Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092187	A. BUILDING: _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 13-15, 2016.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 residents (#10) who required assistance, was assisted with eating during mealtimes. The findings are: Review of Resident #10's current FL-2 dated 12/16/15 revealed: -The resident's diagnoses included dementia, osteoarthritis, cataract, and glaucoma. -The resident was ambulatory with assistive device. -The resident was intermittently disoriented. -The resident had impaired vision. -There was an order for a regular diet. Review of Resident #10's Resident Register revealed the resident was admitted to the facility on 02/02/15. Review of Resident #10's current Care Plan dated 9/21/15 revealed: -The resident received a regular diet.	D 310	**Plan:** Resident #10 will continue to receive PT/OT to assist with ADLs concerning recent change in vision loss per need. Care Plan includes eating assistance with cutting food and to orientate the resident to food placement. PCR will include the Care Plan instructions to coordinate with the Care Plan. The Dietary Tracker will include the same information concerning eating as noted on the Care Plan to assure the therapeutic diets are followed. Staff re-education will be implemented by September 1, 2016 on therapeutic diets and ADL-eating assistance. **Monitoring:** RCC to verify the Diet Tracker and PCR match the diet needs on the Care Plan. ED and RCD to randomly audit the PCR and Diet Tracker to assure they are accurate. ED and RCD to randomly do daily meal checks and verify therapeutic diets are served as ordered.	08/17/16 08/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Regional Director (X6) DATE: 8/17/16

Reviewed & Acknowledged
10/3/16

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D 310	Continued From page 1 -The resident's vision was noted as "very limited (blind)" due to glaucoma, cataracts, and corneal transplant in left eye. -The resident required "extensive assistance" while eating. -Staff were to provide assistance during "meal prep, cutting of food, and orienting resident to where food is located on plate." -The resident needed assistance to open packets due to being "visually impairment/legally blind." Review of Resident #10's Licensed Health Professional Support (LHPS) dated 4/12/16 and 7/05/16 revealed staff were to assist the resident with all activities of daily living including mealtimes. Review of the list of residents who required assistance during mealtime dated 7/13/16 revealed Resident #10 required a regular diet and preferred to use an adapted plate and dish. Observation of the dinner meal on 7/13/16 at 5:08 p.m. for Resident #10 revealed: -Staff brought the resident's food to her and greeted her prior to leaving the table and returning to the kitchen area. -The staff person did not explain where the food items were on the resident's plate prior to leaving her table. -The resident used her hands to locate the food items in her adapted plate in front of her. -The resident bumped her plate, spilled some of her food, and another resident at the table assisted her. -The resident was unable to locate her beverages in front of her and the same resident at the table helped her. -Another resident at the table picked up the resident's hamburger after she could not locate it,	D 310		

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D 310	Continued From page 2 broke it apart, and put it in the resident's hand. -A Personal Care Aide (PCA), who was on her way back to the kitchen area after she had delivered another resident's plate to a different table, replaced the resident's plate with a new plate of food and explained where the food was located on her plate after being notified by the surveyor. Interview with a resident at the table with Resident #10 on 7/13/16 at 4:56 p.m. revealed: -She tried to help the resident as often as she could. -She enjoyed helping her because she was blind and needed her help. -When she was not able to help the resident with eating her meal, the other resident at the table helped her. -She helped the resident by letting her know where food was on her plate, how much was still there, and if she dropped any food while scooping. -She would physically assist the resident by handing her the food, directing her hand with utensil to where food was on her plate, and by handing her beverages. Observation of Resident #10 at the dinner meal on 7/13/16 at 5:31 p.m. revealed: -The first resident verbally and physically prompted the resident. -She had stopped eating prior to a resident assisting her with her meal. -The first resident prompted Resident #10 to where more food was on her plate and how much was left. -The Resident Care Coordinator (RCC) stopped at the resident's table, asked how the residents were doing, and then proceeded to help Resident #10 locate the food left on her plate.	D 310		

