

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL071-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>07/26/2021</b> |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KEELEAN HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2240 SLOOP POINT ROAD<br/>HAMPSTEAD, NC 28443</b> |
|---|---|

| (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 survey was completed on 7/26/21. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living.</p>  | V 000         |   |                    |
| V 118              | <p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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> | V 118         |   |                    |

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

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL071-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>07/26/2021</b> |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KEELEAN HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2240 SLOOP POINT ROAD<br/>HAMPSTEAD, NC 28443</b> |
|---|---|

| (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 118              | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three clients (#1 and #2). The findings are:</p> <p>Finding #1:<br/>Review on 7/23/21 of client #1's record revealed:<br/>- 24 year-old male.<br/>- Admission date of 07/24/16.<br/>- Diagnoses of Moderate Intellectual Developmental Disability, Autism Spectrum, Attention-Deficit/Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), and Schizoaffective Disorder.</p> <p>Review on 7/23/21 of client #1's orders dated 6/21/21 revealed:<br/>- Propanolol (treats hypertension) 40 milligrams (mg) - Take one tablet by mouth three times daily.<br/>- Hydroxyzine hydrochloride (Hcl)(treats anxiety ) 25mg - Take one tablet by mouth three times daily.<br/>- Benztropine Mesylate (treats tremors) 1mg - Take one tablet by mouth twice daily.<br/>- Haloperidol (treats schizophrenia) 10mg - Take one tablet by mouth twice daily.<br/>- Lithium Carbonate Extended Release (treats mood disorders) 300mg - Take two tablets by mouth every morning and take 3 tablets by mouth every evening.<br/>- Mirtazapine (treats depression) 15mg - Take</p> | V 118         |   |                    |

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL071-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>07/26/2021</b> |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KEELEAN HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2240 SLOOP POINT ROAD<br/>HAMPSTEAD, NC 28443</b> |
|---|---|

| (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 118              | <p>Continued From page 2</p> <p>one tablet by mouth every night at bedtime.</p> <p>Review on 7/23/21 of client #1's July 2021 MAR revealed:</p> <ul style="list-style-type: none"> <li>- No staff initials for Haloperidol - 10mg at 7:00pm from 7/09/21 - 7/22/21.</li> <li>- Propanolol - 40mg had been pre-signed as given on 7/23/21 by staff #1 at 12:00pm and 7:00pm.</li> <li>- Hydroxyzine Hcl -25mg had been pre-signed as given on 7/23/21 by staff #1 at 12:00pm and 7:00pm.</li> <li>- Benztropine Mesylate - 1mg had been pre-signed as given on 7/23/21 by staff #1 at 7:00pm.</li> <li>- Lithium Carbonate Extended Release - 300mg had been pre-signed as given on 7/23/21 by staff #1 at 7:00pm.</li> <li>- Mirtazapine - 15mg had been pre-signed as given on 7/23/21 by staff #1 at 7:00pm.</li> </ul> <p>Interview on 7/26/21 client #1 stated he received his medications as ordered.</p> <p>Finding #2:<br/>Review on 7/23/21 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- 35 year-old male.</li> <li>- Admission date of 01/21</li> <li>- Diagnoses of Mild Intellectual Developmental Disability, Obsessive Compulsive Disorder (OCD), ADHD, Tourette Syndrome, and Schizoaffective Disorder.</li> </ul> <p>Review on 7/23/21 of client #2's orders dated 6/21/21 revealed:</p> <ul style="list-style-type: none"> <li>- Buspirone Hcl (treats anxiety) 10mg - Take one tablet by mouth twice daily.</li> <li>- Clonidine Hcl (treats ADHD) 0.1mg - Take one tablet by mouth twice daily.</li> <li>- Lamotrigine (treats mood disorders) 200mg -</li> </ul> | V 118         |   |                    |

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL071-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>07/26/2021</b> |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KEELEAN HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2240 SLOOP POINT ROAD<br/>HAMPSTEAD, NC 28443</b> |
|---|---|

| (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 118              | <p>Continued From page 3</p> <p>Take one tablet by mouth twice daily.</p> <ul style="list-style-type: none"> <li>- Trazadone (treats depression) 150mg - Take two tablets by mouth at bedtime.</li> <li>- Ziprasidone Hcl (treats schizophrenia) 60mg - Take 1 capsule by mouth every evening after supper.</li> </ul> <p>Review on 7/23/21 of client #2's June - July 2021 MARs revealed:</p> <ul style="list-style-type: none"> <li>- No staff initials for Buspirone Hcl - 10mg at 7:00pm from 6/03/21 - 6/29/21.</li> <li>- No staff initials for Ziprasidone Hcl - 60mg at 5:00pm on 6/29/21.</li> <li>- No staff initials for Clonidine Hcl - 0.1mg at 7:00pm from 7/09/21 - 7/22/21 and 7:00am from 7/22/21 - 7/23/21.</li> <li>- No staff initials for Lamotrigine - 200mg at 7:00pm on 7/22/21.</li> <li>- Trazadone - 150mg had been pre-signed as given on 7/23/21 by staff #1 at 7:00pm.</li> </ul> <p>Interview on 7/26/21 client #2 stated he received his medications as ordered.</p> <p>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</p> | V 118         |   |                    |
| V 752              | <p>27G .0304(b)(4) Hot Water Temperatures</p> <p>10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT</p> <p>(b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors.</p> <p>(4) In areas of the facility where clients are exposed to hot water, the temperature of the</p>  | V 752         |   |                    |

Division of Health Service Regulation

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL071-039</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>07/26/2021</b> |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KEELEAN HOME</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2240 SLOOP POINT ROAD<br/>HAMPSTEAD, NC 28443</b> |
|---|---|

| (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 752              | <p>Continued From page 4</p> <p>water shall be maintained between 100-116 degrees Fahrenheit.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation and interview, the facility water temperatures were not maintained between 100-116 degrees Fahrenheit in areas where clients were exposed to hot water. The findings are:</p> <p>Observation on 7/23/21 at approximately 9:30am revealed:<br/>-The hot water temperature in the kitchen was 125 degrees Fahrenheit.<br/>-The hot water temperature in the client bathroom in the hallway was 132 degrees Fahrenheit.</p> <p>Interview on 7/23/21 staff #1 stated:<br/>-She was not aware of the hot water temperatures.</p> | V 752         |   |                    |