| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G794 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 03/27/2013 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AWS | 9110 N CR 700 W<br>SCIPIO, IN 47273 |

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| W000000 | This visit was for a fundamental annual recertification and state licensure survey.<br><br>Survey dates: March 25, 26, and 27, 2013.<br><br>Facility number: 012529<br>Provider number: 15G794<br>AIM number: 201017530<br><br>Surveyor: Steven Schwing, Medical Surveyor III<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br><br>Quality review completed April 3, 2013 by Dotty Walton, Medical Surveyor III. | W000000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| W000149 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on record review and interview for 11 of 25 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients.<br><br>Findings include:<br><br>A review of the facility's incident/investigative reports was conducted on 3/25/13 at 12:29 PM.<br><br>1. On 4/21/12 at 11:30 AM, client #1 pulled client #3's hair. The investigation, dated 4/24/12, indicated the facility substantiated abuse.<br><br>2. On 6/15/12 at 8:10 PM, client #2 grabbed client #4's hair while on the van. The investigative report, dated 6/19/12, indicated, in part, client #4 had "some hair loss." The facility indicated abuse was not substantiated. The investigation did not indicate why abuse was not substantiated.<br><br>3. On 7/20/12 at 10:30 AM at the facility-operated day program, client #4 sat in a male peer's seat. The male peer | W000149 | **W 149**<br>Protection of Clients from Abuse, especially Peer Abuse<br><br>**Corrective action for resident(s) found to have been affected**<br>In order to address Peer Abuse, all staff in the home will receive training from a certified Mandt (agency de-escalation and physical intervention technique) instructor. The training will focus on appropriate positioning or spacing of staff members when a client or clients are escalated. The express purpose of the training is to be in correct position to prevent peer aggression incidents.<br><br>**How facility will identify other residents potentially affected & what measures taken**<br>All residents potentially affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence**<br>All staff will be trained on appropriate spacing and positioning to prevent future cases of peer aggression. | 04/26/2013 |

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| | informed client #4 she was in his seat. When client #4 got up, she swore at him and he did the same. The male peer "pushed or hit" client #4 on the arm and she fell to the ground. There was no apparent injury. The facility substantiated abuse in the investigative report dated 7/25/12.<br><br>4. On 7/22/12 at 6:45 PM, client #1 obtained a spoon by stealing from a housemate who was using the spoon in privacy of own bedroom. The investigative report, dated 7/25/12, indicated client #1 told the housemate she would put the spoon in the sink for her. The report indicated, in part, "[Client #1] obtained a metal spoon & (and) implemented SIB (self-injurious behavior) by using end of spoon handle to insert into abdomen where scar tissue was." The report indicated, in part, "Evident procedure (not) appropriately followed...Mealware (not) implemented appropriately." The Bureau of Developmental Disabilities Services (BDDS) report, dated 7/23/12, indicated, in part, "At approximately 6:45 PM on 7/22/12 [client #1] approached staff stating she needed to talk to them. At that time [client #1] told the staff that she had broken the handle off her spoon and 'stabbed' herself in the abdomen. Staff observed the spoon in the scar area from | | **How corrective actions will be monitored to ensure no recurrence**<br>The home management team is responsible for supervising and training staff. The managers are supervised by the Director who meets with them on a regular basis to monitor plan implementation, including training needs of staff members. | |

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| | an old injury. This site has a significant indentation in which the spoon was inserted. There was little blood or sign of serious injury but [client #1] would not let staff examine her further. At the time of the incident staff had been assisting [client #1] prepare for her shower and as a result she was not wearing her body suit, stomach binder and alarm used to help deter self injury such as this. Staff reported that [client #1] had asked for privacy in order to have a bowel movement and staff left the bathroom for several minutes during which time [client #1] engaged in the SIB. According to staff, [client #1] reported that she obtained the spoon from the kitchen sink after a peer had placed it there and she hid it in her clothing. This was after the evening dishes had been cleaned and put away...Staff on duty during this incident will receive disciplinary action and re-training regarding proper implementation of the BSP (Behavior Support Plan), restrictions and safety procedures in handling metal eating utensils." The facility conducted an "informal" investigation into the incident.<br><br>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/25/13 at 2:58 PM. The QMRP indicated she completed an informal investigation due to the incident | | | |

