Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62916	A. BUILDING: _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRISTOL CARE CENTER	1818 E FLETCHER AVE TAMPA, FL 33612

(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
N 000	INITIAL COMMENTS A complaint survey for complaint #2025005524 was conducted on at The Bristol Care Center. Deficiencies were identified at the time of the survey. Complaint number 2025005524 was cited at N054 and N201.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to follow physician orders related to medication administration for one resident (#1) out of three residents reviewed. Findings included: Review of Resident #1's Admission Record revealed he was admitted to the facility on and discharged on . His medical diagnoses included in hemisphere, subcortical and flaccid , affecting the right dominant side. Review of Resident #1's hospital discharge medication list revealed "Pregabalin 75 mg [milligrams] oral capsule three times a day. Next dose: at 8:00 PM." Review of Resident #1's physician orders revealed an order with a start date of and an end date of for	N 054	N 054 D – Follow Physician Orders Immediate actions taken for residents found to have been affected: Resident #1 was discharged from the facility on Identification of other residents having the potential to be affected: Current residents in the facility were reviewed by to ensure their medications requiring hard scripts were available in the medication cart. No other residents were affected by the deficient practice. Actions taken/systems put into place to reduce risk of future occurrence: Staff Development Coordinator/designee will re-educate licensed nurses by to ensure physicians are notified when a hard script is needed for a new medication and will continue to follow up with	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 054	Continued From page 1 "Pregabalin Oral Capsule 75 MG (Pregabalin) Give 1 capsule by three times a day for due to ." Review of Resident #1's Medication Administration Record revealed in five out five medication administration opportunities, Resident #1 did not receive the ordered Pregabalin 75 milligrams three times a day from through his discharge on . All five medication administration opportunities were documented as "9." Review of the chart codes revealed "9=Other/See Nurse's Notes." Review of Resident #1's electronic medication administration record (eMAR)-Administration Note dated at 6:43 AM revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for due to . "New admit [admission]. Awaiting script [prescription]. MD [Medical Doctor] made aware." Review of Resident #1's eMAR-Administration Note dated at 1:35 PM written by Staff A, Agency Registered Nurse (RN) revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for due to . "I called the pharmacy and the customer services stated: They don't have script for . MD should be notified." Review of Resident #1's eMAR-Administration note dated at 9:00 PM. revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for due to . "on order" Review of Resident #1's eMAR-Administration	N 054	physician and/ or pharmacy until medication is received. How the corrective actions will be monitored to ensure the practice will not recur: DON/designee will review new admissions to ensure hard scripts were received or sent to pharmacy to ensure medication is delivered and available to the resident 3 times a week for 2 weeks then 2 times a week for 2 weeks then weekly. The administrator will oversee audit completion and report findings in the monthly Risk Management/QA Committee meeting for 3 months or until substantial compliance is achieved.	

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N 054	Continued From page 2 note dated at 5:08 AM revealed Pregabalin Oral Capsule 75 MG. Give 1 capsule by three times a day for . due to . There was no documentation for this dose. Review of Resident #1's eMAR-Administration note dated at 1:40 PM revealed Pregabalin Oral Capsule 75 MG. Give 1 capsule by three times a day for . due to . "medication [sic] not on med [medication] not available in ekit [emergency medication kit] pharm [pharmacy] called md [sic] notified." Review of the facility's emergency medication drug list revealed pregabalin 25 mg was available in the emergency drug kit. An interview was conducted on at 1:00 PM with Staff A, Agency RN. She said Resident #1 was a new admission when she was assigned to him, "within his first 24 hours." She said when resident's medications are not in the medication cart, she calls the pharmacy to see where the medication is. She said she called the pharmacy about Resident #1's missing pregabalin medication and the pharmacy said they did not have the prescription, but she does not remember if she called the physician to get a prescription. An interview was conducted on at 1:22 PM with Staff C, Licensed Practical Nurse (LPN), Unit Manager. She said when there is a new admission the medications are put into the electronic record and sent to the pharmacy. Paper prescriptions for controlled medications are faxed to the pharmacy and the medications should be administered according to when the	N 054		

