STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 08/27/18 and concluded on 08/29/18.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		10/3/18

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

Electronically Signed | 09/23/2018

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide care for 3 of 12 sampled residents (Resident #21, #22, and #29) in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to knock on doors, announce themselves, and wait for permission prior to entering residents' rooms, does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: The facility failed to provide a copy of a policy addressing dignity per request. - Observation on 08/27/18 at 3:42 p.m. showed an unidentified CNA knocked, opened the door to Resident #29's room, and stopped when she saw the surveyor conversing with him. The CNA then walked further into the room and offered Resident #29 an afternoon snack. - Observation on 08/28/18 at 10:13 a.m. showed two CNAs (#1 and #2) assisted Resident #22 with toileting in the shower room. As Resident #22 toileted, another CNA (#3) knocked, opened	F 550	1) All staff will be educated at an all staff meeting on September 27, 2018 regarding the resident rights and proper procedure for entering a resident's room. 2) All residents within the facility are at risk. 3) All staff will be educated at an all staff meeting on September 27, 2018. 4) The Director of Nursing (or designee) will complete 5 resident interviews and 5 observations of staff knocking prior to entering resident room. These audits will begin on 09/25/2018 and will be conducted three times per week for 4 weeks, weekly for 4 weeks, then monthly for 10 months. The results of these audits will be reported to the QA committee monthly by the Director of Nursing (or designee).	

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F 550	Continued From page 2 the shower room door, and grabbed a wheel chair in the shower room. The CNAs (#1 and #2) attempted to pull the curtain between Resident #22 and the door when the door opened. The CNA (#3) stated the wheel chair did not belong to Resident #22, and removed it from the shower room. The CNA (#3) failed to wait for permission to enter the shower room. - Observation on 08/28/18 at 11:17 a.m. showed a CNA (#1) assisting Resident #21 with toileting in a facility restroom. During this observation an unidentified staff member opened the bathroom door without knocking, stated "Oh, it's [Resident #21's first name]," and closed the door. The staff member held the door open, while Resident #21 sat on the toilet. The staff member failed to knock and wait for permission to enter the restroom. During an interview on 08/29/18 at 4:37 p.m., when asked questions pertaining to dignity, an administrative nurse (#6) reported staff should knock, announce themselves, and wait for permission before entering a room.	F 550		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage,	F 567		10/3/18

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F 567	Continued From page 3 and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to have a system in place to assure 7 of 12 residents (Resident #9, #11, #13, #24, #26, #27, and #29) had ready access to personnel funds on the weekend. Failure to provide residents access to their personnel funds on the weekend may limit resident's rights to their money.	F 567	1) All residents and representatives will be notified via a letter to discuss the change in the process of access to resident funds. All staff will be informed of process change at the all staff meeting on September 27, 2018. 2) All current residents were at risk.	

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F 567	Continued From page 4 Findings include: When asked questions pertaining to having access to their personal funds, those residents interviewed indicated the following: * 08/27/18 at 3:44 p.m., Resident #29 stated, "No, not [on] Saturdays or Sundays." * 08/27/18 at 3:54 p.m., Resident #13 stated, "I don't think I can get money on the weekends." * 08/27/18 at 4:50 p.m., Resident #27 stated, "I don't know if anybody is in the office on the weekend." * 08/27/18 at 6:03 p.m., Resident #11 stated, "No, not on Saturdays and Sundays." * 08/28/18 at 8:57 a.m., Resident #9 stated, "No, not on the weekends." * 08/28/18 at 09:06 a.m., Resident #24 reported personal funds are not available on the weekends, as there is no personnel in the office. * 08/29/18 at 10:45 a.m., Resident #26 stated, "[Staff are] not here on the weekends. You just get your money on Friday, when you need it for the weekend." During an interview on 08/29/18 at 1:51 p.m., a business office staff member (#8) confirmed residents currently have access to their funds "Monday-Thursday 8:00 a.m.-5:00 p.m. and Friday 8:00 am-4:30 p.m."	F 567	3) The business office will provide a small amount of money to be held securely in the nurses station. The residents or their legal representative can request funds at any time. 4) The business office personnel will conduct 5 resident interviews in regards to residents (or resident representative) being able to access their funds 7 days per. Monitoring will begin on 09/26/2018 and will be completed three times per for 4 weeks, weekly for 4 weeks, then monthly for 10 months. The results of this monitoring will be reported to the QA committee monthly by the business office personnel.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		10/3/18

