

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155675	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2016
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NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 11, 12, 13, 14, 15, 18, 19, and 20, 2016.</p> <p>Facility number: 011039 Provider number: 155675 AIM number: 200299100</p> <p>Census bed type: SNF/NF: 52 SNF: 4 Residential: 16 Total: 72</p> <p>Census payor type: Medicare: 9 Medicaid: 25 Other: 22 Total: 56</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 34233 on July 26, 2016.</p>	F 0000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p>	
F 0278	483.20(g) - (j)			

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

TITLE

(X6) DATE

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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SS=D Bldg. 00	<p>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were completed accurately related to dental status, medications and weight loss. This affected 3 of 12 residents reviewed for MDS assessments. (Residents #70, #32, #24)</p>	F 0278	F278 The MDS for resident #70 has been corrected to reflect current dental status. The MDS for resident #32 has been corrected to reflect anti-depressant use. The MDS for Resident #24 has been corrected to reflect weight loss All residents with dental issues, weight loss and who receive an anti-depressant medication have	08/19/2016

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	<p>Findings include:</p> <p>1. Record review of the annual MDS assessment, dated 04/14/2016, indicated Resident #70 had no dental issues.</p> <p>During the initial observation on 07/12/2016 at 3:42 P.M., Resident #70 was noted to have chipped teeth.</p> <p>During an observation and interview with Resident #70, on 07/18/2016 at 4:30 P.M., accompanied by the DON (Director of Nursing), Resident #70 indicated she had no dental problems and had fourteen teeth. Resident #70's front teeth were noted to be chipped with a gray area.</p> <p>During an interview on 07/18/2016 at 4:35 P.M., the DON indicated the MDS (Minimum Data Set) assessment should have indicated Resident #70 had chipped teeth.</p> <p>During an interview on 07/20/2016 at 9:21 A.M., the MDS coordinator indicated during the resident's head to toe assessment, the resident's mouth should have been examined.</p> <p>2. Resident #32's clinical record was reviewed on 07/14/2016 at 1:54 P.M. Diagnoses included, but were not limited to, diabetes, neuropathy, and</p>		<p>the potential to be affected. The MDS Coordinator was re-educated by the Executive Director on the RAI manual for proper coding of MDS. An audit of the dental, weight loss and antidepressant sections of the MDS will be completed by the Interdisciplinary Team 3 times weekly for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p> <p>Plan of Compliance is effective: August 19, 2016</p>	

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	<p>Alzheimer's/dementia with behavioral disturbance.</p> <p>The quarterly MDS assessment dated 05/31/2016, did not indicate Resident #32 had taken an antidepressant.</p> <p>A doctor's order for Cymbalta 60 mg (milligrams), an anti-depressant, dated 10/13/2015, was provided by the DON (Director of Nursing) on 07/18/2016 at 4:20 P.M. and reviewed at that time. The Medications Administration History indicated Resident #32 received Cymbalta 6 of the 7 days during the look back period for the quarterly MDS assessment.</p> <p>During an interview on 07/18/2016 at 3:37 P.M., the Corporate Nurse indicated completion of the medications section of the MDS should be done according to the RAI (Resident Assessment Instrument) guidelines.</p> <p>During an interview on 07/18/2016 at 3:45 P.M., the DON verified that Resident #32 had taken the antidepressant, Cymbalta, for 6 out of 7 days during the look back period for the quarterly MDS assessment.</p> <p>During an interview on 07/20/2016 at 9:13 A.M., the MDS coordinator</p>			

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F 0279 SS=D Bldg. 00	<p>indicated she reviewed the medications for the MDS assessments and did not code the medication, Cymbalta, appropriately for the quarterly MDS assessment dated 05/31/2016, for Resident #32.</p> <p>The current RAI guidelines were provided by the MDS coordinator on 07/19/2016 at 1:00 P.M. and reviewed at that time. The guidelines indicated, "...Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period..." The guidelines further indicated, "...Code medications ... according to the medication's therapeutic category and/or pharmacological classification, not how it is used..."</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain</p>				