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D 310	Continued From page 3 -The RCC explained to the resident what food items were left and which side of the plate it was located. -Resident #10 resumed eating and finished 100% of her meal after being assisted. Observation of Resident #10 at the lunch meal on 7/14/16 at 12:20 p.m. revealed: -Resident #10 was sitting at the dining room table. -The resident was served a biscuit, 1 cup of tossed salad, 1 cup of water, 1 cup of tea, 1 cup of milk and a small bowl of cereal (1 cup crispy rice). -The resident bumped against her bowl of cereal and almost turned it over. A second resident at the table grabbed the bowl and assisted the resident. -The second resident at the table verbally prompted the resident with locating her food and provided occasional physical assistance to aid her in consuming her meal. -The resident ate three fourths of her meal. -Staff removed the resident from the table to be seen by the doctor. Interview with the Regional Nurse on 7/14/16 at 12:37 p.m. revealed: -Resident #10 had "multiple medication" changes. -She had noticed a recent change with Resident #10 leaning to her side more within the past couple of days. -She would follow-up with Resident #10's doctor and family. -Psychological changes were noticed for Resident #10 as she would usually feed herself. -Resident #10 was removed from the dining room to be seen by the doctor. Interview with Resident #10 on 7/14/16 at 12:40	D 310		

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D 310	Continued From page 4 p.m. revealed: - "Her friends helped her" during meals. -She had not asked for staff to help her when needed. -She preferred to do as much for herself as she could but "may need some help at times." Interview with a second resident at the table with Resident #10 on 7/14/16 at 1:15 p.m. revealed: -She helped the resident with eating her meals when the first resident was not there. -She helped the resident because she could not see and she was her friend. -She had been assisting the resident for "quite a while" with eating for "all three meals each day." -She was not sure if staff were able to help the resident "so she and the first resident helped her every day." Interview with a Personal Care Aide (PCA) on 7/14/16 at 1:20 p.m. regarding Resident #10 revealed: -Staff did everything for the resident except fed her. -The resident fed herself well for all three meals. -Staff were not required to do anything different or special to assist the resident with her meals. -Staff were only asked to make the resident aware of what she had on her plate and where it was located on her plate. -Staff were asked to promote her independence as much as possible during dining. -Other residents may have tried to help her but the resident could feed herself. Interview with a second PCA on 7/14/16 at 1:30 p.m. regarding Resident #10 revealed: -The resident received a regular diet and used an adapted dish for meals. -She used the "clock method" when she	D 310		

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D 310	Continued From page 5 explained where the food was on her plate. She used the times on the clock when she explained where everything was placed on the resident's plate. -Staff were not asked to do anything additional for the resident. -The resident could feed herself and had not asked for staff help. -She had reminded other residents at the table not to feed the resident but it was "okay to prompt the resident by pointing out or saying where food was on her plate." -Staff took Resident #10's food order, brought her plate, and told her where everything was on her plate. -The resident had "always fed herself very well with no changes or issues." -The resident fed herself for all three meals each day. -Staff were required to "set the resident up" for meals. Interview with a third PCA on 7/14/16 at 4:55 p.m. for Resident #10 revealed: -Staff did everything for the resident. -The resident fed herself. -Staff informed the resident where the food was on her plate and whether it was on her left or right side. -The resident fed herself after staff "set her up" for meals. -The resident did well on the regular diet and had no special procedures staff were to follow. -Other residents were not to feed the resident but could "verbally direct her when needed." -Staff encouraged the resident to do as much for herself as possible. -Other residents tried to help feed and assist the resident with her meals.	D 310		

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D 310	Continued From page 6 Interview with the Regional Director of Operations, the Resident Care Coordinator, the Regional Nurse, and the Administrator on 7/15/16 at 5:16 p.m. revealed: -They were aware the resident was being assisted during mealtimes by two other residents at her table. -The other residents had been asked not to feed Resident #10 but it was okay to verbally prompt her. -Resident #10 required extensive assistance for mealtimes per her Care Plan. -Extensive assistance meant that Resident #10 required staff assistance during mealtimes if she could not complete 50% or more of the task herself. -Resident #10 fed herself well after staff placed her sectioned plate in front of her. -Other residents at the table liked helping Resident #10 during meals. -Resident #10 had not asked for help while eating. -They were not aware Resident #10 had dropped food, could not locate food on her plate, or had bumped against her beverage cups or sectioned plate with food during meals. -Resident #10's vision loss had been less than a year ago and she needed more time to adjust to this change and to asking for help when needed. -She wanted to be as independent as she could and did not want staff assistance. -She was more receptive to help during meals from other residents. -They would consider seating Resident #10 by herself so that other residents would not feed her. -Resident #10 would be evaluated further by occupational therapy and physical therapy for any recommendations during mealtimes due to vision loss (legally blind).	D 310		

