Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-153	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACS VILLAGE LLC PHASE II	21 LANDON LANE THOMASVILLE, NC 27360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on February 13, 2026. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000	RECEIVED APR 02 2026 DHSR-MH Licensure Sect	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.). • Management meeting discussion on the deficiency. Advised our team of the expectations to make updates within the 24-hour time frame even if the discharge date is dated for the following day or day of. Our team updated the consumers PCP during the inspection. Due the consumer dates of discharge fluctuating the goal wasn't added as this was a new behavior of the consumer after being in placement for more than 6 months. Indicate what measures will be put in place to prevent the problem from occurring again. •Our management team understands that when a consumer displays a new behavior regardless of the discharge date of reunification with biological family/ placement the behaviors must be documented in the PCP. Indicate who will monitor the situation to ensure it will not occur again. •Our directors and lead QP will take ownership in monitoring to ensure this situation will not occur again. Indicate how often the monitoring will take place. •Lead management and Directors will monitor the situation as needed based on the consumers being serviced actions and behaviors.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LLC Creator/ Assistant Director	03/30/2026

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment goals and strategies to address the needs of 1 of 3 clients (Client #1). The findings are: Review on 2/13/26 of Client #1's record revealed: -Admission date of 10/10/25. -Diagnoses of Major Depressive Disorder, Attention Deficient-Hyperactivity Disorder and Oppositional Defiant Disorder. -Age: 14 years. -1/14/26 Treatment Plan had no goal or strategies to address Client #1's elopement behavior. Review on 2/13/26 of an internal incident report dated for Client #1 revealed: -On 1/31/26 at 3:24 pm, Client #1 walked off from the facility and was returned by law enforcement 20 minutes later. -Client #1 was absent from the facility for approximately 30 minutes. -Staff #2 called law enforcement after Client #1 eloped from the facility. Interview on 2/12/26 with Client #1 revealed: -She eloped from the facility "after the ice storm and before the big snowstorm." -She walked for 15 minutes toward a convenience store located near an interstate and decided to return to the facility when she was returned to the facility by law enforcement.	V 112		

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V 112	Continued From page 2 -"I was gone 30 minutes." -"I was mad and was trying to make a point when I walked away." Interview on 2/12/26 with Staff #2 revealed: -Client #1 walked away from the facility after her mother said she forgot about her visit. -"I thought she (Client #1) was going outside to play in the snow again but she walked off." -"I called the police after I called the Level III (sister facility) and found out she did not walk up there." -Client #1 went to a convenience store near an interstate, was gone from the facility about 30 minutes, and was returned to the facility by law enforcement. Interview on 2/13/26 with the Owner/Director revealed: -"I just went into her (Client #1)'s plan and did an AWOL (Away without Leave) goal and talked to her Social Worker about adding the goal."	V 112	Our management team understand that although the consumer wasn't gone more than 20 minutes and was returned without harm due to law enforcement being called an IRIS report is required. The report was submitted on the day of the deficiency citing. Our lead management will take ownership including (lead QP and Directors) to ensure that any level II incidents will be reported to the IRIS system. Management will monitor this situation as needed based on the consumers actions and behaviors inside the facility.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be	V 114	Directors received the recommendations for the deficiency citing. Director advised all QPs and House managers of the recommendations to ensure the accuracy of the monthly drills. We have provided YouTube training on methods for drills. Since our visit our facility now actively role plays each shift each disaster monthly. House managers and QPs will monitor the accuracy of the drills monthly with the supervision of the Director if needed for additional training. We will continue to provide the documentation of the drills and details of the ambulatory consumers being served.	

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V 114	Continued From page 3 repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to accurately document fire and disaster drills were held for each shift. The findings are: Review on 2/13/26 of the fire and disaster drill log revealed: -1st quarter (January 2025-March 2025), 2nd quarter (April 2025-June 2025), 3rd quarter (July 2025-September 2025) and 4th quarter (October 2025-December 2025) had fire and disaster drills documented at the same time in each quarter and it could not be determined which drill was a fire drill and which drill was a disaster drill. Interview on 2/12/26 with Client #1 revealed: -"We do them (fire drills). Staff sets off an alarm and we go out to the mailbox." -"I can't remember" in response to whether disaster drills were practiced. -"I know staff talk to us about what to do if a tornado happens." Interview on 2/12/26 with Client #2 revealed: -"We go to the mailbox" in response to whether fire drills were practiced. -"We just go to the mailbox" in response to whether disaster drills such as tornados were practiced. Interview on 2/12/26 with Client #3 revealed: -Confirmed fire drills were practiced, and the meeting place was at the mailbox.	V 114		

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V 114	Continued From page 4 -"We just do fire drills but we're given instructions what to do for a bomb threat or people crash (medical emergency) out." Interview on 2/13/26 with Staff #1 revealed: -Fire and disaster drills were practiced once a month. -A "fake smoke" was used to sound the alarm for a fire drill and the meeting place for staff and clients was at the mailbox. -The meeting place for disaster drills such as a tornado drill was the bathroom. Interview on 2/12/26 with Staff #2 revealed: -There were 3 shifts operated at the facility during the weekday: -1st shift was from 7:00 am-3:00 pm. -2nd shift was from 3:00 pm- 11:00 pm. -3rd shift was from 11:00 pm- 7:00 am -Fire drills were conducted once a month and at different times. -"We talk about disasters and make sure what we would do." Interviews on 2/13/26 with the Owner/Director and the Owner/Assistant Director revealed: -They were aware fire and disaster drills were to be held each quarter and repeated for each shift at the Level III facility but were not aware this was to occur at the Level II facility. -They would ensure the fire and disaster drills were conducted at separate times and repeated for each shift with accurate documentation for each drill.	V 114		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367		

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V 367	Continued From page 5 CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:	V 367		

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V 367	Continued From page 6 (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level 2 incidents within 72 hours of becoming aware of the incident. The findings are: Review on 2/13/26 of an internal incident report dated for Client #1 revealed: -On 1/31/26 at 3:24 pm, Client #1 walked off from the facility and was returned by law enforcement 20 minutes later. -Staff #2 called law enforcement after Client #1 eloped from the facility. Interview on 2/12/26 with Client #1 revealed: -She eloped from the facility "after the ice storm and before the big snowstorm." -She walked for 15 minutes toward a convenience store located near an interstate and was returned to the facility by law enforcement. -"I was gone 30 minutes." Interview on 12/13/26 with the Qualified Professional (QP) revealed: -Client #1's incident report on 1/31/26 was identified as a Level 2 because the facility was a Level 2 facility. Interview on 12/13/26 with the Owner/Director revealed: -Client #1's incident report on 1/31/26 was a Level 2 report and should have been entered into the North Carolina Incident Response	V 367		

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V 367	Continued From page 8 Improvement System (IRIS). -She would follow up with the QP to ensure all Level 2 reports were submitted into IRIS to notify the Local Management Entity/Managed Care Organization within the required time.	V 367		