

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

PRINTED: 06/14/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/10/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>JESSE HELMS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 DOVE STREET MONROE, NC 28111</b>		
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F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 656		6/9/18	

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

TITLE

(X6) DATE

Electronically Signed

06/01/2018

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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F 656	<p>Continued From page 1</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, resident interview, hospice representative interview and staff interviews, the facility failed to collaborate with hospice to develop and implement an interdisciplinary care plan for one of one resident reviewed for hospice (Resident #12).</p> <p>The findings included: Review of the contract between the facility and hospice with an effective date 8/26/13 revealed the following:</p> <p>Section 1.6 hospice Plan of Care. A written care plan jointly established, maintained, reviewed and modified as necessary, at regular intervals, by the hospice Medical Director, Attending Physician and hospice Interdisciplinary Group, and with the participation of Skilled Nursing Facility (SNF), to the extent practical, which includes: (a) an assessment of each hospice Patient's needs; (b) an identification of the hospice Services, including management of discomfort and symptom relief, needed to manage and palliate the hospice Patient's terminal illness and to meet the related needs of the hospice Patient's family; and (c) details concerning the scope and frequency of hospice Services.</p> <p>Resident #12 was admitted to the facility 1/29/16 with diagnoses which included: Alzheimer's disease, dementia, chronic obstructive pulmonary disease, and protein calorie malnutrition.</p> <p>A review of Resident #50's Minimum Data Set</p>	F 656	<p>Preparation and/or execution of this Plan of Correction (POC) does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>1)The facility interdisciplinary team will immediately conduct a record audit on Resident #12 and all other hospice residents to ensure that careplans for each resident are accurate, integrated, and applicable to meet the needs of each resident. An updated careplan note reflecting these changes will be included on the resident electronic medical record. A roster of all residents included in this update will be maintained as part of this Plan of Correction. Date Certain: 6/6/18</p> <p>2)The facility interdisciplinary team will immediately review and update all hospice resident careplans to ensure that the careplan includes 1) an assessment of needs. 2) an identification of hospice services, including management of discomfort and symptoms of relief needed to manage and palliate the hospice patient's terminal illness and to meet the related needs of the hospice patient's family. 3) Details concerning the scope and frequency of hospice services. A</p>		

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F 656	<p>Continued From page 2</p> <p>(MDS) revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/7/18. The MDS assessment indicated Resident #50 was unable to complete the Brief Interview for Mental Status due to having been rarely or never understood which indicated severe cognitive impairment. The resident was coded as having had a condition or chronic disease that may have resulted in a life expectancy of less than 6 months. The resident was coded as having had received hospice care while she was a resident at the facility.</p> <p>Review of Resident #12's Electronic Medical Record revealed the resident had an Informed Consent/Election of Benefits with hospice dated 11/30/17.</p> <p>A review completed of Resident #12's care plan which had been documented as having been last reviewed on 3/27/18 revealed no hospice care plan. The only discovered mention of hospice care in the care plan except for the care plan addressing activities of daily living. The information listed related to hospice services were hospice services were discontinued on 9/21/17 and were reinitiated on 11/30/17.</p> <p>An interview was conducted with the Social Worker (SW) on 5/10/18 at 9:25 AM. The SW stated Resident #12 was determined to qualify for hospice services and was readmitted to hospice on 11/30/17 due to the diagnosis of Alzheimer's disease with early onset. The SW stated she did not think she had invited hospice for the last care plan meeting and she usually just sent invitations to care plan meetings to family members. The resident's last care plan meeting was 3/27/18 and</p>	F 656	<p>roster of residents included in this review will be maintained as part of this Plan of Correction. Date Certain 6/6/18</p> <p>3)The facility will conduct regular careplan meetings concerning all hospice residents during regularly scheduled careplan updates, as needed, but quarterly at a minimum. Hospice services will attend bi-weekly careplan update meetings at the facility to discuss hospice patients and applicable changes in patient condition/care. Those updates will be reflected on the facility careplan, when applicable. These meetings will include (at a minimum) a representative of the hospice team, a social worker, and the MDS coordinator. The meeting will discuss updates to both the facility careplan and the hospice careplan to ensure that both careplans are integrative and complimentary to ensure the highest practicable quality of care for each resident. A portion of the meeting will include a quality review, to include risk areas, which will be included as part of the facility Quality Assurance program, which is overseen by the Administrator. A careplan update will be included in the resident's chart after the first initial meeting, and when applicable changes have been made thereafter. A roster of attendees at each meeting will be maintained as part of this POC. A roster of hospice residents discussed will be maintained as part of this Plan of Correction. Date Certain 6/9/18</p> <p>4)The facility will immediately conduct a family/patient careplan meeting with all hospice patients and their families. This</p>		

