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
	MHL060015	A. BUILDING: ______ B. WING ______	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVINS, INC.	3523 NEVIN ROAD CHARLOTTE, NC 28269

(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 and complaint survey was completed on 06/26/2025. The complaint was unsubstantiated (Intake #NC00229120). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities This facility has a current census of 22. The survey sample consisted of audits of 3 current clients.	V 000	V108 – Personnel Training Requirements 1. Correction All current staff will complete required trainings (MH/DD/SA, CPR, First Aid, Infection Control) within 100% compliance. Completion Date: June 1, 2026	6/1/26
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108	2. System Implementation A training compliance log will be implemented and maintained electronically. The log will include: Employee name and position Required trainings Date completed and expiration date Trainer name and credentials Employee and supervisor signatures Training certificates will be issued and retained in personnel files. Completion Date: June 1, 2026 3. Responsibility The HR Director is responsible for ensuring all training compliance. Completion Date: June 1, 2026	6/1/26 6/1/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

4/14/26

Division of Health Service Regulation

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V 108	Continued From page 1 techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 audited Staff (#1 and #2) and 1 of 1 Former Staff (FS #8) had the required training to meet the MH/DD/SA needs of clients. The findings are: Review on 06/11/2025 of Staff #1's personnel record revealed: -Hire date 7/10/2023. -Job title Direct Support Staff (DSP). -No MH/DD/SA training. Review on 06/11/2025 of Staff #2's personnel record revealed: -Hire date 01/03/2024. -Job title DSP. -No MH/DD/SA training. Review on 06/11/2025 of FS #8's personnel record revealed: -Hire date 07/01/1999. -Job title Team Lead. -No MH/DD/SA training. Interview on 06/11/2025 with FS #8 revealed:	V 108	4. Monitoring The HR Director will audit 100% of training records weekly for 60 days. Any deficiencies will be corrected within 48 hours. After 60 days, audits will occur monthly. Completion Date: June 1, 2026 5. Enforcement Employees without required training will not be permitted to work until compliance is verified. Completion Date: June 1, 2026	6/1/26 6/1/26

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V 108	Continued From page 2 -"Yes. I had several trainings throughout the years. I can not recall at the moment (if she had client specific training)." Interview on 06/26/2025 with the Clinical Director revealed: -"I thought I had emailed it (MH/DD/SA Trainings) to you. The clinical team will ensure that the client specific trainings are readily assessable in the staff training files."	V 108	V132 – Neglect/Exploitation & Incident Reporting 1. Correction All staff will be retrained within 15 business days on abuse/neglect reporting, HCPR notification requirements, and 24-hour/5-day reporting timelines.	6/1/26
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).	V 132	Completion Date: June 1, 2026 2. System Implementation A standardized Incident & Allegation Reporting Protocol will be implemented, including: Immediate supervisor notification 24-hour reporting requirement HCPR notification process Department reporting within 5 working days 3. A Clinical Review Form will include: Root cause analysis Staff actions and performance Corrective actions Follow-up plan A Qualified Professional (QP) or Clinical Director will review all incidents. Completion Date: June 1, 2026	6/1/26 6/1/26

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V 132	Continued From page 3 Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to report within 5 working days, the results of the investigation to the Department. The findings are: Review on 06/11/2025 of the facility's records revealed: -There was no HCPR notification for the allegation that Former Staff (FS) #8 slapped Client #1 in the face on 05/20/2025. -There was no evidence that the results of the investigation for the above 05/20/2025 incident was reported to the Department within 5 days. Reviews between 06/11/2025-06/25/2025 of the North Carolina Incident Response Improvement System (IRIS) from 03/01/2025 - 06/09/2025 revealed: -There was no IRIS report submitted for FS #8 slapped Client #1 in the face on 05/20/2025. -There was no HCPR notification for the allegation that FS #3 slapped Client #1 in the face on 05/20/2025. -There was no evidence that the results of the investigation for the above 05/20/2025 incident was reported to the Department within 5 days. Review on 06/11/2025 of an IRIS Report	V 132	4. Monitoring All incidents will be reviewed within 24–48 hours. The Program Manager or designee will audit incident reporting weekly for 60 days. Deficiencies will be corrected within 24 hours. Completion Date: June 1, 2026 5. Enforcement Failure to report incidents timely will result in disciplinary action and retraining. Completion Date: June 1, 2026	6/1/26 6/1/26