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	<p>the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a Care Plan for psychotropic drug use related to the use of an anti-depressant for 1 of 5 residents reviewed for unnecessary medications. (Resident #32)</p> <p>Findings include:</p> <p>Resident #32's clinical record was reviewed on 07/14/2016 at 1:54 P.M. Diagnoses included, but were not limited to, diabetes, neuropathy, and Alzheimer's/dementia with behavioral disturbance.</p> <p>A doctor's order for Cymbalta 60 mg (milligrams), an anti-depressant, was dated 10/13/2015. The order indicated the medication was for, "...Other specified diabetes mellitus with diabetic neuropathy, unspecified..." No care plan for monitoring of side effects for an anti-depressant was noted.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 10/20/2015,</p>	F 0279	<p>F279</p> <p>Resident #32 care plan was updated to reflect anti-depressant use and side effect monitoring has been implemented.</p> <p>All residents receiving antidepressant medication have the potential to be affected. An audit was completed to verify all residents with anti-depressant medications have care plans and side effects monitoring as needed. No issues identified.</p> <p>All licensed nurses will be re-educated regarding care plans for residents on anti-depressant medication and side effect monitoring.</p> <p>An audit will be completed 3 times weekly for 4 weeks, weekly for 4 weeks, and</p>	08/19/2016

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	<p>indicated Resident #32 received an anti-depressant for 7 out of 7 days during the look-back period.</p> <p>During an interview on 07/18/2016 at 3:32 P.M., the DON (Director of Nursing) indicated she was unaware there were no orders for monitoring side effects from the anti-depressant and the facility normally added a separate order for monitoring medication side effects.</p> <p>During an interview on 07/18/2016 at 3:45 P.M., the DON indicated residents on an anti-depressant should be care planned for monitoring for side effects even though the anti-depressant for Resident #32 was ordered for pain related to neuropathy.</p> <p>During an interview on 07/20/2016 at 9:13 A.M., the MDS Coordinator indicated she or the SSD (Social Services Director) developed the care plans for psychotropic medications following completion of the MDS assessment. The MDS Coordinator indicated Resident #32 should have had a care plan for psychotropic medications.</p> <p>3.1-35(a)(c)(1)</p>				<p>then monthly for 3 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p> <p>Plan of Compliance is effective: August 19, 2016</p>		

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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident's pain was controlled related to providing scheduled pain medication for 1 of 30 residents reviewed for pain. (Resident #16)</p> <p>Findings include:</p> <p>During an interview on 07/18/2016 at 10:47 A.M., RN #1 indicated Resident #16's pain patch had been scheduled to be changed on 07/17/2016, but the old patch, dated 07/14/2016, was still in place. The RN further indicated the resident did not have any more medication patches in the medication cart.</p> <p>During an interview on 07/18/2016 at 11:31 A.M., RN #1 indicated she would need to call the doctor to get an order so she could get Resident #16 medication from the EDK (Emergency Drug Kit).</p>	F 0309	<p>F309</p> <p>Resident #16's physician was notified, an order was received to provide pain medication from the Emergency Drug Kit and the Resident's topical pain patch was changed on 7/18/16.. A pain assessment was also completed. Licensed nursing staff continued to monitor Resident's pain with no further concerns identified.</p> <p>All residents with orders for topical pain patches have the potential to be affected. An audit was completed to identify those residents with orders for topical pain patches and ensure topical patches have been administered per physician's orders. No</p>	08/19/2016

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	<p>During an interview on 07/19/2016 at 10:20 A.M. the DON (Director of Nursing) indicated the nurse that was supposed to replace Resident #16's medication patch on 07/17/2016 attempted to call the pharmacy that day (07/17/2016), but could not reach them. The nurse got busy and forgot to call the pharmacy back later. The DON was not sure why the old medication patch had not been removed. The DON also indicated RN #1 checked for placement of the medication patch on 07/18/2016, but did not check the date as she should have.</p> <p>During an interview on 07/19/2016 at 10:31 A.M., the family member of Resident #16 indicated the resident's pain patch was missed on Sunday and the resident had been in "a lot of pain." The family member further indicated when Resident #16's pain patches were changed, as scheduled, the resident's pain was well controlled.</p> <p>During an interview on 07/19/2016 at 11:13 A.M., Resident #16 indicated he had been in some pain yesterday (07/18/2016). The resident further indicated his pain was usually controlled by the pain patches, but it</p>		<p>issues were identified. All licensed nursing staff will be re-educated on administration of topical pain patches, including steps to take when pain patch is not available in the medication cart. An audit of pain patch administration and placement will be completed 3 times weekly for 4 weeks, weekly for 4 weeks, then monthly for three months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly. Plan of Compliance is effective: August 19, 2016</p>	

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	<p>was not yesterday until they applied the new pain patches.</p> <p>During an interview on 07/19/2016 at 11:35 A.M., RN #1 indicated Resident #16's family member brought the outdated patch to her attention. The RN further indicated she had checked the placement of the patch, but had missed the dates.</p> <p>Resident #16's clinical record was reviewed on 07/19/2016 at 11:55 A.M. The Admission MDS (Minimum Data Set) assessment, dated 06/30/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 15 and was cognitively alert and oriented. The resident's diagnoses included, but were not limited to, gastroesophageal reflux disease, arthritis, and chronic pain. The assessment indicated the resident did receive scheduled pain medication.</p> <p>Resident #16's physician orders indicated fentanyl patch, 100mcg/hr (micrograms per hour) once every three days.</p> <p>An Event report for Resident #16 indicated on 07/17/2016 the resident's fentanyl patch was not changed due to the medication not</p>			

