

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/19/2010
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
(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 281	<p>Continued From page 1</p> <p>The findings include:</p> <p>Record review revealed Resident #1 was re-admitted to the facility on 07/12/10 with diagnoses to include: Intracapsular Fracture (Fx) of the right hip and a Supracondylar Fx of the left distal femur. Review of the Operative Records, dated 07/03/10 and 07/04/10 revealed the resident underwent two separate surgeries while admitted to the hospital, a right hip hemiarthroplasty on 07/03/10, and an open reduction, internal fixation of the left distal femoral fracture on 07/04/10.</p> <p>Review of the hospital physician's discharge orders, dated 07/12/10, revealed Resident #1's surgical staples should be removed on 07/18/10. The discharge orders stated Resident #1 should have full weight bearing with a left knee-ankle foot hinged brace with full range of motion, when the resident was out of bed.</p> <p>Review of the nurse's progress note, dated 07/18/10, revealed the staples from Resident #1's right hip incision were removed on 07/18/10, as ordered by the physician. There was no mention of the staples in the surgical incision on the resident's left leg in the progress notes.</p> <p>An interview with Registered Nurse (RN) #1, on 08/18/10 at 3:15 PM, revealed the RN admitted Resident #1 to the facility. The RN stated when the resident arrived at the facility, she transcribed the physician's orders to the resident's Medication Administration Record (MAR). According to the RN, she did not recall seeing the physician's order that indicated the resident's brace was to be worn when out of bed; and if she had seen the order she would have transcribed it to the MAR.</p>	F 281	<p>to TAR's and MAR's. (2) Facility is implementing a Licensed Nurse Care Plan Communication form for all residents. These will be completed 10-15 per week until all residents have one in place. (3) Licensed nurses have received in-service education by the Director of Nurses (DON) on: removing braces/splints for skin assessments in accordance with physician orders and resident plan of care, protocol changes on admit/re-admit orders, LN Care Plan Communication forms on 8/16/10 and 8/23/10. (4) Nursing assistants received in-service education by the DON on the removal of splints/braces for bathing in accordance with the resident's plan of care and reporting any findings of changes in skin noted during inspection of skin while bathing on 8/23/10.</p> <p>Criteria #4 – The CQI tool for the monitoring of implementation of admission/re-admission orders shall be utilized on all admissions/re-admissions for 2 months, then 1 per week for 2 months, then 1 monthly and as indicated under the supervision of the DON.</p> <p>Criteria #5 – Target Date:</p>	09/02/10	

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F 281	<p>Continued From page 2</p> <p>She indicated she wrote the resident's "name-remove staples" on the calendar for 07/18/10, but had not transcribed the order to the MAR. She was not aware of any system that would ensure physician's orders were transcribed to the MAR.</p> <p>Review of the July and August 2010 MARS revealed the facility had not transcribed the removal of Resident #1's surgical staples, nor the physician's order to wear the brace "when out of bed".</p> <p>Review of the calendar at the nurse's desk revealed on 07/18/10 Resident #1's name was listed, with the notation to "remove staples". There was no documentation on the calendar to indicate the location of the surgical staples.</p> <p>Interviews with RN #2, RN #4, LPN #2, LPN #4, LPN #5, LPN #6 and LPN #9 on 08/17/10 at 7:55 PM and 8:00 PM, on 08/18/10 at 12:10 PM and 3:40 PM and on 08/19/10 at 11:00 AM and 11:20 AM, revealed they were not aware Resident #1 had surgery to the left leg and had an incision on the left leg under the brace. The licensed staff thought the brace had been placed on the left leg to immobilize the fracture and it should not be removed due to the fracture. The licensed staff stated they did not question the fact the MAR did not indicate when the brace was supposed to be worn, and no attempts were made to contact the physician to clarify the order. The licensed staff were not aware of a system in the facility to ensure physician's orders were followed. They revealed the order for the removal of the staples should have been written on the MAR and the calendar at the nurse's station.</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>Record review revealed Resident #1 was transferred to the hospital on 08/14/10 due to respiratory distress. Review of the hospital's Adult Admission Assessment, dated 08/14/10, revealed when the brace was removed from the resident's left leg, the staples were still present in the surgical incision. Additionally, hospital staff identified an area 6.5 centimeters (cm) by 5.0 cm on the resident's left inner knee. The area was described as red, with a 1.3 cm by 2.5 cm blackened area in the center. A 0.5 cm by 1.0 cm red and black area was identified on the left outer foot.</p> <p>An interview with the hospital RN, on 08/19/10 at 9:40 AM, revealed she conducted an assessment of Resident #1 on admission to the hospital. The RN stated she removed Resident #1's left leg brace, and observed a wrapping around the resident's leg. When the RN removed the wrapping, she found a dressing that was dated 07/09/10. The RN removed the dressing and found a healing surgical incision with twenty-two (22) staples still in the incision. The RN stated she reviewed the resident's medical records from the previous admission, and determined the staples had been in place since 07/04/10, even though there were physician's orders to remove the staples. The RN indicated that the staples were "loose", and she was able to remove the staples easily. The RN continued to assess the leg, and observed a wound on the left inner knee where the brace had been in place. The RN described the area as bright red with a center that was blackened. In addition, the RN observed a small red and blackened wound on the resident's outer left foot.</p> <p>Observation of Resident #1's wounds with the</p>	F 281			