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V 132	Continued From page 4 unsubmitted and dated 05/20/2025 for Client #1 revealed: -The incident occurred on 05/20/2025. -There was no submit date. -The provider learned of the incident on 05/20/2025. -Incident Information: "Yes" specified for Allegation against facility. "No" specified for will this allegation require a submission of a consumer incident report. -There was no HCPR Facility Allegation section completed. -There was no resident abuse box checked. -FS #8 was "NOT" identified or accused of resident abuse. -Provider Comments dated 06/09/2025: "On or prior to May 22, 2025, [Client #1] reported to his mother that staff member [FC #8] struck him in the face. His mother subsequently texted [Clinical Director], regarding this allegation. Upon receiving the text, [Clinical Director] contacted [Client #1]'s mother via phone. During their conversation, [Client #1]'s mother reiterated that [Client #1] had told her [FS #8] hit me in the face." Interview on 06/10/2025 with the Clinical Director (CD) revealed: -"I did not know that we had to do that (report the allegation to HCPR)." Interview on 06/26/2025 with the CD revealed: -"The clinical team will ensure that matters that need to be reported within 24 hours will be done within that time frame."	V 132		
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	V367 – Incident Reporting Requirements 1. Correction All staff will be retrained within 5 business days on incident reporting requirements, including IRIS submission timelines and documentation standards. Completion Date: June 1, 2026 2. System Implementation A standardized Incident Reporting Checklist will be implemented, including: Date/time of incident Description and classification Individuals involved Immediate actions taken IRIS entry within required timeframe All incidents must be reported to supervisors immediately and entered into IRIS within required timelines. Completion Date: June 1, 2026 3. Responsibility The Clinical Director and Program Manager will ensure compliance with reporting requirements. Completion Date: June 1, 2026	6/1/26 6/1/26 6/1/26

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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	4. Monitoring The Clinical Director or designee will review 100% of incidents within 48 hours. Corrections will be made immediately. Completion Date: June 1, 2026 5. Enforcement Failure to report incidents appropriately will result in disciplinary action. Completion Date: June 1, 2026	6/1/26 6/1/26

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V 367	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report Level III incidents in the Incident Response Improvement System (IRIS) within 24 hours of becoming aware of the incident. The findings are: Reviews between 06/11/2025-06/25/2025 of the North Carolina Incident Response Improvement System (IRIS) from 03/01/2025 - 06/09/2025 revealed: -There was no IRIS report submitted for the allegation that Former Staff (FS) #8 slapped Client #1 in the face on 05/20/2025. Review on 06/11/2025 of an IRIS Report unsubmitted and dated 05/20/2025 for Client #1 revealed: -The incident occurred on 05/20/2025. -There was no submit date. -The provider learned of the incident on 05/20/2025. -Incident Information: "Yes" specified for Allegation against facility. "No" specified for will this allegation require a submission of a consumer incident report. -There was no HCPR Facility Allegation section completed. -There was no resident abuse box section. -FS #8 was "NOT" identified or accused of resident abuse. -Provider Comments dated 06/09/2025: "On or prior to May 22, 2025, [Client #1] reported to his	V 367		

