

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 11, 2012

Mrs. Maureen Bertrand,
Woodridge Nursing Home
P.O. Box 550
Barre, VT 05641

Dear Mrs. Bertrand:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 2, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



AUG 31 2012

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

PRINTED: 08/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2012
NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE P. O. BOX 550 BARRE, VT 05641	
(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 An unannounced, on-site re-certification survey was conducted between 07/30/2012 to 08/02/2012 by the Division of Licensing and Protection. The following deficiencies were identified.	F 000	Please note that Woodridge Nursing Home has achieved compliance with all the requirements as of the completion date specified in the Plan of Correction the deficiency stated. Woodridge requests that this plan of correction serve as its allegation of compliance with all requirements. Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the Home's continued compliance with all applicable laws.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for one resident of 31 in the stage 2 sample. (Resident #178) Findings include: 1. Per record review on 08/01/12 of the care plan dated 05/09/12, Resident #178 was at risk for falls, altered mood related to depression, at risk for skin issues, pain, communication, cognitive deficits, general activities of daily living and alteration in psychosocial well being related to long term placement. Staff were directed to provide a safe environment for wandering, assess negative effects of medications, update the physician with changes in mood/adverse effects of medication, monitor changes in psycho-social well being, and provide a psychological consult PRN (as needed).	F 250	<u>F-250</u> <u>Corrective Action:</u> Resident #178 Care Plan has been updated identifying family members who can have a French speaking conversation with the resident. It has been noted by the family that the resident's cognitive status has deteriorated, she is unaware that her spouse is no longer around and has difficulty understanding and/or communicating in English or French. <u>Other Residents:</u> All residents are at risk. <u>Systemic Changes:</u> Care Plans are revised/updated by the Social Service practitioner as changes present. The process has been reviewed with the entire Interdisciplinary Team. <u>Monitoring:</u> MSW will perform monthly audits of care plan revisions and report monthly x's4 then quarterly at the monthly QA/QI Committee meeting. Reporting will continue until 100% compliance is demonstrated. <u>Completion Date:</u> 8/29/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Maurice Buteux ADMINISTRATOR 8/20/12

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.

PM

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F 250	<p>Continued From page 1</p> <p>Additionally, it was noted that "as [Resident #178's] dementia has progressed [s/he] has reverted back to only speaking French, family assist with interpreting French, [resident] shares a room with [spouse] who assists with interpretation, volunteer visits from french speaking volunteer -1xwk [1 time a week] or as available, ask spouse to assist with communication whenever possible [s/he] relies on [spouse's] direction and [housekeeper is helpful in interpreting], french tapes and that [Resident] often pushes [the spouse] around facility in the wheelchair".</p> <p>A care plan on 07/06/12 updated by social service states "observe for weepiness, irritability, agitation, increased wandering, withdrawal, provide soft touch, hand holding and hugs when weepy, provide 1:1 support in quiet environment, update MD if grief worse or does not subside, utilize French speaking staff PRN to assist with communication". Per review of the nursing note on 07/03/12, the spouse passed away. The social service note of 07/05/12 states "been into room twice to sit with [resident] and talk as spouse passed away and [s/he] went out to the services, signer will try to sit with [resident] tomorrow.</p> <p>Per interview on 08/02/12 at 10:10 A.M. the activity director (AD) stated "we try to seat [Resident #178] next to another French speaking resident when available and the resident had a French speaking volunteer that was in on the 30th of July. The AD stated that french tapes were used at one point but not lately and the TV was put on a french channel but that was closed captioned, for the spouse.</p>	F 250	F250 POC accepted 8/27/12 Thynghieran / Pmc

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F 250	Continued From page 2 Per interview on 08/02/12 at 10:45 A.M., the social service (SS) department personnel stated that the social worker was out on leave. When asked if a psych consult, a follow up visit to the resident, or revision to the plan of care was made, the SS confirmed that "more could be done" in meeting the psycho-social well being of the resident.	F 250	F-329 <u>Corrective Action:</u> Resident #178 MAR notes resident did have a diagnosis of Anxiety dated 7/4/12. Ativan order has been discontinued. Resident #22 MAR notes resident does have a diagnosis of Atypical Psychosis dated 3/29/12.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	The order for Seroquel has been decreased and dose reduction will continue as appropriate. Behavior Assessments and Observation Flow Sheets have been initiated on both of the residents. <u>Other Residents:</u> All residents are at risk. <u>Systemic Changes:</u> Both professional and nonprofessional staff, have been educated on the Behavior Management Policy. <u>Monitoring:</u> The DNS/designee will conduct audits on all residents receiving ant-anxiety or anti-psychotic medications monthly x's4, then quarterly until 100% compliance is reached. Goal to ensure that policy is followed, residents do not receive unnecessary medications and non- pharmacological interventions are initiated prior to the administration of PRN meds. Audit reports will be made monthly x 4 then quarterly until 100% compliance is note to the QA/QI Committee. <u>Completion Date:</u> 8/29/12	