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F 657	Continued From page 5 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident/staff interviews, the facility failed to review/revise the comprehensive care plans to reflect the current status for 3 of 12 sampled residents (Resident #9, #14, and #27). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Comprehensive Care Plan" occurred on 08/29/18. This undated policy stated, " . . . Each resident's comprehensive care plan is designed	F 657	1) Resident #9's care plan has been updated to include his foot care and the daily walks. Resident # 14's care plan was updated at the time of the survey to include the use of Seroquel. Resident # 27's care plan has been updated to include her vision impairment. 2) All residents within the facility are at risk of being affected. 3) All staff will be educated at the all staff meeting on September 27, 2018. All nursing staff will be responsible to update care plans as a change in the plan of care	

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F 657	Continued From page 6 to . . . Aid in preventing or reducing declines in the resident's functional status . . . Enhance the optimal functioning of the resident by focusing on a rehabilitative program . . . The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans . . . At least quarterly . . ." - Observations showed the following: * On the morning of 08/28/18 Resident #9 exited the building in his stocking feet. * 08/29/18 at 9:15 a.m., Resident #9 spoke with a staff member, and then exited the building in his stocking feet. During an interview on 08/29/18 at 10:44 a.m., when asked questions pertaining to the observations of Resident #9's exiting the facility, an administrative staff member (#7) stated, "At times, [Resident #9] requires reminders to put shoes on. The last time he was at the diabetic clinic, he discussed wearing two pairs of socks, if his shoes were not comfortable. If he goes out into the community he is supposed to check out. It is part of his PT [Physical Therapy] program to take walks outside. He usually stops to talk to staff and says, 'I'm going out for my daily walk.'" Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, ". . . Encourage and provide opportunities for exercise, physical activity . . ." During an interview on 08/29/18 at 4:37 p.m., an administrative nurse (#6) confirmed diabetic foot care and therapeutic walks should be included on his care plan.	F 657	occurs. 4) The Director of Nursing (or designee) will review 5 care plans weekly for 8 weeks then monthly for 10 months starting on 09/27/2018. The results of the reviews will be reported to the QA committee monthly by the Director of Nursing.	

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F 657	Continued From page 7 The facility failed to care plan Resident #9's use of two pairs of socks and recommended therapeutic walks. - Review of Resident #14's medical record occurred on all days of survey. Medications included Seroquel (an antipsychotic medication) 25 milligrams at bedtime related to dementia with behavioral disturbance. Review of Resident #14's care plan failed to identify the resident's antipsychotic medication. During an interview on 08/29/18 at 1:10 p.m., an administrative nurse (#6) confirmed Resident #14's care plan lacked information regarding the use of an antipsychotic medication. - During an interview on 08/27/18 at 4:54 p.m., Resident #27 stated, "I have to get [my lenses] checked. I think the lenses need to be stronger. It's pretty hard for me to read." Review of Resident #27's medical record occurred on all days of survey. The "Multidisciplinary Care Conference Data," dated 06/14/18, identified, "[Resident #27] stated her vision seems to be getting 'weaker.' . . . She states she is noticing more difficulty reading the guide on the TV. . . . She is able to read the large print with no difficulty, but struggles with the small print. . . . She did not have her glasses on during the evaluation, but states even with them she still has difficulty." The current care plan failed to address her vision impairment.	F 657		