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F 281	Continued From page 4 hospital Wound Nurse (WN), on 08/19/10 at 9:40 AM, revealed an area on the resident's left inner knee 3.0 cm by 1.2 cm. The outer area was red, with the center portion of the wound deep purple and slightly indurated (hardened). A blister was observed in the wound. There was no drainage or odor observed. Two incision lines on the outside of the left knee and thigh were observed, measuring 9.2 cm long, and the second incision measuring 7.2 cm long. Observation of Resident #1's left foot revealed an area 0.5 cm by 0.6 cm which was dark. An interview with the WN, at the time, revealed the WN described the area on the inner knee as a deep tissue injury, caused by the resident's brace. The WN stated the blister would likely open to reveal a Stage III pressure sore.	F 281	F 282 Comprehensive Care Plans The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care: Criteria #1 – Resident #1 returned from the hospital on 8/19/10, his/her care plan was reviewed and revised as indicated. He/she is receiving care in accordance with his/her plan of care. Criteria #2 – (1) A chart audit was completed on all residents admitted/re-admitted in the past 30 days to identify correct transcription of all treatment orders and follow through of these orders in accordance with their care plan. (2) Head-to-toe skin assessments were performed on all residents to verify accuracy of the last weekly skin assessment documented. (3) Orders for all residents currently utilizing splints/braces were reviewed to determine that orders for splints/braces reflect parameters for removal for bathing and assessments; care plans were revised as indicated. Criteria #3 – (1) Facility is implementing a Licensed Nurse Care Plan Communication form for all residents. These will be completed 10-15 per week until all residents have one in place. (2) Licensed nurses have received in-service education by the Director of Nurses (DON) on: removing braces/splints for skin assessments in accordance with physician orders and resident plan of care, protocol changes on admit/re-admit orders, LN Care Plan Communication forms on 8/16/10 and 8/23/10. (3)	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide services in accordance with the comprehensive care plan for one resident (#1) in the selected sample of seven. The facility failed to ensure Resident #1's left knee brace was only utilized when the resident was out of bed, and failed to assess and monitor the left leg incision site every shift for symptoms of infection. Review of the resident's medical record revealed no evidence the brace had been removed from the resident's leg from 07/12/10 through 08/14/10,	F 282		

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F 282	<p>Continued From page 5</p> <p>when the resident was admitted to the hospital. On admission to the hospital, the nurse removed the resident ' s brace and found a dressing dated as applied on 07/09/10, surgical staples, which continued to be in the surgical site, along with a Deep Tissue Injury on the resident's left inner knee, and a pressure ulcer on the resident's left outer foot.</p> <p>The findings include:</p> <p>Record review revealed Resident #1 was re-admitted to the facility on 07/12/10 with diagnoses to include a Intracapsular Fracture (Fx) of the right hip, and a Supracondylar Fx of the left distal femur. Review of the hospital operative records revealed on 07/03/10 the resident underwent hemiarthroplasty, and on 07/04/10, the resident underwent an open reduction internal fixation of the left distal femoral fracture.</p> <p>Review of the Comprehensive Care Plan for Resident #1, dated 07/12/10, revealed interventions for risk of infection and decline in activities of daily living due to post right hip fx with repair, and left distal femur fx with repair. Interventions included assessment of the incisions every shift, monitoring for signs and symptoms of infection, and to apply left leg brace when up. Review of the July and August, 2010, Certified Nurse Aide (CNA) care plans revealed there was no indication the resident should utilize a brace when out of bed.</p> <p>Review of the July and August, 2010 medication Administration Record (MAR) revealed there was no entry for assessment of the incisions every shift, nor to monitor for signs and symptoms of infection. The MAR stated Resident #1 was to</p>	F 282	<p>education by the DON on the removal of splints/braces for bathing in accordance with the resident's plan of care on 8/23/10.</p> <p>Criteria #4 – The CQI tool for the monitoring of Care Plan Compliance shall be utilized monthly for 2 months and then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5 – Target Date:</p>	09/02/10	

