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
	MHL032-414	A. BUILDING: _____ B. WING _____	09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAK OUT, LLC	412 PINELAND AVENUE DURHAM, NC 27704

(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 September 24, 2021. The complaint was unsubstantiated (intake #NC00181123). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27 G .5600C Supervised Living for Adults with Developmental Disabilities	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nadia Waitts — TITLE: Licensee — (X6) DATE: 10/11/2021

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an assessment was completed prior to the delivery of services affecting one of three audited clients (#1). The findings are: Review on 9/23/21 of Client #1's record revealed: -Admission date of 9/30/20.. -Diagnoses of Hypertension; Cerebella Hypoplasia; Autism Spectrum; Bipolar Disorder; Tobacco Dependence; Sickle Cell Trait, Hyperlipidemia. -There was no evidence of an admission assessment completed for Client #1 prior to the delivery of services. Interview on 9/24/21 with the Qualified Professional revealed: -She was responsible for completing the admission assessment. -She reported that she had been feeling pressured by both the hospital and the managed care organization to take Client #1 in and she had forgotten to complete the admission assessment. -She confirmed that the admission assessment for Client #1 was not inside his file.	V 111	An assessment was completed by the Qualified Professional on 09/15/2020 placed in Consumer's file on 09/27/21	09/27/21
V 121	27G .0209 (F) Medication Requirements	V 121		

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V 121	Continued From page 2 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to obtain drug reviews every six months for three of three clients (#1, #2 and #3) who received psychotropic drugs. The findings are: Review on 9/23/21 of Client #1's record revealed: -Admission date of 9/30/20.. -Diagnoses of Hypertension; Cerebella Hypoplasia; Autism Spectrum; Bipolar Disorder; Tobacco Dependence; Sickle Cell Trait, Hyperlipidemia. -Physician's order dated 8/25/21: -Olanzapine 5 milligram (mg), one tablet at bedtime. -Physician's order dated 8/27/21: -Divalproex Sodium 500 mg, one tablet daily. -Divalproex Sodium 250 mg, three tablets at bedtime. -The July, August and September 2021 Medication Administration Record (MAR)	V 121		

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V 121	Continued From page 3 revealed Client #1 was administered the above medications daily. -There was no evidence of a psychotropic drug review for Client #1's medications in the last six months. Review on 9/23/21 of Client #2's record revealed: -Admission date of 7/7/19. -Diagnoses of Moderate Intellectual Disability; Unspecified Mood Disorder; Impulse Control Disorder. -Physician's order dated 6/11/21. -Lorazepam 0.5 mg, Two tablets twice a day. -Risperidone 0.5 mg, One tablet twice a day. -The July, August and September 2021 Medication Administration Record (MAR) revealed Client #2 was administered the above medications daily. --There was no evidence of a psychotropic drug review for Client #2's medications in the last six months. Review on 9/23/21 of Client #3's record revealed: -Admission date of 7/22/16. -Diagnoses of Disruptive Mood Disorder; Autism Spectrum Disorder; Intellectual and Developmental Disorder; Mild. -Physician's order dated 8/12/21: -Fluoxetine 20 mg, One capsule once a day -Amphetamine Salt Com 20 mg, One tablet three times a day. -Divalproex Sodium 500mg, One tablet three times a day. -Benztropine Mesylate 0.5 mg, One tablet twice a day. -Risperidone 4 mg, One tablet twice a day. -The July, August and September 2021 Medication Administration Record (MAR) revealed Client #3 was administered the above medications daily.	V 121		

Division of Health Service Regulation

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V 121	Continued From page 4 -There was no evidence of a psychotropic drug review for Client #3's medications in the last six months. Interview on 9/24/21 with the Qualified Professional revealed: -Pharmacist for the group home had stopped coming out to the home to do the medications review when COVID-19 pandemic started. -She would have pharmacist review the client's psychotropic medications. -She confirmed the six months psychotropic drug review for Clients #1, #2 and #3 were not completed.	V 121	All clients medications were renewed by Gurley's Pharmacy on 09/30/2021. See attached	09/30/21
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 observation and interview, the facility failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are: Observation on 9/23/21 at 11:00 am of the Living Area revealed: -There was a crack between the edge of the wall and the ceiling that stretched from the living area all the way to the end of the hallway.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BREAK OUT, LLC	412 PINELAND AVENUE DURHAM, NC 27704