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D 310	Continued From page 7 The guardian of Resident #10 could not be reached by telephone prior to the end of the survey.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered for 4 of 6 residents (#6, #7, #8, #9) observed during the medication passes, including errors with a blood pressure/heart medication (#6), a lubricant eye drop (#7), a medication used as a pain reliever (#8), a vitamin D supplement (#9), and a powered laxative to stimulate bowel movements (#7, #9). The findings are: The medication error rate was 24% as evidenced by the observation of 6 errors out of 25 opportunities during the 5:00 p.m. / 6:00 p.m. medication pass on 07/13/16, and the 8:00 a.m. / 9:00 am, medication pass on 07/14/16. 1. Review of Resident #6's current FL-2 dated 06/10/16 revealed: -The resident's diagnoses included acute chronic	D 358	**Plan:** Regional Nurse or Nurse Consultant to provide a medication pass review/re-education to MedTechs by September 1, 2016. **Monitoring:** RCD/ED to randomly observe medication passes to assure medication administration compliance with orders and policies.	

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D 358	Continued From page 8 congestive heart failure, atrial fibrillation, transient ischemic attacks, subdural hematoma, and hypertension. -There was an order for Coreg 3.125mg twice daily with meals. (Coreg is a heart medication used to treat congestive heart failure and treat high blood pressure. According to the manufacturer, Coreg should be taken with food to slow the absorption and reduce the risk of a sudden drop in blood pressure). Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Coreg 3.125mg twice daily with meals. -Coreg was scheduled to be administered at 8:00 a.m. and 5:00 p.m. Observation during the 5:00 p.m. medication pass on 07/13/16 revealed: -The Medication Aide (MA) administered 1 Coreg 3.125mg to Resident #6 at 4:53 p.m. in the resident's room. -The resident had not eaten supper. Observation of Resident #6 on 07/13/16 at 5:13 p.m. revealed the resident was on the porch of the facility preparing to depart with his family at 5:13 p.m. Interview with the MA on 07/13/16 at 6:15 p.m. revealed: -She thought medications ordered with meals could be given within 15 to 20 minutes of the meal. -She thought the resident would be eating at the facility. -She did not realize Resident #6 was planning on leaving the facility with his family to eat. -She told Resident #6's family he needed to eat	D 358		

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D 358	Continued From page 9 soon since he had taken his 5:00 p.m. medications. -Resident #6 usually went out to eat with his family one to two times per week. Interview with the Resident Care Coordinator on 07/13/16 at 6:30 p.m. revealed: -Medications ordered with meals were supposed to be administered right before eating a meal or with a snack. -Resident #6 usually went out to eat with his family on Wednesdays. Interview with a Regional Nurse on 07/13/16 at 6:35 p.m. revealed she would contact the provider related to Coreg being administered with a meal since Resident #6 routinely left the facility weekly to have a meal with his family. Interview with Resident #6 on 07/14/16 at 4:00 p.m. revealed: -The resident had not experienced any signs or symptoms of lowered blood pressure or feeling faint. -The resident had not eaten before he left the facility on 07/13/16. -The resident usually received his medications in his room before supper. 2. Review of Resident #7's current FL-2 dated 07/06/16 revealed diagnoses included Alzheimer's dementia, sepsis, acute kidney injury, and coronary artery disease. A. Review of Resident #7's current FL-2 dated 07/06/16 revealed an order for Miralax take 17grams daily mixed in 4 to 8 ounces of fluid prior to taking. (Miralax is a medication used to aid in constipation by stimulating bowel movements).	D 358		

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D 358	Continued From page 10 Review of a subsequent physician's order dated 07/08/16 for Miralax 17gram daily, mix in 4 ounces of water prior to taking. Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Miralax 17gram, mix 1 capful in 4 ounces of suitable liquid daily. -Miralax was scheduled to be given at 8:00 a.m. Observation of the 8:00 a.m. medication pass on 07/14/16 revealed: -The Medication Aide (MA) poured the Miralax powder in the provided measuring cup without leveling the amount of heaped powdered medication poured. -The MA did not measure the Miralax powder at eye level. -The MA mixed the Miralax powder in approximately 7-8 ounces of water. -She held the cup for Resident #7 and encouraged her to drink at intervals, pausing in between, and used the Miralax mixed in water to take the other ordered oral medications. -There was approximately one ounce of liquid remaining in the cup containing the Miralax and water; the MA told the resident "We will come back to that". -The MA did not offer any more of the Miralax mixed with water to Resident #7. -The MA disposed of the cup containing approximately one ounce of Miralax mixed with water. -Resident #7 did not receive the full dose of Miralax. -The MA documented Miralax 17gm was administered to the resident. Interview with the MA on 07/14/16 at 2:04 p.m. revealed:	D 358		