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N 054	Continued From page 3 hospital recommends when the next dose is supposed to be given. If the pharmacy has not delivered the medications by the time it is due the medication should be pulled from the emergency drug kit and if the medication is not in the emergency drug kit, the physician should be notified and there should be documentation the physician was notified, and the pharmacy should be contacted. She said Resident #1 did not receive his pregabalin because a prescription was not sent to the pharmacy but the physician was notified about it on per the documentation. An interview was conducted on at 2:18 PM with the Director of Nursing (DON). She said for new admissions the nurses get the medication list from the hospital and it is transcribed into the electronic record and sent to the pharmacy electronically. If the medication is a controlled medication and the nurse has the paper prescription the paper prescription is faxed to the pharmacy. If the nurse does not have a paper prescription for a controlled medication the physician is notified and the physician will call the pharmacy and order the medication. The nurse should document the notification to the physician that a prescription was needed for a controlled medication. The DON confirmed pregabalin is a controlled medication and required a prescription. She said if medications are not onsite the nurses will see if the emergency drug kit has the medication. Any controlled medication the nurse would have to get a code from the pharmacy to pull the medication. If the medication is not in the emergency drug kit the physician should be notified and there should be documentation the physician was notified and any orders they may give.	N 054		

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N 054	Continued From page 4 An interview was conducted on at 3:11 PM with the DON. She said she spoke with the pharmacy and during the weekdays the medication cut off time to put in physician medication order is 12:00 AM. If the medication is ordered by 12:00 AM the pharmacy will "try" to get the medications delivered by 4:00 PM the next day. If it is not on the 4:00 PM delivery the medication "should" be on the 3:00 AM delivery. The DON said she called the pharmacy and they confirmed they did not get a prescription for the pregabalin, therefore, the medication was not delivered to the facility, and the nurses could not pull it out of the emergency drug kit because there was no prescription at the pharmacy. She said Resident #1 should have received his pregabalin medication and the nurses should have kept calling the physician until the medication was delivered. Review of the facility's "Administering Medications" policy, reviewed , revealed: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: ... 2. The director of nursing [sic] services supervises and directs all personnel who administer medications and/or have related functions. ... 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication; b. preventing potential medication or food	N 054		

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N 054	Continued From page 5 interactions; and c. honoring resident choice and preferences, consistent with his or her care plan ... Class III	N 054		
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide adequate and appropriate health care by failing to ensure one resident (#1) out of three residents sampled were assessed immediately by a nurse after being found on the floor by facility staff. Findings included: Review of the facility in-service titled Reporting dated showed under Objective, anytime a resident is observed on the floor, witnessed falling to the floor, or assisted to the floor by staff, it is a facility requirement that a Protocol is followed. 1. While on the ground, assess resident for injuries; Range of Motion (ROM), , vitals with , and skin. ... 4. Notify the unit manager/supervisor, or nurse leadership present in the building at the time of	N 201	N 201 D – Right to Adequate and Appropriate Health Care Immediate actions taken for residents found to have been affected: Resident #1 was discharged from the facility on Identification of other residents having the potential to be affected: Residents with in the past 30 days were reviewed to ensure they were evaluated by a licensed nurse prior to being moved to the bed or chair. No other residents were affected by the deficient practice Actions taken/systems put into place to reduce risk of future occurrence:	

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N 201	Continued From page 6 the incident and the risk manager. Review of an Admission Record dated showed Resident #1 was originally admitted to the facility on with diagnoses to include but not limited to , in hemisphere, subcortical, and flaccid , affecting right dominant side. Review of a Nurse Progress note dated , authored by Staff A, Registered Nurse (RN), showed "The [Certified Nursing Assistant,] CNA found the resident lying in the resident restroom. The CNA stated that two CNA placed the resident on the toilet as resident requested and 5 min[utes] later they found the resident on the floor in the resident restroom." It was noted when the nurse entered the resident's room, she observed the CNA lifting the resident to bed. The nurse assessed Resident #1 for , or injuries after the resident was placed in bed. During an interview on at 12:40 p.m., with Staff A, RN, Staff A, RN stated on the day Resident #1 she was in another room administering medication. When she was coming out of the room, someone told her Resident #1 was on the floor. When she went to the room, two CNAs were in the bathroom picking Resident #1 up from the floor and placed him in his wheelchair. Staff A, RN stated she assessed Resident #1 after the CNAs placed him in his chair, she did an incident report, and notified the resident's daughter. Staff A, RN stated whenever a resident has a , the nurse is supposed to assess the resident before a CNA can move the resident. During an interview on at 1:30 p.m., with Staff B, CNA, Staff B, CNA stated she assisted	N 201	Staff Development Coordinator/designee will re-educate licensed clinical staff by on ensuring residents with are evaluated by a licensed nurse prior to the resident being moved to the bed or chair. How the corrective actions will be monitored to ensure the practice will not recur: DON/designee will review residents with weekly for 4 weeks then monthly x3 months to ensure residents are being evaluated by the nurse prior to being moved to the bed or chair. The administrator will oversee audit completion and report findings in the monthly Risk management/QA committee.	