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F 656	<p>Continued From page 3</p> <p>the attendees included the MDS nurse, the dietitian, the day shift floor nurse, and herself. The SW explained the resident's family was invited but did not attend. The SW stated hospice services had not participated in the care plan meetings since the resident had been readmitted to hospice. The SW stated she did not have a hospice care plan for the resident.</p> <p>A second interview was conducted with the SW on 5/10/18 at 10:06 AM. The SW stated if she received input from hospice or a concern, they addressed it. The SW stated hospice did not supply a care plan for the resident. The SW stated there was not a care plan where the hospice care plan and the facility care plans were integrated.</p> <p>An interview was conducted with the MDS nurse on 5/10/18 at 10:19 AM. The MDS nurse stated she did not know if hospice participated in the care plan meetings at the facility and she would have to ask the SW.</p> <p>A phone interview was conducted with the Case Worker from the hospice agency on 5/10/18 at 10:30 AM. The Case Worker stated she had not collaborated with the facility for Resident #12's care plan and she had not been invited to attend care plans for the resident at the facility. The Case Worker stated she reviewed the hospice care plan weekly. The Case Worker stated there was not a process from hospice to integrate the hospice care plan and the facility care plan for the resident. The Case Worker stated she was not familiar with the contract between the hospice agency and the facility and there was not a care plan which was written jointly by hospice and the facility. The Case Worker stated information in</p>	F 656	<p>meeting will include, at a minimum, a representative of the hospice services group, the facility social worker, the MDS coordinator, a member of the nursing services team, a registered dietitian, and the activity coordinator. A roster of residents, dates, and times of meetings will be maintained as part of this Plan of Correction. Date Certain 6/8/18</p> <p>5)The facility will coordinate family and patient careplan meetings with hospice services as appropriate, but quarterly at a minimum. The facility social worker will communicate meeting times with hospice services. Written documentation of the family/patient careplan meeting will be included in the patient's electronic medical record. The facility will maintain a roster to monitor dates and coordination of these meetings for compliance of attendance. Date Certain 6/9/18</p> <p>6)Hospice services will provide a copy of the hospice services care plan for inclusion into the patient's facility electronic medical record, and will provide updated copies as needed, but at least quarterly. Date Certain 6/9/18</p> <p>7)The Administrator will maintain all records and monitoring methods for this Plan of Correction.</p>		

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F 656	Continued From page 4 regards to the resident would be communicated to front line facility staff such as nursing assistants (NAs) through a verbal report.  An interview conducted with the DON was conducted on 5/10/18 at 10:51 AM. The DON stated the facility prepares their care plans with the resident's family. The DON stated hospice was on a different computer system than the facility and there was not a hospice care plan in the software system the facility used. The DON stated there was not a set care plan meeting with hospice. The DON further stated hospice residents were discussed between the hospice staff and the facility staff when the hospice staff were in the facility several times per week. The DON stated frontline staff received information about hospice residents through verbal reports.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, hospice representative interview, and staff interviews, the facility failed to ensure quality of care for the care plan development for one of one resident reviewed for hospice (Resident #12).	F 684	Preparation and/or execution of this Plan of Correction (POC) does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is	6/9/18	