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F 282	<p>Continued From page 6</p> <p>wear a left knee-ankle float hinged brace with full range of motion, but it did not indicate when the brace was supposed to be worn/removed. Review of the medical record revealed no evidence Resident #1's brace had been removed since admission to the facility on 07/12/10. In addition, there was no evidence the left incision had ever been observed for signs and symptoms of infection, during the facility admission 07/12/10 through 08/14/10.</p> <p>Interviews with Certified Nursing Assistant (CNA) #2, CNA #3 and CNA #4, on 08/18/10 at 12:00 PM, 12:10 PM, and 12:20 PM, revealed they were aware Resident #1 had a left knee brace while in the facility, but they were told by licensed staff that the brace was not to be removed.</p> <p>An interview with the Director of Nursing (DON), on 08/18/10 at 1:20 PM, revealed there was no policy/procedure to ensure the licensed staff reviewed each resident's plan of care. She stated she expected licensed staff to review the care plans of each resident to be aware of care required by the resident. The DON explained when the care plans were developed, the staff who developed the care plan should have ensured interventions to monitor the incision site every shift, and the brace removed in bed, were placed on the MAR.</p> <p>Interviews, on 08/19/10 at 1:15 PM, with Registered Nurse (RN) #3 and RN #5 who assisted with the development of the care plans, revealed they reviewed the discharge physician's orders and instructions for Resident #1, and developed interventions based on the information. The RNs stated they sent the care plans out to the resident 's unit after completion; however,</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>they did not monitor whether the interventions were implemented.</p> <p>Interviews with RN #3, RN #4, Licensed Practical Nurse (LPN) #3, LPN #4, LPN #6 and LPN #7, on 08/18/10 at 3:25 PM and 3:40 PM, and 08/19/10 at 11:00 AM, 11:20 AM, 11:35 AM, 11:50 AM, and 11:55 AM, revealed the staff do not review a resident's comprehensive care plan unless there is a question about the care. The licensed staff revealed they usually reviewed the CNS care plan because it was condensed and served as a "quick reference" .</p> <p>Record review revealed Resident #1 was sent to the hospital on 08/14/10. Review of the hospital's Adult Admission Assessment, dated 08/14/10, revealed nursing staff removed Resident #1's brace at the hospital, observed a dressing dated as applied on 07/09/10, surgical staples continued in the incision, and a 6.5 centimeter (cm) by 5.0 cm area on the left inner knee. In addition, the assessment identified a 0.5 cm by 1.0 cm red and blackened area to the left outer foot.</p> <p>Observation of Resident #1 with the Physical Therapy Wound Nurse (WN), on 08/19/10 at 9:40 AM, revealed a Deep Tissue Injury on the left inner knee which measured 3.0 cm by 1.2 cm. The outer area was red in color, with the center deep purple and slightly indurated (hardened). A blister was observed in the wound. Observation of the outside of the left foot revealed a 0.5 cm by 0.6 cm dark area. An interview with the WN, at the time, revealed the areas were consistent with having the brace applied from 07/12/10 to 08/14/10. The WN continued that it was likely the blister would open and the area on the inside left</p>	F 282			

