

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-641</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/25/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BREAK OUT, LLC II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1107 ALLGOOD STREET DURHAM, NC 27704</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual and complaint survey was completed on March 26, 2026. The complaint was substantiated (intake #NC00236441). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and has a current census of 1. The survey sample consisted of audits of 1 current client and 2 former clients.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;</p>	V 118		

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

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V 118	<p>Continued From page 1</p> <p>(D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep the MAR current affecting one of three audited clients (#1). The findings are:</p> <p>Review on 3/25/26 of Client #1's record revealed: -Admission date of 2/27/26. -Diagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder (ADHD); Conduct Disorder; Trauma and Stressor-Related Symptoms. -He was 12 years old. -Physician's orders for the following medications: -3/2/26:     -Guanfacine 2 milligrams (mg)(ADHD)- Take two tablets daily twice a day.     -Olanzapine 5 mg (Mood/Behavior)- Take one tablet daily at bedtime. -3/4/26:     -Methylphenidate 5 mg (ADHD)- Take two tablets daily twice a day. -No physician orders for Melatonin 3 mg- Take two tablets daily at bedtime.</p> <p>Observation on 3/25/26 at approximately 10:00</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>am of Client #1's medications revealed:                      -Guanfacine 2 mg was available for administration.                      -Olanzapine 5 mg was available for administration.                      -Methylphenidate 5 mg was available for administration.                      -Melatonin 3 mg was not available for administration.</p> <p>Review on 3/25/26 of Client #1's MAR for March 2026 revealed:                      -Guanfacine 2 mg was not marked as administered on 3/7 and 3/12 @ 7 pm.                      -Olanzapine 5 mg was not marked as administered on 3/7 and 3/12.                      -Methylphenidate 5 mg was not marked as administered on 3/3, 3/9, 3/12,3/13 @ 7pm.                      -Melatonin 3 mg was marked as administered from 3/1-3/6 and 3/12-3/24.</p> <p>Interview on 3/25/26 with the Qualified Professional revealed:                      -Pharmacy facility uses had been making some mistakes on the MARs.                      -Second shift staff were supposed to have marked some of the dates as administered the medications, but did not know why they were not marked.                      -All staff had been trained in Medication Administration; however, it seemed like "they just do whatever they want to do."                      -Pharmacy had printed Melatonin on Client #1's MAR by error.                      -Staff should have caught it and not marked anything on the MAR for Melatonin.                      -Staff should have reviewed Client #1's MAR for accuracy when they received his medications and new MAR.                      -They would be conducting a medication</p>	V 118		

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V 118	Continued From page 3  administration refresher course for all the staff. -Administrative actions may be taken against staff regarding future errors made by them. -She acknowledged there were discrepancies on Client #1's MAR.	V 118		