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F 0323 SS=E Bldg. 00	<p>being available. A new order was received on 07/18/2016 to put two 50mcg patches on from the EDK.</p> <p>The current facility policy, titled "Transdermal Drug Delivery Systems" and dated 01/01/05, was provided by the DON (Director of Nursing) on 07/19/2016 at 10:51 A.M. and was reviewed at that time. The policy indicated, "...if patch remains in place, remove..."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the residents' environment was free from hazards related to medication disposed of in the trash can. This had the potential to affect 39 of 56 independently mobile residents who resided in the building.</p> <p>Findings include:</p> <p>During an observation of medication administration on 07/18/2016 at 7:11</p>	F 0323	<p>F323</p> <p>The pills were removed from the trash and placed in the sharps container on 7/18/2016.</p> <p>39 residents had the potential to be affected. No residents were affected.</p> <p>All licensed nursing staff will</p>	08/19/2016

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	<p>A.M., RN #1 disposed of one vitamin D table and two acetaminophen tablets in the trash can attached to the side of the medication cart.</p> <p>During an interview on 07/18/2016 at 7:21 A.M., RN #1 indicated the medication should have been disposed of in the sharps container, not in the trash can.</p> <p>During an interview on 07/19/2016 at 10:04 A.M., the ADON (Assistant Director of Nursing) indicated medications were to be disposed of in the sharps container.</p> <p>During an interview on 07/19/2016 at 1:00 P.M., the MDS (Minimum Data Set) Coordinator indicated there were 39 independently mobile residents residing in the facility.</p> <p>The current facility policy, titled "6.0 General Dose Preparation and Medication Administration", was provided by the Administrator on 07/20/2016 at 8:30 A.M. and was reviewed at that time. The policy indicated, "...If a medication which is not in a protective container is dropped, facility staff should discard it in a sharps container."</p> <p>3.1-45(a)(1)</p>		<p>be re-educated on the proper disposal of medications.</p> <p>Medication pass will be observed to monitor for proper disposal of medication 3 times weekly for 4 weeks, weekly for 4 weeks, and then monthly for 3 months. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly.</p> <p>Plan of Compliance is effective: August 19, 2016</p>		

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F 0332 SS=D Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 2 medication errors out of 29 opportunities for error, resulting in a 6.9% error rate. This affected 2 of 6 residents observed for medication pass (Resident #70 and #59).</p> <p>Findings include:</p> <p>1. During an observation of medication administration on 07/18/2016 at 7:11 A.M., RN (Registered Nurse) #1 administered Resident #70's medication, including 15 mg (milligrams) of olanzapine.</p> <p>Resident #70's clinical record was reviewed on 07/18/2016 at 12:15 P.M. The resident's physician orders indicated Zyprexa (olanzapine) 10 mg once a day at 7:00 A.M.</p> <p>2. During an observation of medication administration on 07/18/2016 at 7:21 A.M., RN #1 administered medication,</p>	F 0332	<p>F332</p> <p>Physician of Resident #70 and Resident #59 were notified of the occurrences with the medications on 7/18/2016. No new orders were received. Residents #70 and # 59 were reassessed by the nurse and no adverse effects were noted.</p> <p>All residents have the potential to be affected. Review of all residents completed with no issues identified.</p> <p>All licensed nursing staff will be re-educated on the guidelines for 5 rights of medication administration.</p> <p>Medication observations will</p>	08/19/2016

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NAME OF PROVIDER OR SUPPLIER MORNING BREEZE RETIREMENT COMMUNITY AND HEALTHC	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N LAKEVIEW DR GREENSBURG, IN 47240
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R 0000 Bldg. 00	<p>including 10 mEq (milliequivalents) of potassium chloride to Resident #59.</p> <p>Resident #59's clinical record was reviewed on 07/18/2016 at 12:20 P.M. The resident's physician orders indicated potassium chloride 30 mEq twice a day at 8:00 A.M. and 8:00 P.M.</p> <p>The current facility policy, titled "General Guidelines for Administering Medication" and revised on 07/26/2006, was provided by the Administrator on 07/18/2016 at 1:15 P.M. and reviewed at that time. The policy indicated, "...The nurse will check the medication name, strength, route and dose that are on the prescription label against the Medication Administration Record and assure that the information on the individual unit-dose package matches. The nurse is the final check in preventing medication errors and it is his/her responsibility to assure every medication administered is correct..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>		<p>be completed on a minimum of 3 licensed staff weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly for 3 months. The observations will be conducted by the DON or designee. Result of the medication observations will be presented and reviewed in the monthly QA meetings. If any areas of concerns are identified action plans will be developed and continued until substantial compliance is achieved.</p> <p>Plan of Compliance is effective: August 19, 2016</p>	

