STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942945	04/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grafton House	168 Marine Street Saint FL 32084	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service
St - A - 0090 - 58a-5.0191(11) Fac - Training -

Specific Tag Findings:

0000-Initial Comments

A biennial relicensure survey was conducted on , 2014.
Grafton House had Licensure deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and staff interview, the facility failed to have an accurate heath assessment for 2 of 10 sampled residents, Residents #1 and #10.

The findings include:

1. Resident #1 had a Health Assessment dated . It revealed a left neck and repair and was partial weight bearing on her left leg. The assessment read that she was to receive services. Under additional comments, it revealed the resident was , forgetful, pleasant, and needed constant supervision for risk. Under the status section report if any , 3, or 4 pressure was present, it was left blank. Under Requires 24-hour nursing or care, it was left blank.

The Administrator on at 1:30 p.m. confirmed that the Health Assessment for Resident #1 was not completed in those two sections.

2. Resident #10 had a Health Assessment revealing calorie controlled/ low fat/ low diet. The Administrator on at 11 a.m. stated that this was not correct and the resident was on a regular diet. She stated the doctor did not send over the new order for this diet. She received a faxed order dated

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review, and staff interview, the facility failed to have a resident meet continued residency criteria for 1 of 10 sampled residents, Resident 1.

The findings include:

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On at 10 a.m., a telephone interview was conducted with Employee A, a caregiver. She identified Resident #1 as having a Resident #1. She stated that the home health nurse came in and took care of it but if it was leaking she would clean it up.

Resident #1 had a Health Assessment dated It revealed a left neck and repair and was partial weight bearing on her left leg. She was to receive services. Under additional comments, it revealed the resident was , forgetful, pleasant, and needed constant supervision for risk. Under status section of report if any , 3, or 4 pressure was present, it was left blank. Under Requires 24-hour nursing or care, it was left blank.

The Administrator was interviewed on at 1:30 p.m. She stated Resident #1 was living at the facility when she had a and went out to the hospital and was found to have a She then went to a nursing home for rehabilitation for a few weeks. Then the resident's family really wanted the resident to return to the facility. They were not told of any by the family of the nursing home. When the resident arrived and they pulled off her socks, they noted a on her left heel. When the first home health company arrived, they did not want to address the heel and only wanted to do physical They wanted her to ambulate but they were told that she was only allowed partial weight bearing. So family requested a different home health agency to come out. The requested home health agency came out the next day and assured the facility they would take care of the resident's heel. She did not know what stage the was at the time of readmission to the facility. She acknowledged that the Health Assessment was blank under

A telephone interview was conducted with the home health nurse from at 3:35 pm. She stated that a Physical assessed the resident on and immediately notified nursing of the heel On , they sent out a certified nurse. They measured the left heel to be 3 cm by 5.5 cm and it was dark. Since it was not opened, they could not measure the depth. Therefore they determined it was "unstageable". At first they had a over this but because there was drainage from it they put on a different dressing. She stated that was being applied daily to the She stated that the staff at the Assisted Living Facility was providing this care. She stated the home health nurse only came out twice a week and the facility staff completed the daily treatments. She stated that the right heel had a scab on it and it was open to air.

Resident #1 clinical record did not have any treatment for the resident's The Administrator notified the home health agency who faxed over a copy of the current assessment and treatment orders. The start of care from the home health agency revealed the patient had at least one unhealed at or high or designated as "unsteagable". It showed a 2x1 on the right heel and a 4.5 x 4 to left heel (unstagable and and a surgical which was healed on the left hip.

There was a physician order for care to heels for Resident #1 that read:

1) apply to closed heel daily

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2) clean opened with normal , apply and kling gauze to protect twice a week until healed.

Resident #1 was observed on at 353 pm. She was sitting in her wheelchair with socks and podis boots on both feet. She stated her feet hurt her for 2 months now. She refused to let anyone touch her feet. Under her left sock, it was observed to have some type of dressing on the left heel.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review, and staff interview, the facility failed to ensure that residents were free from physical by having a 3/4 length bed rails for 1 of 10 sampled residents, Resident #10.

The findings include:

On at 9:15 a.m., Resident #10 was observed lying in her bed with the right side of the bed against the wall and the left side of the bed with a 3/4 length bed rail. The Administrator on at 9:30 a.m. stated that she had this bed rail since admission on .

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, medication record review and staff interview, the facility failed to maintain an accurate Medication Observation Record (MOR) for 2 of 2 sampled residents, Residents #8 and #9.

The findings include:

1) On at 12:50 p.m. Employee B was observed assisting residents with self-administration of medication. She first brought over a medication card of 800 mg to Resident #8 and explained to the resident what she was giving him. The Medication Card dated revealed 800 mg take 1 tablet three times a day with food. The Resident took the medication and Employee B went back to the medication observation record (MOR) to document giving the resident this medication. The record was blank for the whole month of 2014. Employee B hand wrote in the hours of 7 a.m., 1 pm, and 7 p.m. and signed the at 1p.m. dose. She could not explain why no one else signed for this medication.

2) On at 1 p.m. Employee B went to Resident #9 with a medication card of 25 mg. The Medication Card dated read 25 mg take one tablet twice a day at 8 a.m. and 2 p.m and 3 tablets (75mg) at bedtime. She removed one handed it to the resident, and told her what she was giving her. The resident took it. Employee B went back to document this medication in the resident's MORs. The 2014 Medication Record revealed 25 mg one tablet every morning and 50 mg one tablet at bedtime. Employee B confirmed that the medication orders on the cards did not match the Medication Observation Record.

Class III

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0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on employee record review and staff interview the facility failed to provide Communicable Statement for 3 our of 3 employees for (The Administrator and Employees A,&B).

The Findings include:

Record review of the Administrator's personnel file revealed no documentation from a physician stating the employee was free from communicable .

Record Review of Employee A's personnel file revealed a hire date of as a care giver. Further review revealed no documentation from a physician stating the employee was free from communicable .

Record review of Employee B's personnel file revealed a hire date of as a care giver. Further review revealed no documentation from a physician stating the employee was free from communicable .

On at 3:00pm, an interview with the Administrator was conducted. The interview confirmed that the facilty not have the communicable statement for these employees.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on employee record review and staff interview the facility failed to ensure Emergency Preparedness and Evacuation training , training and Food service training was conducted within 30 days of hire for 2 out of 3 Employees. (Employee A&B)

The findings include:

Record review of Employee A' s personnel file revealed a hire date of as a care giver. Further review revealed no documentation in Emergency Preparedness and Evacuation or Food Service training.

Review of Employee B personnel file revealed a hire date of as a care giver. Further review revealed revealed no documentation of Emergency Preparedness and Evacuation training and training.

On at 3:00pm an interview with the Administrator was conducted. The Interview revealed that there was no documentation for Emergency Preparedness and Evacuation training for Employee's A&B, no documentation for training for Employee B, and no documentation for Food Service training for Employee A.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on employee record review and staff interview the facility failed to ensure Training within 30 days of employment for 1 out of 2 employees. Employee B.

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The findings include:

Record review of Employee's B personnel file revealed a hire date of . . as a care giver. Further review revealed no documentation of . . . . ' training.

On . . . . at 3:00 pm an interview was conducted with the Administrator. Interview revealed that there was no documentation of . . training for Employee B.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Grafton House
168 Marine Street
Saint FL 32084

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/JM/sm
Enclosure

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