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D 358	Continued From page 11 -Resident #7 would sometimes hold the cup and drink the Miralax herself. -Resident #7 received all of the Miralax in the cup today. -The MA was not aware that the Miralax for Resident #7 was heaped and not leveled when poured to measure in the cap. -The MA knows to measure at eye level when preparing liquid or powered medications. Interview with the Regional Nurse and the Resident Care Coordinator on 07/14/16 at 2:35 p.m. revealed: -The MAs were expected to measure powdered medications at eye level in the appropriate measuring devices. -The MAs were expected to measure the powered medication to the ordered amount. -The resident should have drank all the Miralax in the cup. Interview with the Special Care Unit Coordinator (SCUC) on 07/14/16 at 4:40 p.m. revealed Resident #7 had not had any issues with constipation. B. Review of Resident #7's current FL-2 dated 07/06/16 revealed an order for Artificial Tears 2 drops into both eyes three times daily. (Artificial Tears is used to treat dry eyes). Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Artificial Tears 2 drops in each eye three times daily. -Artificial Tears was scheduled to be given at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Observation of the 8:00 a.m. medication pass on 07/14/16 revealed:	D 358		

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D 358	Continued From page 12 -The Medication Aide (MA) advised Resident #7 it was time for her to have her eye drops. -The MA provided Resident #7 a tissue. -The MA, one attempt at a time with each eye, positioned the Artificial Tear container over Resident #7's closed eyelids, touched the corner of the closed eyelids, squeezed the container over each closed eye, causing several drops to stream down both sides of the resident's face. -The MA did not pull the lower eyelid down to form a pocket when she administered the eye drops. -The Artificial Tear drops did not make contact with the surface of the eyes. -The MA did not ask the resident to lay down or open her eyes. Interview with the MA on 07/14/16 at 2:04 p.m. revealed: -It was hard for Resident #7 to tilt her head back when eye drops are administered. -The MA was taught to lift the top eyelid to administer eye drops into the eyes. Interview with the Regional Nurse and the Resident Care Coordinator on 07/14/16 at 2:35 p.m. revealed: -The MAs were supposed to administer eye drops in the lower eye lid. -The MAs were expected not to allow the tip of the eye drop bottle to touch the skin in order to avoid contamination of the medication. 3. Review of Resident #8's current FL-2 dated 06/23/16 revealed: -The resident's diagnoses included dementia, hypertension, dyslipidemia, pacemaker, seasonal allergies, anxiety, irritable bowel syndrome and constipation. -There was an order for Acetaminophen 325mg,	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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
D 358	Continued From page 13 2 tablets every 8 hours as needed for pain. (Acetaminophen is a medication used to treat minor aches and pains). Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Acetaminophen 325mg, take 2 every 8 hours as needed for pain. -Acetaminophen 325 mg, 2 tablets was last administered on 07/06/16 at 5:52 a.m. Observation of the medication pass on 07/14/16 at 10:12 a.m. revealed: -Resident #8 complained of pain to the Medication Aide (MA) in her right upper arm/shoulder and back, at 10:05 a.m. and at 10:12 a.m. -Resident #8 rubbed her right upper arm and showed facial grimacing when describing her pain. -The MA told Resident #8 she would check to see what she could give her for pain. -The MA went back to the medication cart and continued to give medications to other residents. -The MA did not administer any pain medications to Resident #8. Interview with the MA on 07/14/16 at 10:25 a.m. in the hallway revealed Resident #8 had received all of her medication. Interview with Resident #8 on 07/14/16 at 11:15 a.m. in the day room revealed her right upper arm/shoulder and back were hurting. Interview with the MA on 07/14/16 at 11:23 a.m. in the hallway revealed: -She had not forgotten about Resident #8's pain. -She was "multitasking". -The MA would ask Resident #8 if she was in pain	D 358		

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D 358	Continued From page 14 since a lot of residents in the Special Care Unit (SCU) would say they are in pain and later deny any pain. -She would check to see what medication Resident #8 could take for pain. Observation of the MA on 07/14/16 at 11:25 a.m. revealed: -The MA asked Resident #8 if she was in pain and the resident responded yes. -The MA reviewed the medication list for Resident #8 in the electronic MAR. -The MA placed Tylenol 325mg, 2 tablets in a soufflé cup. -The MA administered the Tylenol 325mg, 2 tablets to Resident #8 at 11:26 a.m., 1 hour and 21 minutes after the resident's first complaints of pain. Interview with Resident #8 on 07/14/16 at 4:35 p.m. in the dining room revealed she was no longer hurting. Interview with the MA on 07/14/16 at 2:04 p.m. revealed: -The MA did not forget to check on Resident #8's pain and pain medication. -The MA was responsible for administering all the resident's medications in the SCU. -The MA was working her way back to follow up with Resident #8 and her pain. Interview with the Regional Nurse and the Resident Care Coordinator on 07/14/16 at 2:35 p.m. revealed the MAs were expected to give residents as needed pain medication within 5 to 10 minutes after a resident complains of pain. 4. Review of Resident #9's current FL-2 dated 12/22/15 revealed diagnoses included dementia,	D 358		