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N 201	Continued From page 7 Resident #1 to the bathroom on the day of his . Staff B, CNA stated her and the orientee placed Resident # 1 on the toilet and left him in the bathroom because he asked for privacy. She stated she left his room because she overheard another resident screaming in another room. When she got to the other room she had to assist the other resident on the toilet. She stated when she was headed to Resident #1's room, a housekeeper told her Resident #1 was on the floor in the bathroom. Staff B, CNA stated her and the orientee assisted Resident #1 off the floor and placed him in his wheelchair. The nurse assessed him before they assisted him to his bed. Staff B, CNA stated the nurse was standing in the room while they were picking the resident up off the floor. During an interview on at 1:27 p.m. with Staff C, License Practical Nurse/ Unit Manager (LPN UM), Staff C, LPN UM stated on , Resident #1 wanted to use the bathroom and two CNA staff placed him on the toilet and gave him his call light. She stated Resident #1 had off the toilet, but she was not present on the unit when he . Staff C, LPN UM stated the protocol is if the nurse is not present, the CNAs are supposed to notify the nurse, the nurse does her assessment on the resident, and they notify the doctor and the family. The CNAs are not allowed to move the patient and they must wait until the nurse assesses the resident. During an interview on at 3:00 p.m. with the Director of Nursing (DON), the DON stated when a resident , the CNAs notify the nurse, the nurse conducts an assessment and completes an incident report, they notify the primary care provider and the family, and Emergency Services if needed depending on the	N 201		

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N 201	Continued From page 8 situation. The DON stated CNAs are not allowed to move a resident after a until the nurse assesses the resident. Class III	N 201		

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F 000	INITIAL COMMENTS A complaint survey for complaint #2025005524 was conducted on at The Bristol Care Center. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. Complaint number 2025005524 was cited at F684 and F755.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure one resident (#1) out of three residents sampled were assessed immediately by a nurse after being found on the floor by facility staff. Findings included: Review of an Admission Record dated showed Resident #1 was originally admitted to the facility on with diagnoses to include but not limited to , in hemisphere, subcortical, and flaccid , affecting right dominant side.	F 684	F 684 D – Quality of Care Immediate actions taken for residents found to have been affected: Resident #1 was discharged from the facility on Identification of other residents having the potential to be affected: Residents with in the past 30 days were reviewed to ensure they were evaluated by a licensed nurse prior to being moved to the bed or chair. No other residents were affected by the deficient practice	

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 Review of a Nurse Progress note dated , authored by Staff A, Registered Nurse (RN), showed "The [Certified Nursing Assistant,] CNA found the resident lying in the resident restroom. The CNA stated that two CNA placed the resident on the toilet as resident requested and 5 min[utes] later they found the resident on the floor in the resident restroom." It was noted when the nurse entered the resident's room, she observed the CNA lifting the resident to bed. The nurse assessed Resident #1 for , or injuries after the resident was placed in bed. During an interview on at 12:40 p.m., with Staff A, RN, Staff A, RN stated on the day Resident #1 she was in another room administering medication. When she was coming out of the room, someone told her Resident #1 was on the floor. When she went to the room, two CNAs were in the bathroom picking Resident #1 up from the floor and placed him in his wheelchair. Staff A, RN stated she assessed Resident #1 after the CNAs placed him in his chair, she did an incident report, and notified the resident's daughter. Staff A, RN stated whenever a resident has a , the nurse is supposed to assess the resident before a CNA can move the resident. During an interview on at 1:30 p.m., with Staff B, CNA, Staff B, CNA stated she assisted Resident #1 to the bathroom on the day of his . Staff B, CNA stated her and the orientee placed Resident # 1 on the toilet and left him in the bathroom because he asked for privacy. She stated she left his room because she overheard another resident screaming in another room. When she got to the other room she had to assist the other resident on the toilet. She stated when	F 684	Actions taken/systems put into place to reduce risk of future occurrence: Staff Development Coordinator/designee will re-educate licensed clinical staff by on ensuring residents with are evaluated by a licensed nurse prior to the resident being moved to the bed or chair. How the corrective actions will be monitored to ensure the practice will not recur: DON/designee will review residents with weekly for 4 weeks then monthly x3 months to ensure residents are being evaluated by the nurse prior to being moved to the bed or chair. The administrator will oversee audit completion and report findings in the monthly Risk management/QA committee.	

