

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-414	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2022
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NAME OF PROVIDER OR SUPPLIER BREAK OUT, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 412 PINELAND AVENUE DURHAM, NC 27704
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(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on February 1, 2022. The complaints were unsubstantiated (Intake #NC00184890 and #NC00184967). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The sample size consisted of 1 former client.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____