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| | not fitting into abuse, neglect, exploitation or significant injury of unknown origin category. The QMRP indicated an informal investigation was conducted the same as a formal investigation. The QMRP stated, "Investigation no different than others."<br><br>5. On 10/13/12 at 7:00 PM, client #2 was singing and dancing in the dining room with a microphone. When client #3 got up to join her, client #2 slapped client #2 on her left cheek. Client #3 was not injured. The facility substantiated abuse in the investigative report dated 10/17/12.<br><br>6. On 10/17/12 at 12:25 PM at the facility-operated day program, client #4 was hit on the forehead by a marker thrown by a male peer. The facility substantiated abuse in the investigative report dated 10/23/12.<br><br>7. On 11/1/12 at 4:30 PM, client #2 "physically attacked" client #4 by pinning client #4 between the door and the wall. The investigative report, dated 11/6/12, indicated, in part, "It was alleged that [client #4] stole and drank [client #2's] water. [Client #2] ran after [client #4] and pinned her between [client #4's] bedroom door and the wall." Client #4 had a "small red area" on her elbow. The facility substantiated abuse in the | | | |

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| | investigative report dated 11/5/12.<br><br>8. On 11/14/12 at 3:15 PM, clients #1 and #2 hit each other. The investigative report, dated 11/19/12, indicated, in part, "After reviewing all information available, it was apparent that while [client #2] was talking to staff and accusing [client #1] of using all the hot water and other unspecified alleged transgressions, [client #1] became angry and verbally challenged [client #2] This angered [client #2] and both individuals physically aggressed toward the other and kicked each other before staff could separate them." The facility substantiated abuse.<br><br>9. On 12/24/12 at 3:05 PM, client #2 struck client #3 with an open hand on the shoulder causing a "small red mark." The facility substantiated abuse. The investigative report, dated 12/27/12, indicated, in part, "[Client #3] was hit by [client #2] and she does have a right to not be hit by anyone."<br><br>10. On 2/8/13 at 10:05 AM, client #1 slapped client #3's hand when client #3 placed her finger near client #1's face. The facility substantiated abuse in the investigative report dated 2/13/13.<br><br>11. On 2/12/13 at 5:15 PM, client #3 was | | | |

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| | slapped on her back by client #2 as client #3 was putting away dishes. The report indicated, "[Client #2] physcially (sic) hit [client #3]." The report indicated, in part, "All evidence reviewed demonstrates that [client #2] physcially (sic) aggressed on [client #3] by slapping her in her back when [client #3] was putting away dishes. [Client #2] did not verbally indicate frustrations with [client #3], however after hanging up the phone she walked past her and physically assualted (sic) her." The investigative report, dated 2/15/13, indicated abuse was substantiated. Client #3 was not injured.<br><br>A review of the facility's Group Home Abuse and Neglect policy, dated 12/5/12, was conducted on 3/25/13 at 2:36 PM. The policy indicated, in part, "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse. Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Verbal abuse is speaking, writing or gesturing in a derogatory manner to a client or in proximity of a client. Psychological abuse includes doing or saying anything that would humiliate an individual, like teasing or making fun. It includes threats of punishment or deprivation as well as | | | |

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| | threats or intimidation. Neglect includes failure to provide appropriate care, food, medical care or supervision. Exploitation includes any deliberate misplacement of individual's money, wrongful use of an individual's money or belongings. If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place. If the charges are substantiated disciplinary action will be taken which may include termination. Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities."<br><br>An interview with the QMRP was conducted on 3/26/13 at 10:59 AM. The QMRP indicated client #2 was the main source of client to client incidents. The QMRP indicated client #2 would hit others with no antecedents or precursors. The QMRP indicated the facility's policy prohibited abuse. The QMRP stated the staff "try their best to prevent" client to client abuse. The QMRP stated the staff "work very hard to keep it from happening but it still does." | | | |