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F 684	Continued From page 2	F 684		

she was headed to Resident #1's room, a housekeeper told her Resident #1 was on the floor in the bathroom. Staff B, CNA stated her and the orientee assisted Resident #1 off the floor and placed him in his wheelchair. The nurse assessed him before they assisted him to his bed. Staff B, CNA stated the nurse was standing in the room while they were picking the resident up off the floor.

During an interview on at 1:27 p.m. with Staff C, License Practical Nurse/ Unit Manager (LPN UM), Staff C, LPN UM stated on , Resident #1 wanted to use the bathroom and two CNA staff placed him on the toilet and gave him his call light. She stated Resident #1 had off the toilet, but she was not present on the unit when he . Staff C, LPN UM stated the protocol is if the nurse is not present, the CNAs are supposed to notify the nurse, the nurse does her assessment on the resident, and they notify the doctor and the family. The CNAs are not allowed to move the patient and they must wait until the nurse assesses the resident.

During an interview on at 3:00 p.m. with the Director of Nursing (DON), the DON stated when a resident , the CNAs notify the nurse, the nurse conducts an assessment and completes an incident report, they notify the primary care provider and the family, and Emergency Services if needed depending on the situation. The DON stated CNAs are not allowed to move a resident after a until the nurse assesses the resident.

Review of the facility in-service titled Reporting dated showed under Objective, anytime a resident is observed on the floor,

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F 684	Continued From page 3 witnessed falling to the floor, or assisted to the floor by staff, it is a facility requirement that a Protocol is followed. 1. While on the ground, assess resident for injuries; Range of Motion (ROM), , , vitals with , and skin. ... 4. Notify the unit manager/supervisor, or nurse leadership present in the building at the time of the incident and the risk manager.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

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	105140	A. BUILDING _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRISTOL CARE CENTER	1818 E FLETCHER AVE TAMPA, FL 33612

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F 755	Continued From page 4 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide physician ordered medication for one resident (#1) out of three residents reviewed. Findings included: Review of Resident #1's Admission Record revealed he was admitted to the facility on and discharged on . His medical diagnoses included in hemisphere, subcortical and flaccid , affecting the right dominant side. Review of Resident #1's hospital discharge medication list revealed "Pregabalin 75 mg [milligrams] oral capsule three times a day. Next dose: at 8:00 PM." Review of Resident #1's physician orders revealed an order with a start date of and an end date of for "Pregabalin Oral Capsule 75 MG (Pregabalin) Give 1 capsule by three times a day for , due to ." Review of Resident #1's Medication Administration Record revealed in five out five medication administration opportunities, Resident #1 did not receive the ordered Pregabalin 75 milligrams three times a day from through his discharge on . All five medication administration opportunities were documented as	F 755	F 755 D – Pharmacy Services/Procedures/Pharmacist/Records Immediate actions taken for residents found to have been affected: Resident #1 was discharged from the facility on Identification of other residents having the potential to be affected: Current residents in the facility were reviewed by to ensure their medications requiring hard scripts were available in the medication cart. No other residents were affected by the deficient practice. Actions taken/systems put into place to reduce risk of future occurrence: Staff Development Coordinator/designee will re-educate licensed nurses by to ensure physicians are notified when a hard script is needed for a new medication and will continue to follow up with physician and/ or pharmacy until medication is received. How the corrective actions will be monitored to ensure the practice will not recur: DON/designee will review new admissions to ensure hard scripts were received or sent to pharmacy to ensure medication is	