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V 367	Continued From page 8 mother that staff member [FC #8] struck him in the face. His mother subsequently texted [Clinical Director], regarding this allegation. Upon receiving the text, [Clinical Director] contacted [Client #1]'s mother via phone. During their conversation, [Client #1]'s mother reiterated that [Client #1] had told her [FS #8] hit me in the face." -Attestation box "Not" checked. Interview on 06/26/2025 with the Clinical Director revealed: -" The clinical team will ensure they have been properly trained on the North Carolina IRIS system and reporting standards."	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility staff failed to ensure the facility and its grounds were maintained in a clean, safe, attractive and orderly manner. The findings are: Observation on 06/13/2025 at approximately 11:00 am revealed: Entry way: -There was a mild smell of gas upon entering the building. Entry ceiling: -There were 12 light grey and brown stained square ceiling panels.	V 736	V736 – Physical Environment & Maintenance 1. Correction All identified environmental concerns (gas odor, plumbing, ceiling damage, sanitation issues) will be corrected within 14 days. Deep cleaning and repairs will be completed. Completion Date: June 1, 2026 2. System Implementation A Facility Maintenance & Inspection Log will be implemented, including: Date of inspection Areas inspected Issues identified Corrective actions taken All maintenance work will be supported with documentation (receipts, invoices, etc.). Completion Date: June 1, 2026	6/1/26 6/1/26

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V 736	Continued From page 9 -There were 4 broken light grey and brown stained square ceiling panels. -There was 1 cracked light grey-stained square ceiling panels. -There were 3 slightly bulged light grey-stained square ceiling panels. -There was 1 light grey-stained square ceiling panel with chipped paint pieces. -There was 1 white square ceiling panel with a tennis ball sized circular hole in the middle. -There were 2 square shaped holes with missing ceiling panels. Office ceiling near the window: -There was 1 greyish-brown bulging ceiling panel. -There was 1 ceiling panel with 2 dark grey medium sized circular rings. -There was 1 dark grey on the side of the air vent. Kitchen: -There was a 5-inch cracked floor tile near the doorway. -There was a sink with reddish-brown rust in and around the drain. -There was reddish-brown rust and white calcium stains covered the bottom of the sink. -There was reddish-brown rush and white calcium stains on the floor under the sink near the drain. -There were 2 black lids covered in debris. -There were approximately 15 serving utensils, 5 metal trays, 5 bowls, and a pot stored on the counter. -There was an inoperable refrigerator with plastic dollar tree bags, a plastic container top, cord board boxes, 10 cans of beans, condiments, pancake mix, syrup, peanut butter, cooking oil, and cord board appliances boxes. Restrooms: -There were "Out of Order" and "Please do not	V 736	3. Responsibility The Program Director is responsible for ensuring facility compliance. Completion Date: June 1, 2026 4. Monitoring Facility inspections will be conducted weekly for 60 days. Issues will be corrected within 48 hours. Completion Date: June 1, 2026 5. Enforcement Unsafe conditions will result in immediate corrective action and removal of affected areas from use until resolved. Completion Date: June 1, 2026	6/1/26 6/1/26 6/1/26

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V 736	Continued From page 10 use (01/23/2024)" signs on the female and male restroom doors. -There were "Caution, Do Not Enter" signs on the female and male restroom doors. Observation on 06/25/2025 at approximately 12:30 pm revealed: -There was a toilet with running water. Interview on 6/25/25 with Client #6 revealed: -"Yes, It just started (gas smell). -"It (kitchen) was like that when I came here." -"I don't know (ceiling had been in the current condition). Water does come down." -Did not know about the restrooms. Interview on 6/25/25 with Staff #3 revealed: -"I couldn't tell you how long (the ceiling has been in the current condition).It doesn't drip; it just looks bad." -"I smelled it (gas) a couple of times, but it is not strong. It's been a while since I smelled it." -The bathrooms have been out of order for a year. -"The lines in the ground is a problem and its expensive to fix." -"It has been in that state as long as I can remember (kitchen). We don't use it. It has not been in use for 10 years. I guess its sanitary, it just looks rough." Interview on 6/25/25 with Staff #4 revealed: -"It (ceiling) may have gotten worse since the storms last year. I can't say when it started." -"I have smelled gas before, but I can't remember when." -"The kitchen has been out of order for years. The fire Marshall came last year or the year before and said we were not in compliance, and we needed to remove the gas stove. It was left to	V 736		