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V 736	Continued From page 5 Observation on 9/23/21 at 11:05 am of Client #2's bedroom revealed: -There was an unfinished patched up work on the ceiling. It was not sanded down and painted over. Observation on 9/23/21 at 11:20 am of the outside area of the home revealed -Outside window frames were starting to show rot and needed to be painted over. -Section of the roof by the entrance had mildew/mold on top of the ceiling. -There was some rotten wood observed on the ceiling part in front of the house. -Front storm door was dirty/stained. -One of the sidings on the right side of the house was coming off. Interview on 9/24/21 at 11:00 am with the Qualified Professional revealed: -Facility owned the home. -They were responsible for maintaining the home. -They recently had a storm go by and created some damages to the roof. -They had fixed some of the damages, but still had some other things to complete inside the home. -She was unaware on what may had caused the crack on the wall that stretched from living area to the end of the hallway. -She confirmed the facility failed to ensure grounds were maintained in a clean, safe and attractive manner.	V 736	The repairs were made on 09/29/2021. Repairs were made on 09/29/2021. A new roof was put on the home on 10/05/2021. See attached pictures of repairs.	09/29/21 09/29/21 10/05/21 09/29/21 10/05/21

GURLEY'S PHARMACY
114 WEST MAIN STREET
DURHAM, NC 27701

Medication Therapy Management Program

Date- 9/30/21

North Carolina Medicaid --- MEDICATION THERAPY MANAGEMENT PROGRAM
Medication Review Communication Form

To:(Primary Care Physician): _____ Date: 9/30/21
Fax: _____ Phone: _____

From (Pharmacy): GURLEY'S PHARMACY Phone: 919-688-8978 Fax: 919-688-8072

Patient Name: [redacted] Medicaid ID#: _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. Please provide a response for every recommended action.

Medication Related Issues Identified	Recommended Plan of Action	PCP Response and Comments
__ Medication Dose/Frequency/Duration __ Adverse Drug Event __ Therapeutic Duplication __ Drug/Drug Interaction __ Drug/Disease Interaction __ Drug/Food Interaction __ Discontinued Medication __ Medication Compliance __ Contraindication __ Drug Allergy __ Other: _____	1. No recommendations at this time. 2. 3. 4.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment: 3. Accept Recommendation __ Yes __ No Comment: 4. Accept Recommendation __ Yes __ No Comment:

Cost-Effective Recommendations		
__ Dose Consolidation __ Dose Optimization __ Generic Alternative __ Other: _____	1. 2.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment:

Patient Specific Education Provided: _____

Comments: Reviewed medications, dosage, & goals of therapy - no concerns

Time Spent with Patient: _____ Scheduled plan for follow-up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: 9/30/21 RPh Reviewer: [signature] PA

Date: _____ Primary Care Physician: _____

DARLEY'S PHARMACY
114 WEST MAIN STREET
DURHAM, NC 27701

Medication Therapy Management Program

Date: 9/30/21

North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM
Medication Review Communication Form

To (Primary Care Physician): _____
Fax: _____

Date: 9/30/21
Phone: _____

From (Pharmacy): DARLEY'S PHARMACY
Phone: 919 688 8178 Fax: 919 688 8072

Patient Name: [redacted]

Medicaid ID#: _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. Please provide a response for every recommended action.

Medication Related Issues Identified	Recommend Plan of Action	PCP Response and Comments
__ Medication Dose/Frequency/Duration __ Adverse Drug Event __ Therapeutic Duplication __ Drug/Drug Interaction __ Drug/Disease Interaction __ Drug/Food Interaction __ Discontinued Medication __ Medication Compliance __ Contraindication __ Drug Allergy __ Other: _____	1. No recommendations at this time. 2. 3. 4.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment: 3. Accept Recommendation __ Yes __ No Comment: 4. Accept Recommendation __ Yes __ No Comment:

Cost Effective Recommendations		
__ Dose Consolidation __ Dose Optimization __ Generic Alternative __ Other: _____	1. 2.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment:

Patient Specific Education Provided: _____

Comments: Reviewed medications, dosage, goals of therapy - no concerns

Time Spent with Patient: _____ Scheduled plan for follow up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: 9/30/21 RPh Reviewer: Jennifer Brendock

Date: _____ Primary Care Physician: _____

GURLEY'S PHARMACY
114 WEST MAIN STREET
DURHAM, NC 27701

Medication Therapy Management Program

Date: 9/30/21

North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM
Medication Review Communication Form

To: (Primary Care Physician) _____ Date: 9/30/21
Fax: _____ Phone: _____

From (Pharmacy): GURLEY'S PHARMACY Phone: 919-688-8978 Fax: 919-688-8972

Patient Name: [redacted] Medicaid ID#: _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. Please provide a response for every recommended action.