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F 755	Continued From page 5 "9." Review of the chart codes revealed "9=Other/See Nurse's Notes." Review of Resident #1's electronic medication administration record (eMAR)-Administration Note dated at 6:43 AM revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for , due to . "New admit [admission]. Awaiting script [prescription]. MD [Medical Doctor] made aware." Review of Resident #1's eMAR-Administration Note dated at 1:35 PM written by Staff A, Agency Registered Nurse (RN) revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for , due to . "I called the pharmacy and the customer services stated: They don't have script for . MD should be notified." Review of Resident #1's eMAR-Administration note dated at 9:00 PM. revealed Pregabalin Oral Capsule 75 MG Give 1 capsule by three times a day for , due to . "on order" Review of Resident #1's eMAR-Administration note dated at 5:08 AM revealed Pregabalin Oral Capsule 75 MG. Give 1 capsule by three times a day for , due to . There was no documentation for this dose. Review of Resident #1's eMAR-Administration note dated at 1:40 PM revealed Pregabalin Oral Capsule 75 MG. Give 1 capsule by three times a day for ,	F 755	delivered and available to the resident 3 times a week for 2 weeks then 2 times a week for 2 weeks then weekly. The administrator will oversee audit completion and report findings in the monthly Risk Management/QA Committee meeting for 3 months or until substantial compliance is achieved.	

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due to . . "medication [sic] not on med [medication] not available in ekit [emergency medication kit] pharm [pharmacy] called md [sic] notified."

Review of the facility's emergency medication drug list revealed pregabalin 25 mg was available in the emergency drug kit.

An interview was conducted on at 1:00 PM with Staff A, Agency RN. She said Resident #1 was a new admission when she was assigned to him, "within his first 24 hours." She said when resident's medications are not in the medication cart, she calls the pharmacy to see where the medication is. She said she called the pharmacy about Resident #1's missing pregabalin medication and the pharmacy said they did not have the prescription, but she does not remember if she called the physician to get a prescription.

An interview was conducted on at 1:22 PM with Staff C, Licensed Practical Nurse (LPN), Unit Manager. She said when there is a new admission the medications are put into the electronic record and sent to the pharmacy. Paper prescriptions for controlled medications are faxed to the pharmacy and the medications should be administered according to when the hospital recommends when the next dose is supposed to be given. If the pharmacy has not delivered the medications by the time it is due the medication should be pulled from the emergency drug kit and if the medication is not in the emergency drug kit, the physician should be notified and there should be documentation the physician was notified, and the pharmacy should be contacted. She said Resident #1 did not

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receive his pregabalin because a prescription was not sent to the pharmacy but the physician was notified about it on per the documentation.

An interview was conducted on at 2:18 PM with the Director of Nursing (DON). She said for new admissions the nurses get the medication list from the hospital and it is transcribed into the electronic record and sent to the pharmacy electronically. If the medication is a controlled medication and the nurse has the paper prescription the paper prescription is faxed to the pharmacy. If the nurse does not have a paper prescription for a controlled medication the physician is notified and the physician will call the pharmacy and order the medication. The nurse should document the notification to the physician that a prescription was needed for a controlled medication. The DON confirmed pregabalin is a controlled medication and required a prescription. She said if medications are not onsite the nurses will see if the emergency drug kit has the medication. Any controlled medication the nurse would have to get a code from the pharmacy to pull the medication. If the medication is not in the emergency drug kit the physician should be notified and there should be documentation the physician was notified and any orders they may give.

An interview was conducted on at 3:11 PM with the DON. She said she spoke with the pharmacy and during the weekdays the medication cut off time to put in physician medication order is 12:00 AM. If the medication is ordered by 12:00 AM the pharmacy will "try" to get the medications delivered by 4:00 PM the next day. If it is not on the 4:00 PM delivery the

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medication "should" be on the 3:00 AM delivery. The DON said she called the pharmacy and they confirmed they did not get a prescription for the pregabalin, therefore, the medication was not delivered to the facility, and the nurses could not pull it out of the emergency drug kit because there was no prescription at the pharmacy. She said Resident #1 should have received his pregabalin medication and the nurses should have kept calling the physician until the medication was delivered.

Review of the facility's "Administering Medications" policy, reviewed , revealed:
Policy Statement:
Medications are administered in a safe and timely manner, and as prescribed.
Policy Interpretation and Implementation:
... 2. The director of nursing [sic] services supervises and directs all personnel who administer medications and/or have related functions.
... 4. Medications are administered in accordance with prescriber orders, including any required time frame.
5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:
a. enhancing optimal therapeutic effect of the medication;
b. preventing potential medication or food interactions; and
c. honoring resident choice and preferences, consistent with his or her care plan ...