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F 657	Continued From page 8 During an interview on 08/29/18 at 4:37 p.m., an administrative nurse (#6) confirmed Resident #27's vision impairment should be included on her care plan.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to safely secure oxygen cylinders in 1 of 1 resident room (Resident #37). Failure to properly secure three oxygen cylinders in a resident's room placed residents, visitors, and staff at risk of injury in the event the unsecured tank falls and becomes a projectile object. Findings include: Review of the facility policy titled "Oxygen Use And Safety" occurred on 08/29/18. This undated policy stated, ". . . All oxygen cylinders should be chained in place, racked or stored in stable carts at all times . . . All oxygen cylinders in resident rooms will be stabilized using a base or carts." Observation on 08/27/18 at 4:28 p.m. showed three unsecured oxygen cylinders in Resident	F 695	1) Two small tanks were removed from the resident's room and returned to issuing agency during survey. The large tank was secured immediately (by the resident) after the surveyor left the room and was found upright and secured in the storage container by the administrative nurse immediately upon notification from the surveyor. 2) Any resident requiring use of the cylinder oxygen tanks is at risk. 3) Resident has been educated again regarding the need to secure tanks in his room. All staff have been notified and detailed education will take place at the All Staff Meeting on 9/27/2018. Nursing staff will be monitoring compliance of securing cylinder properly at all times.	10/3/18

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F 695	Continued From page 9 #37's room. Two small cylinders were on a shelf and one larger cylinder stood upright in the resident's room. The resident also stated the two smaller cylinders did not work and had been in his room for a while. During an interview on 08/28/18 at 3:44 p.m. an administrative nurse (#6) confirmed she expected the three oxygen tanks in Resident #27's room to be secured.	F 695	4) The Director of Nursing (or designee) will perform audits to verify oxygen tank is secure two times per day for two weeks, daily audits for two weeks, three times per week for 4 weeks, then two times per week for 4 weeks, then monthly for 9 months. The audits will be initiated on 09/27/2018. Results of the audits will be reported to the QA committee monthly by the Director of Nursing (or designee).	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should	F 803		10/3/18

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F 803	Continued From page 10 be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility menus, review of facility policy, and staff interview, the facility failed to ensure staff provided the serving size indicated by the menu during meals and tray line service for 2 of 4 meals observed (Evening Meal 08/27/18 and Breakfast 08/28/18). Failure to ensure staff provided the correct portion size placed residents at risk for decreased intake and may result in unplanned weight loss. Findings include: Review of the facility policy/procedure titled "Portion Control" occurred on 08/29/18. This undated policy stated, ". . . Standard portions will be served for all food items to ensure nutritional adequacy and to avoid waste. . . . The portion size listed on the menu extensions will be followed. . . ." - Observation of the evening meal on 08/27/18 at 5:30 p.m., showed the serving sizes looked small. Interview with the cook (#4) serving, identified the serving of creamed corn as "1/3 cup", and coleslaw as "two ounces", with resident's requesting a small portion served a half scoop of each. A separate scoop for small portions was not present at the tray line. The menu for this meal identified the regular serving for the creamed corn and the coleslaw as 1/2 cup and the small portion as 1/3 cup. The cook (#4) failed to follow the menu portion sizes.	F 803	1) All dietary staff will be educated regarding the correct serving utensil to utilize. Serving staff were educated at the dietary staff meeting held on 8/30/2018. Additional education will also be provided at the all staff meeting on 9/27/2018. 2) All residents have the potential to be affected. 3) New serving utensils have been ordered with better markings to indicate the size of the serving utensil. 4) The Dietary Manager (or designee) will monitor portion size served to 5 residents during varied meals daily for 2 weeks, then three times per week for 2 weeks, then two times per week for 2 weeks, then weekly for 2 weeks, then monthly for 10 months. The results of the monitoring will be reported to the QA meeting monthly by the Dietary Manager (or designee). Monitoring will begin on 09/27/2018.	