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F 282 F 314 SS=G	Continued From page 8 knee would be a Stage III pressure sore. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide care and services to promote the prevention of pressure sore development for one resident (#1) in the selected sample of seven. The facility failed to provide care to Resident #1 in accordance with physician's orders and the comprehensive care plan related to applying a left knee-thigh full range of motion brace to the resident's left leg. Even though physician's orders included a left knee brace to be applied when out of bed, the facility left the left knee brace on the resident from 07/12/10 to 08/14/10. Resident #1 was admitted to the hospital on 08/14/10, and when the hospital licensed nurse removed the brace, she found a Deep Tissue Injury on the resident's left inner knee and a pressure sore on the resident's left outer foot. The finding include: A review of the facility's Skin Assessments policy	F 282 F 314	F 314 Pressure Sores Based on the comprehensive assessment of a resident the facility shall ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable: Criteria #1 – (1) Resident #1 returned from the hospital on 8/19/10, a thorough skin assessment was completed at that time. (2) All treatment orders were place on the Treatment Administration Record (TAR) and reviewed by two nurses for accuracy. His/her care plan was reviewed and revised as indicated for pressure sore care/prevention. Criteria #2 – (1) A chart audit was completed on all residents admitted/re-admitted in the past 30 days to identify correct transcription of all treatment orders and follow through of these orders. (2) Head-to-toe skin assessments were performs on all residents to verify accuracy of the last weekly skin assessment documented. (3) Orders for all residents currently utilizing splints/braces were reviewed to determine that orders for splints/braces reflect parameters for removal for bathing and assessments. Criteria #3 – (1) Facility is implementing a Licensed Nurse Care Plan Communication form for all residents. These will be completed 10-15 per week until all residents have one in place. (2) Licensed nurses have received in-service education by the Director of Nurses	

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F 314	<p>Continued From page 9</p> <p>and procedure, no date, revealed the admission skin assessment would be conducted on admission to reflect the skin conditions present on admission that may/do require skin treatment measures such as abrasions, skin tears, bruises, wounds of any cause, surgical sites, stoma sites and rashes or other skin eruptions. Weekly skin assessments should be conducted to reflect the resident's current skin status. The descriptions should reflect measurements, color, and other descriptors based on the actual finding. The assessment should identify abrasions, skin tears, bruises, disease related lesions, surgical sites, stoma sites, and rashes or other skin eruptions.</p> <p>A record review revealed Resident #1 was re-admitted to the facility from the hospital on 07/12/10 with diagnoses to include a Intracapsular Fracture (Fx) of the right hip and a Supracondylar Fx of the left distal femur. A review of the Operative Records, dated 07/03/10 and 07/04/10, revealed the resident had two surgeries while at the hospital. The resident had a right hip hemiarthroplasty conducted on 07/03/10 and an open reduction, internal fixation of the left distal femoral fracture on 07/04/10. The resident had incisions on the right hip and on the outer left knee and thigh.</p> <p>A review of the hospital Discharge Physician's Orders, dated 07/12/10, revealed the resident was to wear a left knee-ankle-foot hinged brace with full range of motion when the resident was out of the bed.</p> <p>A review of the Comprehensive Care Plan for activities of daily living due to post right hip fx with repair and left distal femur fx with repair and potential for skin breakdown, dated 07/12/10,</p>	F 314	<p>skin assessments in accordance with physician orders and resident plan of care, protocol changes on admit/re-admit orders, LN Care Plan Communication forms on 8/16/10 and 8/23/10. (3) Nursing assistants received in-service education by the DON on the removal of splints/braces for bathing in accordance with the resident's plan of care and reporting any findings of changes in skin noted during inspection of skin while bathing on 8/23/10.</p> <p>Criteria #4 – The CQI tool for the monitoring of Pressure Sore prevention shall be utilized monthly times 2 months, then quarterly as per established CQI calendar, under the supervision of the DON.</p> <p>Criteria #5 – Target Date:</p>	09/02/10	