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| | 9-3-2(a) | | | |

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| W000249 | 483.440(d)(1)<br>PROGRAM IMPLEMENTATION<br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br>Based on observation, interview and record review for 1 of 2 clients in the sample (#3), the facility failed to ensure staff implemented her medication training objectives.<br><br>Findings include:<br><br>An observation was conducted at the group home on 3/26/13 from 6:24 AM to 8:41 AM. At 7:53 AM, client #3 received her medications from staff #10. Client #3 was not offered or prompted to wear her glasses. Staff #10 did not prompt client #3 to initial the Medication Administration Record (MAR) to indicate if she agreed with wearing her glasses or after self-administering her Calcium.<br><br>A review of client #3's record was conducted on 3/26/13 at 9:38 AM. Client #3's Individual Support Plan (ISP), dated 10/1/12, indicated she had medication training objectives to sign the MAR by marking yes or no if she agreed to wearing her glasses for the day and initial | W000249 | **W 249**<br><br>Staff Prompting for Wearing Glasses<br><br>**Corrective action for resident(s) found to have been affected**<br><br>The staff member responsible for the error will be trained to implement ISP med training goal for client #3, and a “cheat sheet” for reminders of goals will be used to assist staff.<br><br>**How facility will identify other residents potentially affected & what measures taken**<br><br>All residents potentially affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes** | 04/26/2013 |

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| | the MAR after self administering her Calcium medication.<br><br>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/27/13 at 1:27 PM. The QMRP indicated client #3's medication goals should be implemented daily.<br><br>9-3-4(a) | | **facility put in place to ensure no recurrence**<br><br>In addition to the staff member responsible for the error, all other staff will also receive the training in order to prevent recurrence. All staff will have access to the "cheat sheet."<br><br>**How corrective actions will be monitored to ensure no recurrence**<br><br>The home management team is responsible for supervising and training staff. The managers are supervised by the Director who meets with them on a regular basis to monitor plan implementation, including training needs of staff members. | |

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| W000263 | 483.440(f)(3)(ii)<br>PROGRAM MONITORING & CHANGE<br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>Based on record review and interview for 1 of 2 clients in the sample (#1), the facility's specially constituted committee (HRC) failed to ensure written informed consent was obtained from client #1's guardians for her restrictive behavior support plan (BSP).<br><br>Findings include:<br><br>A review of client #1's record was conducted on 3/26/13 at 10:14 AM. Client #1's Individual Support Plan (ISP), dated 10/1/12, indicated she had legal guardians. Client #1's BSP, dated 1/1/13, indicated she had targeted behaviors including physical aggression, PICA (ingestion of non-nutritive substances), self-injurious behavior (SIB), elopement, and suicide threats and gestures. The BSP included the use of restrictive interventions including psychotropic medications (Haldol, Lorazepam, Trazadone, Lamictal and Seroquel XR) and physical restraints. There was no documentation in client #1's record indicating the guardians gave written informed consent for the implementation | W000263 | **W 263**<br><br>BSP Guardian Consent<br><br>**Corrective action for resident(s) found to have been affected**<br><br>Client #1's guardian was sent another certified letter and has since returned the signed consent form for the BSP.<br><br>**How facility will identify other residents potentially affected & what measures taken**<br><br>This is the only client in the home who has this issue. The others are their own guardians and willingly consent to treatment. One roommate has a health care representative who is responsive to requests.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence** | 04/26/2013 |

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| | of client #1's BSP.<br><br>The plan indicated she had the following restrictions as indicated in her BSP: "[Client #1] has a history of self-injurious behavior using pieces of glasses (eyeglasses) that she had broken. Due to the safety concerns regarding SIB her access to her glasses will be restricted. She will be allowed to wear the glasses for specified amounts of time each day while supervised by staff. She will have the opportunity to increase the amount of time she is allowed (to) wear her glasses based on her demonstration of responsible behavior while wearing them. Each time [client #1] enters the home, staff will ask her if she has any small sharp items that she can hand over to staff. In the past, [client #1] had body searches, which is very restrictive and not always effective because many items can be hidden. We would like to attempt the less restrictive method of simply asking. If she does hand over an item, it should be handled as part of a room sweep and can be documented on that form. [Client #1] has used her personal items to harm herself. A restriction she had in place previously to keep her safe was to have her closet door locked with clothing that she used to self strangle and other items placed in the locked closet as needed. We now will lock in a secure location. [Client #1] has | | Guardian was contacted again and responded since he was made aware of the problem of not having the consent signed. The HRC form has a checkbox where consent is obtained prior to submitting a restrictive plan to the committee.<br><br>**How corrective actions will be monitored to ensure no recurrence**<br><br>Behavior Clinician and QDDP are responsible for getting signed consents for BSPs and for retaining documentation that it has been obtained. Both are supervised by the Director who meets with them regularly. | |