Medication Related Issues Identified	Recommended Plan of Action	PCP Response and Comment
__ Medication Dose/Frequency/Duration __ Adverse Drug Event __ Therapeutic Duplication __ Drug/Drug Interaction __ Drug/Disease Interaction __ Drug/Food Interaction __ Discontinued Medication __ Medication Compliance __ Contraindication __ Drug Allergy __ Other: _____	1. No recommendations at this time. 2. 3. 4.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment: 3. Accept Recommendation __ Yes __ No Comment: 4. Accept Recommendation __ Yes __ No Comment:

Cost Effective Recommendations		
__ Dose Consolidation __ Dose Optimization __ Generic Alternative __ Other: _____	1. 2	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment:

Patient Specific Education Provided: _____

Comments: Reviewed medications, dosages, goals of therapy and concerns

Time Spent with Patient: _____ Scheduled plan for follow-up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: 9/30/21 RPh Reviewer: Jonathan Hendrick

Date: _____ Primary Care Physician: _____

QUALEY'S PHARMACY
114 WEST MAIN STREET
ZEBULON, NC 27597

Medication Therapy Management Program

Date 9/30/21

North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM
Medication Review Communication Form

To (Primary Care Physician): _____ Date 9/30/21
Fax: _____ Phone: _____

From (Pharmacist): Qualey's Pharmacy Phone: 919 600 8578 Fax: 919 600 8572

Patient Name: [redacted] Medicaid ID#: _____

Prescription Issues: Based on review of the recipient's medication profile (page 2), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. Please provide a response for every recommended action.

Medication Related Issues Identified	Recommended Plan of Action	PCP Response and Comment(s)
__ Medication Dose/Frequency/Duration __ Adverse Drug Event __ Therapeutic Duplication __ Drug/Drug Interaction __ Drug/Disease Interaction __ Drug/Food Interaction __ Discontinued Medication __ Medication Compliance __ Contraindication __ Drug Allergy __ Other: _____	1. No Recommendations at this time.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment: 3. Accept Recommendation __ Yes __ No Comment: 4. Accept Recommendation __ Yes __ No Comment:
	2.	
	3.	
	4.	

Cost-Effective Recommendations

__ Dose Consolidation __ Dose Optimization __ Generic Alternative __ Other: _____	1.	1. Accept Recommendation __ Yes __ No Comment:
	2	2. Accept Recommendation __ Yes __ No Comment:

Patient Specific Education Provided: _____

Comments: Reviewed medications, drugs p. goals of therapy and concerns

Time Spent with Patient: _____ Scheduled plan for follow up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: 9/30/21 RPh Reviewer: Jonathan Hendrick

Date: _____ Primary Care Physician: _____

DURLEY'S PHARMACY
119 WEST MAIN STREET
DURHAM, NC 27701

Medication Therapy Management Program

Date: 9/30/21

North Carolina Medicaid — MEDICATION THERAPY MANAGEMENT PROGRAM
Medication Review Communication Form

To: (Primary Care Physician): _____ Date: 9/30/21
Fax: _____ Phone: _____

From (Pharmacist): DURLEY'S PHARMACY Phone: 919-688-0978 Fax: 919-688-8017

Patient Name: [redacted]

Medicaid ID#: _____

Prescription Issues: Based on review of the recipient's medication profile (page 1), the following medication related issues have been identified for your review to ensure clinically appropriate and cost-effective use of drug therapy. Please provide a response for every recommended action.

Medication Related Issues Identified	Recommended Plan of Action	PCP Response and Comments
__ Medication Dose/Frequency/Duration __ Adverse Drug Event __ Therapeutic Duplication __ Drug/Drug Interaction __ Drug/Disease Interaction __ Drug/Food Interaction __ Discontinued Medication __ Medication Compliance __ Contraindication __ Drug Allergy __ Other: _____	1. No recommendations at this time. 2. 3. 4.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment: 3. Accept Recommendation __ Yes __ No Comment: 4. Accept Recommendation __ Yes __ No Comment:
Cost Effective Recommendations		
__ Dose Consolidation __ Dose Optimization __ Generic Alternative __ Other: _____	1. 2.	1. Accept Recommendation __ Yes __ No Comment: 2. Accept Recommendation __ Yes __ No Comment:

