

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF STUART

**650 NW FORK RD
STUART, FL 34994**

(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
A 000	Initial Comments An unannounced Complaint survey (#2021015741) and Generator Monitoring survey were conducted on _____ and _____ at Harborchase of Stuart. The facility had deficiencies identified at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition _____ in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to contact the resident's health care provider and resident's family when the resident exhibited a significant change; and maintain a written record, updated as needed, of any significant changes, and changes in the method of medication administration for 1 of 1 residents reviewed requiring assistance with self-administration of medications, Resident #1. The findings included: a) Per information provided by Resident #1's spouse on _____, Resident #1 was admitted to	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 025	Continued From page 2 the facility on Resident had diagnoses to include 's , high and receives medications for these illnesses, in addition to an medication and an medication for behaviors. At the time of admission, Resident #1 was able to ambulate independently without assistance and was able to engage with others. On at 3:00 PM, the spouse arrived and found Resident #1 sitting in the Dining Room. Food debris was all around him. He was drooling, and he was wet. Walking was difficult, and the spouse tried to get him to use his walker. There was a significant decline noticed. On , the spouse arrived around 2:00 PM and found Resident #1 sitting in the Dining Room. He was once again exhibiting a significant decline. He was unable to ambulate, was drooling and was in a stupor. From through , the spouse noticed a continued decline with drooling, crying, and inability to walk and use a wheelchair. Hospice was contacted. On , the Hospice nurse discovered Resident #1 has not been receiving any of his medications for approximately 2 weeks, from to The first written documentation found which showed a medication request sent to the Pharmacy was a fax dated The Pharmacy responded on requesting valid physician orders and clarifications for the gel and Milk of Magnesia. There was no further attempt to respond to the Pharmacy's	A 025			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 025	Continued From page 3 request until The resident finally received his physician-ordered medications on, after almost 2 weeks of receiving no medications. At no time from through, did the facility reach out to the spouse to notify of any significant changes in behavior or activities of daily living (ADLs), or change in medication administration or lack thereof. A review of Nurse's Notes shows lack of documentation of the decline in health and ADL status or issues involving medication administration. The Advanced Registered Nurse Practitioner was notified of the medication issues on when physician orders for medications was requested. On at 2:35 PM, an interview was conducted with the Administrator and Vice President of Health and Wellness. They acknowledged that there had been a break down in communication between the facility and the Pharmacy that resulted in Resident #1 not receiving his medications from through They confirmed that the spouse and physician had not been notified by the facility regarding an issue with the medications prior to Class III	A 025			
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container;	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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
A 054	Continued From page 4 or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known _____, the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a detail medication record for 1 of 1 residents received who required assistance with self-administered medications, but who did not receive these medications as ordered by his health care provider for Resident #1. The findings included: Per review of Resident #1's	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 054	Continued From page 5 Medication Observation Record (MOR), the following was noted: 10 mg daily (used for) not given from to Carb-Levo 25-100 mg 3 times a day (used for) not given from to 25 mg 2 times a day (used for) not given from PM to PM gel (used for) to be given only as needed was given every day from to 400 mg daily (supplement) not given from to 10 mg 2 times a day (used for) not given from to 500 mg 2 times a day (used for) not given from to daily (used for high) not given from to 25 mg 2 times a day (.....) not given on PM dose, PM dose, 50 mg at bedtime (.....) not given on and 10 mg daily (used for high) not given from to Rosuvastatin 10 mg daily (used for high) not given from to 100 mg daily (.....) not given from to The only documentation found on MOR as to why these medications were not provided were notes documented on the of the MOR: 9:00 AM, " not in cart, awaiting from pharmacy" "all meds awaiting"; and	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 054	Continued From page 6 "9AM meds not in cart". Further review of Resident #1's record revealed no evidence the physician was advised the medications were not being administered as ordered. Class III	A 054			
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , ... , not to exceed 4	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2021
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF STUART			STREET ADDRESS, CITY, STATE, ZIP CODE 650 NW FORK RD STUART, FL 34994		
(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	
A 056	Continued From page 7 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxed, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample	A 056			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2021
---	--	---	--