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R 0295 Bldg. 00	<p>containing medication, were stacked on top of each other in the top drawer of the medication cart. LPN (Licensed Practical Nurse) #10 indicated the medications belonged to Resident #G, Resident #H, and Resident #J. The LPN further indicated medications were not supposed to be prepared in advance.</p> <p>During an interview on 07/20/2016 at 1:20 P.M., the DON (Director of Nursing) indicated medications were not to be prepared in advance.</p> <p>The current facility policy, titled "General Guidelines for Administering Medication" and revised on 07/26/2006, was provided by the Administrator on 07/18/2016 at 1:15 P.M. and was reviewed at that time. The policy indicated, "...Medications are administered at the time they are prepared. They are not pre-poured or pre-set in any manner."</p> <p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure resident medications were secured for 1</p>	R 0295	<p>All licensed nursing staff will be re-educated on policy for medication administration.</p> <p>Medication administration observations will be completed on 4 residents 5 times per week times 4 weeks, then 3 times per week times 4 weeks, and then 1 time per week times 4 weeks to ensure procedure is followed.</p> <p>Plan of Compliance is effective: August 19, 2016</p> <p>R295</p>	08/19/2016			

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	<p>of 1 residents who self medicate. (Resident #C)</p> <p>Findings include:</p> <p>During an observation and interview on 07/20/2016 at 10:38 A.M., Resident #C indicated she kept her medications in a drawer in her room and that she administers her own medications. Resident #C further indicated the drawer did not lock. The drawer was observed and no lock was noted. Resident #C indicated she did not know if the door to her room locked and she has never locked her door.</p> <p>During an observation and interview with LPN (Licensed Practical Nurse) #10 on 07/20/2016 at 1:05 P.M., Resident #C was noted walking down the hall away from her room. Her room door was left open and no one was inside. The drawer containing her medications, norvasc 2.5 mg (milligrams), metoprolol 50 mg and tylenol 325 mg, was not locked. A small metal box was noted laying on the resident's bed. LPN #10 indicated to Resident #C, who had returned to her room, the box was for her medications. LPN #10 indicated the box, that had a lock, did not have a key. As the nurse and resident left the room, the resident requested her door to be closed. The</p>		<p>Locked box was placed in resident #C room and medications were locked and secured for proper medication storage on 7/20/2016. Resident # C was educated along with their family members regarding the policy for maintaining and securing medications.</p> <p>Resident #C is the only resident that self administers. Licensed nursing staff re-educated regarding proper medication storage, utilizing the guidelines for self administration policy. Residents on assisted living were audited and interviewed to ensure that no other residents had medications that were not secured.</p> <p>DON or designee will audit that resident has locked box in apartment and that medications are stored in the locked box. Audits will be completed 5 times per</p>	

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	<p>room was not locked.</p> <p>During an interview on 07/20/2016 at 10:54 A.M., LPN #10 indicated Resident #C self-administered her medications. LPN #10 further indicated when residents were allowed to keep their medications in their rooms, the medications were to be kept locked up. She indicated Resident #C's medications were not locked up, they were kept in an unlocked drawer in the resident's room.</p> <p>During an interview on 07/20/2016 at 12:03 P.M., the Administrator indicated residents who were allowed to keep medications in their rooms had to keep them in a drawer.</p> <p>During an interview, on 07/20/2016 at 1:20 P.M., the DON (Director of Nursing) indicated she was not aware the medications had to be kept secured in a locked container.</p> <p>The Quarterly Assessment for Self-Administration of Medications, dated 06/25/2016, was provided by the DON on 07/20/2016 at 11:45 A.M. and reviewed at that time. The assessment indicated Resident #C was capable of administering her own medications and the medications would be stored in her room.</p>		<p>week times 4 weeks, then 3 times per week times 4 weeks, and then 1 time per week times 4 weeks to ensure procedure is followed.</p> <p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited.</p>	

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	The Medication Self Administration Evaluation Policy was provided by the DON on 07/20/2016 at 12:57 P.M. and reviewed at that time. The policy indicated, "...Residents who self-administer medication will safeguard medications from other residents by means of an individually keyed apartment door lock. In addition, residents may be provided an additional locked unit within their apartment as an additional safeguard upon request..."				