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| | engaged in self injury with jewelry. This resulted in medical treatment during which she complained of hallucinations and was hospitalized. [Client #1's] jewelry will be locked in a secure place with her hygiene products. [Client #1] has used false fingernails in the past and often requests their purchase. Team members have expressed concern about past efforts to harm herself and that she will use these sharp objects for that purpose. False fingernails will be restricted. Consistent with restrictions in place at her previous home, she will live in a secure setting that includes door and window alarms. [Client #1] is prescribed psychotropic medication for mental health issues and to control problem behavior, which is restrictive. A medication reduction plan is included with the BSP. Room sweeps will be conducted on a regular basis. Due to [client #1's] history of SIB and PICA the Activity closet will be kept locked to limit access to potentially dangerous items such as scissors, pencils, pens, small craft items such as beads, etc. She will have supervised access to the activity items at scheduled times and when she requests them for an appropriate use. Due to [client #1's] history of SIB and PICA hygiene items will be kept locked to limit access to potentially dangerous items. She will have supervised access to the | | | |

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| | hygiene items at scheduled times and when she requests them for an appropriate use. Due to [client #1's] history of SIB and PICA cleaning supplies will be kept locked to limit access to potentially dangerous items. She will have supervised access to the items at scheduled times and when she requests them for an appropriate use. Due to [client #1's] history of SIB metal and hard plastic kitchen utensils will be kept locked to limit access to potentially dangerous items such as knives, forks, spoons, etc. Staff will use these items as necessary to prepare [client #1's] meals and [client #1] will have access to flexible rubber spoons to use to eat her meals. [Client #1's] home should be kept free of sharp items that she could use to harm herself. In order to maintain consistent climate control for client health and comfort, and to prevent damage to the equipment, thermostats will have lockable covers placed over them. [Client #1] sometimes has difficulties at meal time with peers who have lesser restrictions regarding eating implements, poorer table manners or with whom she is angry. [Client #1] (and a housemate with similar restrictions) often harasses her peers with complaints of it not being fair etc., causing behavioral issues such as aggression. When needed due to behavioral issues such as verbal or | | | |

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| | physical aggression, [client #1] will dine separately or with her peer who has similar restrictions. All other aspects of mealtime, preparation, clean up, etc. will be shared by all housemates. The goal is to ultimately integrate all residents in participating in true family style dining on a fulltime basis and programming is in place to facilitate this happening. Due to the possibility of damage and to protect from access to potentially dangerous items, such as cords, the entertainment center in the main living area will have a Plexiglas covering over the TV. Due to the risks posed by her roommates' behavior and health/safety issues, all raw and unprocessed, i.e. not chopped/cooked, fruits and vegetables will be stored in a refrigerator in the locked garage. A supply of properly processed fruits and vegetables (chopped or cooked to a soft consistency) that are on the menu will be maintained in the refrigerator inside the home and [client #1] will have normal access to these items. [Client #1] will have free access to the items stored in the garage refrigerator if she desires to do so. In order to access the items, [client #1] will make the request of the staff, who will unlock the garage and consistent with [client #1's] supervision level observe her while she chooses and obtains the items she desires. Dependent upon her roommates' progress in dealing with their | | | |