F329 POC accepted 8/27/12
Thynnier RN Pmc

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F 329	<p>Continued From page 3</p> <p>by:</p> <p>Based on staff interview and record review, the facility failed to assure, for 2 of 10 applicable residents, that each resident's drug regimen was free from unnecessary medications, that non pharmacological interventions were tried prior to administration of PRN (as needed) psychotropic medications and that adequate monitoring was completed. (Residents #178 & #22) Findings include:</p> <p>1. Per record review on 08/01/12, Resident #178 was medicated with Lorazepam (anti-anxiety medication) 20 times in a one month period but did not have a diagnosis of anxiety listed on the problem list. A care plan updated on 07/06/12 by social services states "observe for weepiness irritability agitation, increase wandering, withdrawal, provide soft touch, hand holding and hugs when weepy, provide 1:1 support in quiet environment, update MD if grief worse or does not subside, utilize French speaking staff PRN to assist with communication."</p> <p>Per review of the Medication Administration Record (MAR), an anti-anxiety medication was started on 07/04/12 as Lorazepam 0.5 mg (milligrams) 1 tab every 4 hours as needed (PRN) for mild-moderate agitation or Lorazepam 1 mg every 4 hours PRN for severe agitation. Per review of the nursing note of 07/03/12 it states "spouse passed away at 7:19 P.M., son came in, no behaviors". The nursing note on 07/06/12 states "family in to visit and request Ativan for [resident] regarding visiting hour/ services-difficult to console-medicated with Ativan for the services". Nursing notes of 07/10/12 at 4:00 P.M. state "resident looking worried and wandering</p>	F 329	

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F 329	<p>Continued From page 4</p> <p>around". On the evening shift of 7/14/12 the nurse wrote at 9:10 P.M. that Resident #178 is less anxious tonight, that s/he was well groomed and stayed in the circle most of the evening with minimal wandering. The note also stated that s/he took his/her medications without issues and that the nurse gave Ativan at 8:00 P.M. and then s/he went to bed. The nursing note of 07/22/12 states "resident wandering in other rooms needs redirection, [s/he] is following staff up and down hallways, resident is pleasant and not agitated, Ativan given to assist with restlessness staff to continue to redirect PRN".</p> <p>Per review of the Treatment Administration Record (TAR) there were no behavior assessments nor indication that other interventions were attempted prior to administration the Lorazepam.</p> <p>Per interview at 9:48 A.M. on 08/01/12, the Unit Manager (UM) stated "I was told that the son took [Resident] to the funeral home and [s/he] freaked out, so I guess when [s/he] came back [s/he] needed something for the grief" but also stated "it looks as if [the resident's] behaviors are not really different then the normal wandering". The UM confirmed there was no documentation to indicate that other interventions were tried first, no documentation of adequate monitoring nor indications for the use of the anti-anxiety medication.</p> <p>2. Per record review on 08/01/12, Resident #22 received an anti-psychotic without adequate monitoring or behavioral interventions prior to starting the medication. Per review of the facility's Management of Anti-psychotic</p>	F 329		