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D 358	Continued From page 15 anemia, hypertension, gastroesophageal reflux disease and osteoarthritis. A. Review of Resident #9's current FL-2 dated 12/22/15 revealed an order for Vitamin D3 1000 units, take daily. (Vitamin D is a supplement to build and keep bones strong). Review of a subsequent physician's order dated 05/06/16 for Vitamin D3 2000 units by mouth daily. Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Vitamin D3 2000 units, take one tablet daily. -Vitamin D3 was scheduled to be given at 8:00 a.m. Observation of the 9:00 a.m. medication pass on 07/14/16 revealed: -The MA prepared and administered one Vitamin D3 1000 units to Resident #9 at 10:23 a.m. instead of 2000 units as ordered. -The resident received the Vitamin D3 1000 units at 10:23 a.m. -The MA documented OOC (out of cycle) in the electronic MAR for Vitamin D3 1000units which indicated the medication was administered late. Review of medications on hand on 07/14/16 revealed: -There was one card labeled Vitamin D3 1000 units, dispensed 04/22/16 with a quantity number of 30 tablets, and instructions to give one daily. -There was a second card labeled Vitamin D3 2000 units, dispensed 06/30/16 with a quantity number of 30 tablets, and instructions to give one daily. -No tablets had been used from the card	D 358		

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D 358	Continued From page 16 dispensed on 06/30/16 with Vitamin D 2000 units. Interview with the MA on 07/14/16 at 2:04 p.m. revealed: -The MA did not notice the instruction label for the Vitamin D3 was for 1000units instead of the ordered 2000 units for Resident #9. -All of the medications in the cart should match the medications that are ordered. -She should have administered Vitamin D3 2000 units to Resident #9. -She will have the Special Care Unit Coordinator (SCUC) send the Vitamin D3 1000units back to the pharmacy. Interview with the Regional Nurse and the Resident Care Coordinator on 07/14/16 at 2:35 p.m. revealed: -MAs were supposed to administer all medications according to the instructions on the MAR. -If there was a medication in the cart that was different than what is on the MAR, the MA should stop, pull the card, let the coordinator know and not give the medication. B. Review of Resident #9's current FL-2 dated 12/22/15 revealed an order for Miralax, mix one capful (17grams) in 8 ounces of liquid and drink once daily after a meal. Review of the July 2016 Medication Administration Record (MAR) revealed: -There was an entry for Miralax 17gram mix in 8 ounces of liquid daily after a meal. -Miralax was scheduled to be given at 9:00 a.m. Observation of the 9:00 a.m. medication pass on 07/14/16 revealed: -The MA poured the Miralax powder in the lid of	D 358		

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D 358	Continued From page 17 the medication container without leveling the amount of powdered medication poured. -The lid was not marked with measuring increments. -The MA did not use the provided clear marked measuring cup that covered the container lid. -The MA did not measure the Miralax powder at eye level. -The MA mixed the Miralax powder with approximately 7-8 ounces of orange juice. -Resident #8 was sitting in a day room with other residents while some residents were receiving foot care. -The MA handed Resident #9 the cup containing the Miralax mixed with orange juice and walked away. Observation of Resident #9 on 07/14/16 at 10:35 a.m. revealed the resident was holding the empty cup that contained the Miralax and orange juice. Observation of the MA on 07/14/16 at 10:36 a.m. revealed: -The MA checked on Resident #9. -The MA took the empty cup from Resident #9. Interview with the MA on 07/14/16 at 2:04 p.m. revealed: -The MA knows to measure at eye level when preparing liquid or powered medications. -The MA was not aware that the Miralax for Resident #9 was heaped and not leveled when poured to measure in the cap. -The MA was not aware that there was a clear measuring cap provided over the Miralax lid for Resident #9. Interview with the Regional Nurse and the Resident Care Coordinator on 07/14/16 at 2:35 p.m. revealed:	D 358		

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D 358	Continued From page 18 -The MAs were expected to measure powdered medications at eye level in the appropriate measuring devices. -The MAs were expected to measure the powered medication to the ordered amount. -MAs were expected to always observe residents take all of their medications.	D 358		