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF STUART	650 NW FORK RD STUART, FL 34994

(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
A 056	Continued From page 8 or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to make every reasonable effort to ensure prescriptions for 1 of 1 residents reviewed who received assistance with self-administration of medication were filled or refilled in a timely manner for Resident #1. The findings included: Resident #1 was admitted to the facility on [redacted] with diagnoses which include [redacted] type II, [redacted] 's, [redacted] Per Resident #1's Health Assessment dated [redacted], Resident #1 required supervision with Ambulation, Eating and Transfers. He was total assist with Bathing, [redacted], Grooming, and Toileting. Resident required assistance with self-administration of medications.	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF STUART

**650 NW FORK RD
STUART, FL 34994**

(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
A 056	Continued From page 9 Per review of Resident #1's health record and Medication Observation Record (MOR), it was found that the Medication Technicians assigned to Memory Care Unit, the Memory Care Director, and the Director of Nursing all failed to take necessary and appropriate steps to ensure Resident #1 received all of his physician-ordered medications as directed, without interruption, from _____. Per review of Resident #1's health record and Medication Observation Record (MOR), it was found that the Medication Technicians assigned to the Memory Care Unit, the Memory Care Unit Director, and the Director of Nursing all failed to take necessary and appropriate steps to ensure that the following prescriptions for Resident #1 were filled or refilled in a timely manner to prevent Resident #1 from going without his physician-ordered medications between _____ through _____: a) _____, 10 mg daily (used for _____) - not given from _____ to _____ b) Carb-Levo 25-100 mg 3 times a day (used for _____'s _____) not given from _____ to _____ c) _____ 25 mg 2 times a day (used for _____) not given from _____ PM to _____ PM d) _____ gel (used for _____) to be given only as needed was given every day from _____ to _____ e) _____ 400 mg daily (supplement) not given from _____ to _____ f) _____ 10 mg 2 times a day (used for _____) not given from _____ to _____ g) _____ 500 mg 2 times a day (used for _____) not given from _____ to _____ h) _____ daily (used for high _____) not given from _____ to _____	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF STUART

**650 NW FORK RD
STUART, FL 34994**

(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
A 056	Continued From page 10 i) _____ 25 mg 2 times a day (_____) not given on _____ PM dose, _____ PM dose, _____ PM dose, _____ j) _____ 50 mg at bedtime (_____) not given on _____ and _____ k) _____ 10 mg daily (used for high _____ _____) not given from _____ to _____ l) Rosuvastatin 10 mg daily (used for high _____ _____) not given from _____ to _____ m) _____ 100 mg daily (_____) not given from _____ to _____ The first written documentation found which showed a medication request sent to the Pharmacy was a fax dated _____. The Pharmacy responded on _____ requesting valid physician orders and clarifications for the _____ gel and Milk of Magnesia. There was no further attempt to respond to the Pharmacy's request until _____. The resident finally received his physician-ordered medications on _____, after almost 2 weeks of missing doses of his medications. The only documentation found on MOR as to why these medications were not provided were notes documented on the _____ of the MOR: _____, 9:00 AM, " _____ not in cart, awaiting from pharmacy" _____, "all meds awaiting _____"; and _____, "9A/P meds not in cart". Review to the Nurse's Notes, the following was found: _____, - "Notified wife we need his _____, _____" _____, - "DC (discontinue) _____, start Milk of _____" _____, - "0 meds in cart, notified Pharmacy."	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969790	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HARBORCHASE OF STUART

**650 NW FORK RD
STUART, FL 34994**

(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
A 056	Continued From page 11 Notified Director of Nursing." - " , ordered." On at 2:35 PM, an interview was conducted with the Administrator and Vice President of Health and Wellness. They acknowledged that there had been a break down in communication between the facility and the pharmacy that resulted in Resident #1 not receiving his medications from to Class III	A 056		