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F 314	<p>Continued From page 10</p> <p>revealed interventions to apply a left leg brace when up and licensed staff were to conduct weekly skin assessments. A review of the July and August 2010 Certified Nurse Aide (CNA) care plans revealed there was no documentation to indicate the resident was supposed to wear a left knee brace when up.</p> <p>A review of the July and August 2010 Medication Administration Records (MAR) revealed the facility had not indicated when the resident was supposed to wear the left knee-ankle float hinged brace with full range of motion.</p> <p>A review of the weekly skin assessments, dated 07/12/10, 07/22/10 and 08/02/10 revealed the licensed staff documented the resident had a brace on the left leg. An interview with RN #1 on 08/17/10 at 3:15 PM revealed when she conducted the skin assessment on admission, she removed the brace and identified there was a dressing on the left outer leg. She stated she did not look under the dressing. An interview with LPN #11 (who conducted the assessment on 07/22/10), revealed she did not remove the brace to look at the resident's skin because she thought staff were not supposed to remove the brace. Interviews with RN #2 and LPN #2 on 08/17/10 at 7:55 PM and 8:00 PM (who conducted the skin assessment on 08/02/10), revealed they removed the brace but they did not see any skin breakdown or dressing on the resident's left leg.</p> <p>Interviews with RN #2, RN #4, LPN #2, LPN #4, LPN #5, LPN #6 and LPN #9 on 08/17/10 at 7:55 PM and 8:00 PM, on 08/18/10 at 12:10 PM and 3:40 PM and on 08/19/10 at 11:00 AM and 11:20 AM, revealed they were not aware Resident #1 had undergone surgery to the left leg, and had an</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/19/2010
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F 314	<p>Continued From page 11</p> <p>incision on the left leg, under the brace. The licensed staff thought the brace had been placed on the left leg to immobilize the fracture and should not be removed due to the fracture. They were unsure of the origin of the information, and thought they had received the information in shift report, or by word of mouth. The licensed staff stated they did not question the fact the MAR did not indicate when the brace was supposed to be worn, and they made no attempts to contact the physician to clarify the order. They stated they would have removed the leg brace if they had conducted a skin assessment to ensure there was no skin breakdown.</p> <p>An interview with the Director of Nursing (DON) on 08/18/10 at 1:20 PM revealed there was no system in place to ensure physician's orders were transcribed accurately, and no system to ensure licensed staff reviewed the residents' comprehensive care plans. She stated nurses were expected to transcribe the physician's orders accurately and review the comprehensive care plans so they would provide care to the resident's according to the care plans.</p> <p>A record review revealed Resident #1 was transferred to hospital on 08/14/10 due to respiratory distress. A review of the hospital's Adult Admission Assessment, dated 08/14/10, revealed when the nurse removed the brace, she identified a 6.5 centimeter (cm) by 5.0 cm area on the left inner knee. The area was red and in the center there was a 1.3 cm by 2.5 cm. blackened area. In addition, a 0.5 cm by 1.0 cm. red and blackened area to the left outer foot was identified.</p> <p>An interview with the hospital Registered Nurse</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>(RN) on 08/19/10 at 9:40 AM, revealed Resident #1 arrived on the floor, on 08/14/10, and she conducted a complete assessment of the resident. She stated when she removed the brace from the resident's left leg she noticed a "wrap" around the resident's leg. She removed the wrap and found a dressing, that was dated 07/09/10, over a healed surgical incision with surgical staples still in place. She stated she assessed the leg and found a wound on the left inner knee. The area was bright red and had an area in the center that was blackened. She stated further assessment of the left leg and foot where the brace had been, revealed a small red and blackened wound on the resident's outer left foot.</p> <p>A review of the hospital's PT Wound Evaluation, dated 08/16/10, revealed the resident had a suspected Deep Tissue Injury to the left inner knee measuring 6.5 cm by 5.0 cm. and within the reddened area there was a 1.3 cm by 2.5 cm. blackened area. The area was purple in color and had edema (swelling) present. Additionally, there was an 0.5 cm by 0.6 cm. pressure sore with a black scab on the left outer foot.</p> <p>Observation of the wounds with the PT Wound Nurse at the hospital on 08/19/10 at 9:40 AM revealed a deep tissue injury pressure sore on the left inner knee measuring 3.0 cm by 1.2 cm.. The peri-wound (outer area) was red. The center portion of the wound was deep purple and slightly indurated (hardened). The lower part of the center portion had a blister. There was no drainage or odor observed. On the outside of the left foot, there was a 0.5 cm by 0.6 cm. dark pressure sore. An interview with the WN revealed she felt the area on the left inner knee</p>	F 314		

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F 314	Continued From page 13 was a deep tissue injury due to the area being a dark purple, and when the brace was on, the area matched up approximately to the hinge joint of the leg brace. The area on the left outer foot matched up approximately with the foot plate at the bottom of the brace. She stated the blister on the left inner knee would likely open and result in a stage III pressure sore.	F 314			