Patient Specific Education Provided: _____

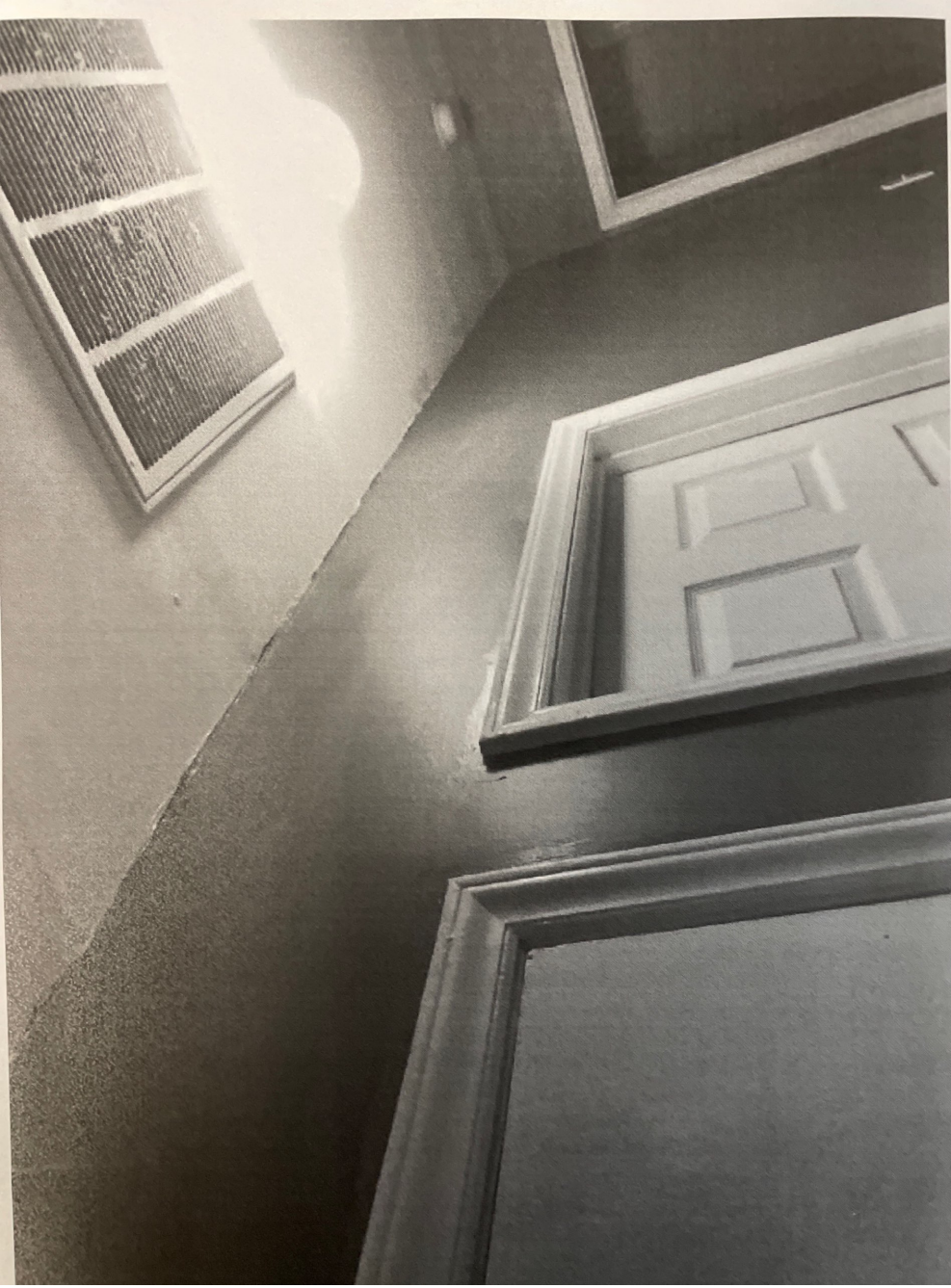
Comments: Reviewed medications, dosages & goals of therapy - no concerns

Time Spent with Patient: _____ Scheduled plan for follow up appointment: _____

Primary Care Physician and Pharmacist signatures are required by NC Medicaid to assure compliance with the frequency of review and agreement on actions undertaken. Please complete, sign and return fax to pharmacy.

Date: 9/30/21 RPh Reviewer: Jonathan Pharmacist

Date: _____ Primary Care Physician: _____



BREAK OUT LLC, ACCESS TO CARE

Access to Care:

Referral/ Referral Application and Admission Profile

Consumer Na[redacted]

LME: Alliance

Desired Admission Date:
9/20/2020

Referral source:
UNC WakeBrook

Date submitted to review team: 9/15/2020

Renewed his acceptance into the program via zoom meeting with UNC WakeBrook & Tasha McArthur

Home Demographics:

Current # of beds available:
1

Any upcoming discharges:

Yes ☐

No ☐

Date of Discharge: _____

Mental and Physical supports needs that should be addressed:

His Crisis plan should be followed (per recommendations)
Physical with his diet per mom

Strengths:

Great communicator / nice family / very assertive

Pertinent Personal Information

Family Dynamics:

Mom very active lives in Louisiana
Dad / Stepfather lives in NC very active in his life

Diagnosis:

F81.0, 272.0 F31.9
D50.3 F17 8.2

Social:

Very social / likes to go out in the community