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F 684	<p>Continued From page 5</p> <p>The findings included: Review of the contract between the facility and hospice with an effective date 8/26/13 revealed the following:</p> <p>Section 1.6 hospice Plan of Care. A written care plan jointly established, maintained, reviewed and modified as necessary, at regular intervals, by the hospice Medical Director, Attending Physician and hospice Interdisciplinary Group, and with the participation of Skilled Nursing Facility (SNF), to the extent practical, which includes: (a) an assessment of each hospice Patient's needs; (b) an identification of the hospice Services, including management of discomfort and symptom relief, needed to manage and palliate the hospice Patient's terminal illness and to meet the related needs of the hospice Patient's family; and (c) details concerning the scope and frequency of hospice Services.</p> <p>Section 3.6 hospice recognizes that SNF is required under State and Federal regulations to have individualized care plans with physician concurrence on each resident soon after admission, and to revise said care plans as needed based upon the condition of the Resident. As SNF has care plan meetings at least quarterly, SNF agrees to notify hospice in writing or verbally the dates and regularly scheduled times of the meetings. hospice will participate in the interdisciplinary care plan process to include quality review and cooperate with SNF so as to ensure that care plans for hospice Patients are consistent with, and allowed by laws and regulations, the same as SNF's; that the care plans meet the highest professional standards and state licensure requirements for Long Term Care Facilities as well as Medicare Conditions of</p>	F 684	<p>prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>1)The facility interdisciplinary team will immediately conduct a record audit on Resident #12 and all other hospice residents to ensure that careplans for each resident are accurate, integrated, and applicable to meet the needs of each resident. An updated careplan note reflecting these changes will be included on the resident electronic medical record. A roster of all residents included in this update will be maintained as part of this Plan of Correction. Date Certain: 6/6/18 2)The facility interdisciplinary team will immediately review and update all hospice resident careplans to ensure that the careplan includes 1) an assessment of needs. 2) an identification of hospice services, including management of discomfort and symptoms of relief needed to manage and palliate the hospice patient's terminal illness and to meet the related needs of the hospice patient's family. 3) Details concerning the scope and frequency of hospice services. A roster of residents included in this review will be maintained as part of this Plan of Correction. Date Certain 6/6/18 3)The facility will conduct regular careplan meetings concerning all hospice residents during regularly scheduled careplan updates, as needed, but quarterly at a minimum. Hospice services will attend bi-weekly careplan update meetings at the facility to discuss hospice patients and applicable changes in patient</p>		

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F 684	<p>Continued From page 6</p> <p>Participation for Long Term Care Facilities and hospices.</p> <p>Section 3.7 SNF recognizes that hospice is required under State and Federal regulations to have individualized care plans with physician concurrence on each patient soon after admission, and to revise said care plans as needed based upon the condition of the patient. Hospice will discuss each patient every fifteen (15) days and notify SNF of any updated care plans. SNF will participated in the interdisciplinary care plan process to include quality review and cooperate with hospice so as to ensure that care plans for hospice Patients are consistent with, and to the extent allowed by laws and regulations, the same as SNF's; that the care plans meet the highest professional standards and state licensure requirements for hospices as well as Medicare Conditions of Participation for hospices and Long Term Care Facilities and Joint Commission on Accreditation of Healthcare organization requirement for hospices; and that the care plan reflects participation of hospice, SNF, and the patient/family to the extent possible.</p> <p>Resident #12 was admitted to the facility 1/29/16 with diagnoses which included: Alzheimer's disease, dementia, chronic obstructive pulmonary disease, and protein calorie malnutrition.</p> <p>A review of Resident #50's Minimum Data Set (MDS) revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/7/18. The MDS assessment indicated Resident #50 was unable to complete the Brief Interview for Mental Status due to having been rarely or never understood which indicated severe cognitive</p>	F 684	<p>condition/care. Those updates will be reflected on the facility careplan, when applicable. These meetings will include (at a minimum) a representative of the hospice team, a social worker, and the MDS coordinator. The meeting will discuss updates to both the facility careplan and the hospice careplan to ensure that both careplans are integrative and complimentary to ensure the highest practicable quality of care for each resident. A portion of the meeting will include a quality review, to include risk areas, which will be included as part of the facility Quality Assurance program, which is overseen by the Administrator. A careplan update will be included in the resident's chart after the first initial meeting, and when applicable changes have been made thereafter. A roster of attendees at each meeting will be maintained as part of this POC. A roster of hospice residents discussed will be maintained as part of this Plan of Correction. Date Certain 6/9/18</p> <p>4)Hospice services will discuss patient care at least every fifteen (15) days and notify the facility of any careplan updates that occur outside of regularly coordinated meetings between the facility and hospice services noted in section one (1) of this plan of correction. Date Certain 6/9/18</p> <p>5)The facility will immediately conduct a family/patient careplan meeting with all hospice patients and their families. This meeting will include, at a minimum, a representative of the hospice services group, the facility social worker, the MDS coordinator, a member of the nursing</p>		