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F 329	<p>Continued From page 5</p> <p>Medication Flow Sheet, it states "behaviors must be documented at least 1 week prior to administration and include non-medical interventions every shift". Per review of the admitting problem list, there is no diagnosis of atypical psychosis, only dementia. Per review of the Minimum Data Set (MDS) of 03/26/12 in section-E-Behavior, it indicates 'no psychosis' and in E3000-overall presence of behavior, it indicates 'signs and symptoms did not have impact on others or resident'. Per review of a care plan that was initiated on 05/02/12 for the management of psychoactive medications, it reads "atypical psychosis-specific behaviors combative, biting, hitting, striking out, restlessness, behavior must be monitored and documented at least 1 wk (week) prior to initiation of new medications or a change in medication dose, this must include non medical interventions that have been tried and the effects of that intervention".</p> <p>Per review of the nursing notes one week prior to the initiation of an Anti-psychotic, there was no documentation for every shift prior to the start of Seroquel, as follows: 03/21/12 - Ativan for anxiety including repeated questions, expression of frustration, repeated attempts of walking without assist and not responsive to 1 to 1 & re-direction 03/25/12 5:58 PM - great difficulty ambulating, evidence of confusion 'my legs won't untangle,' also presents with agitation and irritability toward staff and difficulty following directions and expressing needs, following patient mood improved pleasant and cooperative with staff direction 03/25/12 - adamantly yells at staff 'I like help but</p>	F 329		

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F 329	Continued From page 6 not too much', patient's inability to express thoughts clearly results in angry outburst, patient expresses feeling invaded, much word searching 03/26/12 1500-2300 - positive mood daughter in to visit, settled to sleep at 1930 until 2230, awoke and found sitting up in bed crying softly becoming agitated, salad speech, Ativan 0.5 mg given for agitation 03/27/12 - res cheerful with positive mood tonight 03/28/12 - care plan meeting today discussed her anxiety and PRN Ativan use during evening hours [resident] is experiencing sundowning, during the day does not experience this at this time, daughter agrees to introduction of an anti-psychotic if MD agrees 03/28/12 - Ativan given for for s/s of restlessness and agitation with little effect 03/29/12 - s/s agitation AEB [as evidenced by] furred brow short angry responses to questions weepy, daughter in to sign permission anti-psych meds and had behaviors of restlessness, outburst, fidgety, refusing care, weepy. Per interview on 08/01/12 at 2:00 PM the nurse practitioner (NP) stated "[s/he] had some behaviors that the nursing staff said was getting worse and we didn't think that it was pain and we didn't want [the resident] to escalate where [s/he] might get hurt." The NP confirmed that there was no documentation that showed consistent, specific, quantifiable behaviors nor adequate monitoring with non-pharmacological interventions prior to the use of an anti-psychotic medication.	F 329			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441			

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F 441	<p>Continued From page 7</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>F-441</p> <p><u>Corrective Action:</u> Residents #155 & #31 did not suffer any secondary complications as a result of the RN or LNA's performance.</p> <p><u>Other Residents:</u> All residents are at risk.</p> <p><u>Systemic Changes:</u> In-Service education conducted for a professional and nonprofessional staff on the Infection Control Program and the Prevention of Spreading Infection.</p> <p><u>Monitoring:</u> DNS or designee will conduct medication pass audits that will identify the proper cleaning of medication carts and medication handling. Medication pass audits will be completed with all professional nurses passing medications. Dining room audits will be conducted during meal pass to ensure that hand hygiene is followed as per policy.</p> <p>Reports will be made by the DNS monthly to the QA/QI committee x's4, then quarterly until audits demonstrate 100% compliance in the prevention of the spread of infection.</p> <p><u>Completion Date:</u> 8/29/12</p> <p>F441 POC accepted 8/27/12 TMyhler RN/ Pmc</p>	

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F 441	<p>Continued From page 8</p> <p>Based on observation and staff interview, the facility failed to maintain a safe and sanitary environment during the observed lunch meal on 7/31/12 and during a medication pass on 8/1/12 for 2 residents (#155 and #31) identified in the sample. The findings include:</p> <p>1. Per observation of the lunch meal in the main dining room on 7/31/12 at 11:30 A.M., a Licensed Nursing Assistant (LNA) was observed picking up a serving tray with an un-gloved hand and touching the bottom of the tray when carrying it to a resident's table. The LNA then placed the tray down and did not glove or sanitize his/her hands and removed a wrapped ham sandwich from the tray, removed the plastic wrap from the sandwich, held the bread from the top of the sandwich in his/her un-sanitized/un-gloved hand and used the other hand to spread mustard on the sandwich with a knife.</p> <p>Per interview with the LNA at 12:20 P.M. on 7/31/12, he/she confirmed that he/she had not sanitized or used gloved hands after touching the bottom of the serving tray and before touching a resident's food. The LNA confirmed the bottom of the serving tray was a contaminated surface. Per interview with the Infection Control Nurse and Staff Educator on 8/2/12, he/she confirmed that the LNA should have sanitized or gloved before touching food to be consumed by a resident.</p> <p>2. Per observation of the 8:00 A.M. medication pass for Resident #155 on 8/1/12 at 8:03 A.M., a Registered Nurse (RN) was observed dropping an Amantidine capsule on the un-sanitized top surface of the medication cart and containing un-sanitized scissors. The RN picked up the</p>	F 441		