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F 803	Continued From page 11 - Observation of breakfast on 08/28/18 at 8:17 a.m. showed the staff member served the hot cereals with a 1/2 cup scoop. Interview with the cook (#5) identified she would give another partial to whole scoop of hot cereal for resident's who received larger portions. A separate scoop for regular portions was not present on the tray line. The menu for this meal identified the regular serving for the hot cereal as six ounces or 3/4 cup and a small portion as four ounces or 1/2 cup. The cook (#5) failed to follow the menu portion sizes.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility	F 812	1) All staff will be educated at the all staff	10/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

(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) COMPLETION DATE
F 812	Continued From page 12 policy/procedure, manufacturer's labeling, and staff interview, the facility failed to properly store beverages per manufacture's guidelines and/or facility policy for 2 of 2 observations of food storage (Kitchen and South Nurse's Station Nutrition Center). Failure to mark foods with a discard date when opened has the potential to result in foodborne illness, to residents, staff, and visitors. Findings include: Review of the facility's policy and procedure titled "Food Storage" occurred on 08/29/18. This undated policy stated, ". . . Ready-to-eat foods shall be marked with a discard date at the time of opening or preparation: . . ." Review of manufacturer's labeling showed the following: * Plus 2, a nurtritional supplement, identified the product is to be used within 14 days of thawing; * Thickened milk beverage identified the product is to be used within four days of opening; and * Thickened water beverage identified the product is to be used within seven days of opening. - Observation during the initial kitchen tour on 08/27/18 at 2:15 p.m. with an administrative dietary staff member (#5) showed the family style refrigerator in the kitchen contained two thawed cartons of Plus 2 and an opened quart of thickened milk, all undated. This staff member (#5) disposed of the undated cartons. - Observation during the full dietary tour on 08/29/18 at 1:00 p.m. with an administrative	F 812	meeting on September 27, 2018 regarding the proper marking procedure for opened items. 2) All residents are at risk of being affected. 3) All staff will be educated and be required to mark food items with the date that they are opened. 4) The Dietary Manager (or designee) will monitor open items in refrigerator for a discard date in the kitchen, dining room, north nurse's station/medication room, and south nurse's station nutrition refrigerator daily for two weeks, three times per week for 2 weeks, two times per week for 4 weeks, then weekly for 10 months. The Dietary Manager (or designee) will report the results of the monitoring to the QA committee monthly. Monitoring will begin on 09/27/2018.	

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F 812	Continued From page 13 dietary staff member (#5) showed the following: * An open undated thickened water in the dining room refrigerator. In the South Nurse's Station Nutrition Center refrigerator: * Seven thawed undated cartons of Plus 2. * An open undated carton of prune juice. In an interview during the dietary tour, the administrative dietary staff member (#5) identified facility policy is to date all beverages when opened or thawed to assure staff use the product within the specified time frame. This staff member also expected staff to label the prune juice with an open date.	F 812		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality	F 868	1) The Medical Director has been	10/3/18

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F 868	Continued From page 14 Assessment and Assurance (QA) program, review of facility policy, and staff interview, the facility failed to ensure a physician actively participated as a member of the QA committee for 4 of 4 quarters (last two quarters in 2017 and first two quarters in 2018). Failure to have a physician participate in the facility's quality assurance activities deprives the committee of the physician's unique contributions for analysis of quality concerns and assisting with decision making based on identified concerns. Findings include: Review of the facility's policy and procedure titled "Quality Assurance and Performance" occurred on 08/29/18. This undated policy stated, ". . . The QA Committee shall be interdisciplinary and shall . . . Consist at a minimum of . . . The director of nursing services . . . The Medical Director or his/her designee . . . At least three other members of the facility's staff . . . The infection preventionist . . ." The facility provided documentation showing the QA committee meets monthly, and consists of the Activity Director, Dietary Manager, Director of Nursing, Environmental Services Director, Health Information Manager, Minimum Data Set (MDS) Coordinator, and Physical Therapy Director. During an interview on 08/29/18 at 1:50 p.m., an administrative nurse (#6) reported she "brings all the records to the monthly medical staff meeting and [the Medical Director] reviews all the minutes and signs as having been reviewed by the Medical Director." The administrative nurse (#6)	F 868	scheduled to attend the meetings quarterly. 2) All residents are at risk of being affected. 3) Quality Assurance Director will ensure the Medical Director attends meetings at least quarterly. 4) Quality Assurance Director will ensure the Medical Director attends meetings at least quarterly.	

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F 868	Continued From page 15 confirmed the Medical Director has not been in attendance during the QA committee meetings on a quarterly basis.	F 868		