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F 684	<p>Continued From page 7</p> <p>impairment. The resident was coded as having had a condition or chronic disease that may have resulted in a life expectancy of less than 6 months. The resident was coded as having had received hospice care while she was a resident at the facility.</p> <p>Review of Resident #12's Electronic Medical Record revealed the resident had an Informed Consent/Election of Benefits with hospice dated 11/30/17.</p> <p>Review of Resident #12's Record of Admission sheet revealed the primary payor for the resident was hospice.</p> <p>A review completed of Resident #12's care plan which had been documented as having been last reviewed on 3/27/18 was completed on 5/8/18 at 3:47 PM. The review revealed no hospice care plan. The only discovered mention of hospice care in the care plan except for the care plan addressing Activities of Daily Living function rehabilitation care plan. The information listed related to hospice services were hospice services were discontinued on 9/21/17 and were reinitiated on 11/30/17.</p> <p>An interview was conducted with the Social Worker (SW) on 5/10/18 at 9:25 AM. The SW stated Resident #12 was on hospice when she first was admitted to the facility. The resident's condition then stabilized and the resident no longer met hospice criteria and was discharged from hospice services. The resident was then determined to qualify for hospice services and was readmitted to hospice. The SW stated the resident was nonresponsive due to cognitive loss. The SW stated hospice services had not</p>	F 684	<p>services team, a registered dietician, and the activity coordinator. A roster of residents, dates, and times of meetings will be maintained as part of this Plan of Correction. Date Certain 6/8/18</p> <p>6)The facility will coordinate family and patient careplan meetings with hospice services as appropriate, but quarterly at a minimum. The facility social worker will communicate meeting times with hospice services. Written documentation of the family/patient careplan meeting will be included in the patient's electronic medical record. The facility will maintain a roster to monitor dates and coordination of these meetings for compliance of attendance. Date Certain 6/9/18</p> <p>7)Hospice services will provide a copy of the hospice services care plan for inclusion into the patient's facility electronic medical record, and will provide updated copies as needed, but at least quarterly. Date Certain 6/9/18</p> <p>8)The Administrator will maintain all records and monitoring methods for this Plan of Correction.</p>		