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F 441	<p>Continued From page 9</p> <p>capsule with the scissors and placed the pill in the medication cup for the resident to consume. The RN was also observed touching the inside top rim of a medication cup containing Lactulose with un-sanitized/un-gloved hands prior to giving the cup to Resident #155 to consume. The RN was also observed taking one medication cup containing Lactulose from the top of the un-sanitized medication cart and placing it inside another medication cup on top of pills that were dispensed for Resident #155 to consume.</p> <p>Per interview with the RN, he/she indicated that the medication cart top was sanitized once a shift. The RN confirmed that the top of the medication cart was a contaminated surface having a lap top computer on top, and that pens and a notebook were also stored on top of the cart. The RN confirmed the Amantidine pill should have been discarded and another pill should have been administered. The RN per interview on 8/1/12, confirmed that he/she should not have held the medication cup by the inside rim with un-sanitized/un-gloved hands and that the cup containing Lactulose that was sitting on the medication cart should not have been placed inside and on top of Resident #155's pills.</p> <p>3. Per observation on 8/1/12 at approximately 8:30 A.M., during the 8:00 A.M. medication pass for Resident #31, a Registered Nurse (RN) was observed breaking infection control technique by taking gloved hands and touching the un-sanitized bed control to raise Resident #31's bed up and then not changing gloves and touching the face and eye area of Resident #31 and attempting to administer Erythromycin ointment into the eye of Resident #31 before</p>	F 441			

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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 441	Continued From page 10 being interrupted by the surveyor and the surveyor requested the RN change his/her gloves prior to administration of the ointment. Per interview with the RN on 8/1/12, he/she confirmed that he/she should have changed gloves after touching the bed remote. Per interview with the Infection Control Nurse and Staff Educator on 8/1/12, they confirmed that the facility expectation is that the nurse should change gloves when they become contaminated before administering medications to residents.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475045	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/2/2012
NAME OF PROVIDER OR SUPPLIER WOODRIDGE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 550 BARRE, VT	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 272	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure that the Minimum Data Set assessment reflected accurate information related to skin integrity for one resident. This affected one (Resident #30) of 31 stage 2 sampled records reviewed. Findings include:</p> <p>Per record review, Resident #30 was admitted on 11/27/00 with diagnoses of dementia, brittle diabetes, hypothyroidism, edema, hydrocephalus, progressive neurodegenerative disease, bilateral marked paratonic rigidity of both lower extremities and the left upper extremity, and mixed urinary incontinence. A Plan of Care dated 06/02/12, for actual impairment of skin integrity indicated a dry, dark callous to left outer heel that measured 2.0 centimeters (cm) by 2.5 cm with reddened non blanchable tissue at the perimeter. The quarterly</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 272	<p>Continued From Page 1</p> <p>Minimum Data Set Assessment (MDS) dated 07/30/12 indicated Resident #30 was at risk for pressure ulcers but no pressure ulcer was indicated.</p> <p>The area to left outer heel was observed on 08/01/12 at 11:17 A.M. with the Licensed Practical Nurse (LPN) assigned on the Sunset View wing of Evergreen Place unit. Resident #30 was positioned in a Broda geriatric reclining chair with both lower extremities elevated on the footrest and supported with pillows. The skin was intact with a dark crescent shaped area noted to left outer heel. A protective, padded mepilex dressing was in place over the area and covered the entire heel. Resident #30's legs were wrapped in ace wraps to reduce edema and both lower extremities were wrapped with fleece knee length boots.</p> <p>Interview of the MDS Coordinator on 08/01/12 at approximately 12:00 P.M. revealed that the MDS was completed just days prior and did not reflect the area that was first noted on 06/02/12 and remained as of 08/01/12. The MDS Coordinator stated that the area was not observed but staff stated on interview that the treatments were preventative and the MDS coordinator thought the area was resolved.</p>		