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V 736	Continued From page 11 whoever to maintain and it is not maintained. If I had to guess, its been like this for maybe 5 or 6 years. Clients do not use it." -"Maybe a year or 2 (restrooms out of order). I think its something with plumbing that is the problem..." Interview on 6/25/25 with Staff #5 revealed: -"Before it was used to serve food and it was in good condition. It has been in this condition for a while now. I would say for more than 7 years." -The kitchen is not by the clients. -Restrooms have been out of order since 2023. -"As far as I heard, the water was backing up and it would cost too much money to fix. It's not filthy, its just issues with the plumbing." Interview on 6/24/2025 with the Clinical Director revealed: -"Since I got here in 02/13/2023 (the kitchen has been in the current condition)." -"I have been told that the kitchen has not been in use for the past 15 years." -"The bathroom on the right, the participants were using it, and it got backed up. The plumbers came out in 2024 and the quote for the work to be done was over $30,000." -"We were told they would not be used and there were adequate bathrooms for the participants." Interview on 6/26/2025 with the Clinical Director revealed: "The only information that I have is that is a quote was provided and that there is plan to have that work completed by August 15, 2025, but I believe the work is going to start the end of July (2025)."	V 736		
V 738	27G .0303(d) Pest Control	V 738		

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
	MHL060015	A. BUILDING: ____ B. WING ____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEVINS, INC.	3523 NEVIN ROAD CHARLOTTE, NC 28269

(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 738	Continued From page 12 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observation and interviews, the facility was not kept free from insects. The findings are: Observation on 06/13/2025 at approximately 11:12 am revealed: -There was a dead roach under the chair in the kitchen. -There was a dead roach in the kitchen sink. -There were 2 dead roaches under the kitchen sink near the drain. -There was matter similar to rodent droppings on the counter next to kitchen sink. Observation on 06/25/2025 at approximately 12:30 pm revealed: -12 dead roaches on the restroom floor. Interview on 6/25/25 with Staff #6 revealed: -"No roaches, only water bugs." -There were no rodents. Interview on 6/25/25 with Staff #7 revealed: -"There are no roaches, but there are big water bugs." -"I see them often." -"I have not seen any (rodents) per say." Interview on 06/13/2025 with the Qualifed Professional revealed: -"We have roaches."	V 738	V738 – Pest Control 1. Correction A licensed pest control company will conduct a full inspection and treatment within 5 business days. All affected areas will be cleaned, sanitized, and sealed. Completion Date: June 1, 2026 2. System Implementation A Pest Control Log will be implemented, including: Inspection dates Findings Treatment provided Follow-up actions Food storage procedures will be reinforced. Sealed containers will be used. Daily cleaning logs will be maintained. Completion Date: June 1, 2026 3. Responsibility The Program Director or designee will oversee pest control compliance. Completion Date: June 1, 2026	6/1/26 6/1/26 6/1/26

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V 738	Continued From page 13 -"We have rodents." Interviews on 06/25/2025 and 6/26/2025 with the Clinical Director revealed: -"When we see them (roaches), we sweep them. We sweep and mop daily and vacuum once a week." -"I have never seen a mouse, but I have had staff report seeing mice. It was reported to me twice." -"Nevin's will continue to have the pest and termite come out on a monthly basis and if we notice that there appears to be more pests or rodents we will increase the services to ensure that the environment is free of pests and rodents as much as possible."	V 738	4. Monitoring Environmental checks will be conducted weekly for 60 days, then monthly. Pest control services will occur at least bi-monthly. Completion Date: June 1, 2026 5. Enforcement Any signs of pest activity will trigger immediate treatment and corrective action. Completion Date: June 1, 2026	6/1/26 6/1/26