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| | personal behavioral and health/safety issues, it is acknowledged that these items will need to remain under lock and key for the foreseeable future. Due to elopement risks a child safety lock will be added to the gate on the fence to the backyard. This lock will allow for added security if [client #1] attempts to elope and allow additional time for staff to respond in order to ensure her safety, while also allowing easier egress than a conventional lock in the case evacuation is needed. Due to ongoing risks of self injury and a recent incident in which [client #1] attempted to re-open an old wound with a broken hanger, all hangers will be removed from her room. Additionally her closet will be modified to eliminate the need for hangers by replacing the existing shelf and hanger system with built in shelves and/or a small dresser. This will allow [client #1] to maintain her clothing in her room by folding them and placing them on the shelving or in the dresser. [Client #1] has worn a body suit/swim suit for several years under her clothing, to assist in helping prevent her from re-opening the scar of an old self-inflicted wound. When upset and [client #1] has the opportunity, one of the first things she will attempt to do is re-open this wound. In recent months she has been more successful in gaining access to the wound site and has | | | |

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| | caused injury to herself. Due to recently inflicting more serious injury to an old wound during an SIB incident, the IDT (interdisciplinary team) has recommended that the stomach binder be worn over the body/swim suit at all times during waking hours. Additionally an alarming device will be attached to the binder and garments to alert staff if [client #1] attempts to remove her clothing to access the wound site. When [client #1] retires for the night the binder and body/swim suit are removed, and staff will observe [client #1] until she is sleeping soundly to help prevent her attempting to re-open the wound."<br><br>Client #1's record indicated a letter was sent to the guardians on 3/6/12 (for previous BSP) and 12/14/12 (for current plan) requesting, "The regulations that AWS has to follow in providing services to [client #1] also require that we obtain her guardian's signed consent for the interventions outlined in the BSP. Included in this mailing is a consent form for that purpose. If you would please return that document in the enclosed self addressed return envelope we would greatly appreciate it." A handwritten note on the 12/14/12 letter indicated, "Sent to guardians on date of letter no response."<br><br>An interview with the Qualified Mental | | | |

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| | Retardation Professional (QMRP) was conducted on 3/27/13 at 2:29 PM. The QMRP indicated the facility had on-going issues with client #1's guardians submitting written consent for plans. The QMRP indicated the guardians were contacted by phone, letter sent and follow-up calls made in order to obtain the written informed consent for the BSP however unsuccessfully. The QMRP indicated the facility did not have written informed consent for client #1's BSP. An email from the QMRP was received on 3/27/13 at 2:08 PM. The email indicated, "If you read through my notes you can see that we have a hard time obtaining written consents and I (sic) it documents that I have had to call him and ask to send thing back and keep calling and sometimes I still don't get them. [Name of behavior consultant] resent the consent earlier this month again."<br><br>9-3-4(a) | | | |

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| W000323 | 483.460(a)(3)(i)<br>PHYSICIAN SERVICES<br>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.<br>Based on record review and interview for 1 of 2 clients in the sample (#3), the facility failed to ensure her vision was assessed annually.<br><br>Findings include:<br><br>A review of client #3's record was conducted on 3/26/13 at 9:38 AM. Client #3 did not have documentation of a vision exam in her record. Her most recent annual physical exam was conducted on 5/2/12. At the annual exam, her vision and hearing were not assessed. The facility was unable to provide documentation indicating when client #3's most recent vision exam was conducted.<br><br>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/26/13 at 10:36 AM. The QMRP indicated she was unable to locate documentation indicating client #3's vision was assessed. The QMRP stated, "We're late." The QMRP indicated vision should be assessed every 2 years and annually at the annual physical. In an email received on 3/27/13 at 12:11 PM, the QMRP indicated client #3's most | W000323 | **W 323**<br><br>Annual Vision Exam<br><br>**Corrective action for resident(s) found to have been affected**<br><br>Client #3 was scheduled for a vision exam, and it already has taken place.<br><br>**How facility will identify other residents potentially affected & what measures taken**<br><br>All residents potentially affected, and corrective measures address the needs of all clients.<br><br>**Measures or systemic changes facility put in place to ensure no recurrence**<br><br>All residents of the home also have had their vision checked in April, 2013. | 04/26/2013 |

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| | recent vision exam was conducted on 11/17/10.<br><br>9-3-6(a) | | **How corrective actions will be monitored to ensure no recurrence**<br><br>The Nurse and QDDP monitor required medical examinations, including vision appointments. Both are supervised by the Director, and they meet regularly. | |