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F 684	<p>Continued From page 8</p> <p>participated in the care plan meetings. The SW stated she did not think she had invited hospice for the last care plan meeting. The SW stated she usually just sends invitations to care plan meetings to family members. The resident's last care plan meeting was 3/27/18 and the attendees included the MDS nurse, the dietitian, the day shift floor nurse, and herself. The SW stated the resident's family was invited but did not attend. The SW stated she did not have a hospice care plan for the resident. The SW further stated the facility only did care plans on certain parts or for certain problems, for example, if the resident had a combative behavior, she would do a care plan for the resident being combative. The SW stated there would not be a care plan for hospice.</p> <p>A second interview was conducted with the SW on 5/10/18 at 10:06 AM. The SW stated she had received input from hospice from the care plan staff. The SW stated she did not enter anything in the care plan about hospice. The SW stated there was not a care plan, or intervention for hospice in the care plan. The SW stated if she received input from hospice or a concern, they address it. The SW stated hospice did not supply a care plan for the resident. The SW stated she thought hospice left a note when they visit the resident, and she was unable to identify if a note entered into the system or a handwritten note. The SW stated there was not a care plan where the hospice care plan and the facility care plans were integrated.</p> <p>An interview was conducted with the MDS nurse on 5/10/18 at 10:19 AM. The MDS nurse stated she did not know if Resident #12 had a hospice care plan and she would have to ask the Medical Records Manager. The MDS nurse stated she</p>	F 684			

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(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 684	<p>Continued From page 9</p> <p>did not know if hospice participated in the care plan meetings at the facility and she would have to ask the SW.</p> <p>An interview was conducted with the Medical Records Manager (MAM) on 5/10/18 at 10:22 AM. The MAM stated there was a hospice assessment plan of care in addition to handwritten hospice notes which she scans and enters into the facility's EMR system. The MAM stated there were several recertification notes under the provider section of Resident #12's hospice tab.</p> <p>A phone interview was conducted with the Case Worker from the hospice agency on 5/10/18 at 10:30 AM. The Case Worker stated she had not collaborated with the facility for Resident #12's care plan. The Case Worker stated she had not been invited to attend care plans for the resident at the facility. The Case Worker stated the care plan for hospice was reviewed twice per week and she reviewed the hospice care plan weekly. The Case Worker stated the facility staff would have access to the hospice care plan but she did not know if the facility staff had reviewed the hospice care plan. The Case Worker stated there was not a process from hospice to integrate the hospice care plan and the facility care plan for the resident. The Case Worker stated she was not familiar with the contract between the hospice agency and the facility. The Case Worker stated there was not a care plan which was written jointly by hospice and the facility. The Case Worker stated there was not a separate care plan kept at the hospice office. The Case Worker stated information in regards to the resident would be communicated to front line facility staff such as Nursing Assistants (NAs) through a</p>	F 684			

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

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NAME OF PROVIDER OR SUPPLIER  <b>JESSE HELMS NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 DOVE STREET MONROE, NC 28111</b>		
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F 684	<p>Continued From page 10</p> <p>verbal report. The Case Worker stated the care plan after each visit was handwritten. The Case Worker stated there was an Interdisciplinary Group which consisted of members of only the hospice staff and they would discuss their hospice Care Plan.</p> <p>An interview conducted with the DON was conducted on 5/10/18 at 10:51 AM. The DON stated the facility prepares their care plans with the resident's family. The DON stated the SW reviewed the hospice care plan with the nursing staff. The DON stated hospice was on a different computer system than the facility. The DON stated there was not a hospice care plan in the software system the facility used. The DON stated there was not a set care plan meeting with hospice. The DON stated hospice residents were discussed between the hospice staff and the facility staff when the hospice staff were in the facility several times per week. The DON stated he would have to refer me to the hospice staff to discuss interventions or goals related to areas in the hospice care plan. The DON stated frontline staff received information about hospice residents through verbal reports. The DON stated there were notes which were in the system under hospice which had been scanned into their computer system.</p> <p>A copy of the hospice Plan of Care (POC) for Resident #12, dated 12/1/17, was received on 5/10/18 at approximately 11:20 AM. The POC included information such as the resident's name, address, diagnoses, and advance directives (code status). Other information included were listed such as goals, a nursing plan of care will be established that meets the patient's needs. The resident's medications were listed. The orders</p>	F 684			

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F 684	Continued From page 11 section of the POC documented the hospice Nurse was to coordinate the plan of care with the facility staff. The POC was signed by the hospice physician on 12/1/17. Further review of the POC revealed no associated measurable goals or interventions related to identified diagnoses, problems, or focus areas.	F 684		