Inc. Meantime VI	1

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities - continued

County	Facility Cited	Citations
Martin	New Beginnings With Love, Inc. Adult Facility	1
McDowell	Berrybranch Farm Family Home	1
	Lebrun Hone	2
	Quality Adult Care	1
Mecklenburg	Alexander Youth Network-Charlotte Day Treatment	1
	Bonnie' Home for Youth	2
	Brenda Gibson Home	1
	Brite Horizon	1
	Community Treatment Alternatives I	1
	Community Treatment Alternatives II	2
	Harmony Recovery Center	1
	Mary McCullough Home	1
	Neuro-Restorative-Sardis	1
	New Foundation	1
	Next Level Family Solutions, LLC	1
	SECU Youth Crisis Center, A Monarch Program	1
Moore	Bethesda, Inc.	1
	The Bethany House, Inc.	1
Nash	Brockington's Home Healthcare	1
	T,Y,L. (Thank You Lord)	1
Northampton	Family Advantage LLC	2
Onslow	McCullen Home	1
Pasquotank	JK2C LLC DBA BHG Elizabeth City Treatment Center	1
Person	Sharpe and Williams Eden's Home #1	1
Richmond	Creative Helping Hands, LLC	2
Robeson	First Image Inc. Grace Court	1
	Wilkinson Family	2
Rowan	Life-Way Homes	1
	New Beginnings Residential Services	1
	The Learn More Enrichment Program	2
	UCU Residential Services LLC	2
Rutherford	All in One Adult Day Services	1
	Foothills at Red Oak Recovery	2
Union	Southwood Place Group Home #1	1
Vance	Brightside Homes IV	1
	Higher Aspiration Behavioral Health Care, LLC	3
Wake	Absolute Home and Community Services 2	1
	Absolute Home-Apex	1
	Access Health System 2	1
	Care One Homes	1
	Eagle PSR	1
	Etta's Residential	1
	Mary's Manor II	1
	Novella's Place, Inc. 1	1
	Rose Home	2
	Skywell Health, Inc.	1
	Twinkle-Star Home Care LLC	1
Wayne	Dontaes House	2
	The Vaughan-Family Home 1	2

Table B-2: Private Group Homes, Outpatient and Day Treatment Facilities - continued

Wilkes	Sparta Road Home	1
Wilson	Grace 4 the Youth, LLC	2
	Wilson County Group Home #4	1
Total	**120 Facilities Cited**	**152**

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

County	Facility	Citations
Cumberland	Cape Fear Valley Medical Center	1
Durham	Duke Regional Hospital	1
Rutherfordton	Rutherfordton Regional Hospital	2
Wayne	UNC Health Wayne	1
Total	**4 Facilities Cited**	**5**

No citations were issued to the following types of facilities: Community-Based ICF-IIDs, Private Unlicensed Facilities, State Alcohol and Drug Abuse Treatment Centers, State Developmental Centers (ICF-IIDs), State Neuro-Medical Treatment Centers, State Psychiatric Hospitals or State Residential Programs for Children.