NAME OF PROVIDER OF SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE UNVERSITY PLACE NURSING AND REHABILITATION CENTER STREET ADDRESS. CITY. STATE, ZIP CODE VMUD SUMMARY STATEMENT OF DEFICIENCIES 200 GLENWATER DRIVE VMUD SUMMARY STATEMENT OF DEFICIENCIES In PREDX FRANCET ADDRESS. CITY. STATE, VAN DE CORRECTION PREDX TAG SUMMARY STATEMENT OF DEFICIENCIES In PREDX PREDVERS Y ADDRESS. CITY. STATE, VER DOUBLE DR TAG SUMMARY STATEMENT OF DEFICIENCIES In PREDX PREDX PREDX CROSS-REFERENCES TO THE APPROPRIATE DR TAG An unannounced COVID-19 Focused Survey was conducted on 8/26/2020 through 8/27/2020. F000 F000 F000 Subpart-B-Requirements for Long Tem Care F000 Facilities. Event ID# 91TJ11. F000 F000 F000 An unannounced COVID-19 Focused Infection F000 Control Survey and complaint allegations investigation was substantiated as a result of the survey. Event ID# 91TJ11. F880 9/25 SS=D CFR(s): 483.80(a) (1/2)(4)(e)(f) F 880 9/25 SS=D Infection Prevention and control program.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED				
B200 GLENWATER DRIVE CHARLOTTE, NC 22222 Image: Colspan="2">Image: Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2">Colspan="2"Colsp		345142		B. WING		C 08/27/2020			
Overline Preserve Txo SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTING ACTION 4 HOLLID BE (EACH CORRECTING ACTION (EACH									
PHEFIX TAG (EACH OPERCENCE MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCE OF OTHE APPROPRIATE DEFICIENCY E 000 Initial Comments E 000 An unannounced COVID-19 Focused Survey was conducted on 8/26/2020 through 8/27/2020. The facility was found in compliance with 42 CFR §483.73 related to ±-0024 (b(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 91TJ11. F 000 F 000 INITIAL COMMENTS F 000 An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 8/26/2020 through 8/27/2020. F 000 The survey. Event ID #91TJ11. F 000 F 880 9/25 SS=D CFR(s): 483.80(1/12(2)4)(e)(f) F 880 9/25 SAD Infection Control The facility must establish and maintain an infection prevention ad control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. F 880 9/25 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: S483.80(a) Infection prevention ind control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: S483.80(a) Store and other individua									
An unannounced COVID-19 Focused Survey was conducted on 8/26/2020 through 8/27/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Subpart-B-Requirements for Long Term Care Facilities. Event ID# 91TJ11. F 000 NITIAL COMMENTS F 000 An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 8/26/2020 through 8/27/2020. There were a total of 2 complaint allegations investigated; 1 allegation was substantiated as a result of the survey. Event ID #91TJ11. F 880 Infection Prevention & Control SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a)(1) A system for prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETI			
was conducted on 8/26/2020 through 8/27/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Subpart-B-Requirements for Long Term Care Facilities. Event ID# 91TJ11.F 000F 000INITIAL COMMENTSF 000An unannounced COVID-19 Focused Infection control Survey and complaint investigation were conducted on 8/26/2020 through 8/27/2020. There were a total of 2 complaint allegations investigated: 1 allegation was not substantiated and 1 allegation was out substantiated and 1 allegation was substantiated as a result of the survey. Event ID #91TJ11.F 880F 880Infection Prevention & Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.F 880§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control orgarm (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing indentifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	E 000	Initial Comments		E 00	0				
Control Survey and complaint investigation were conducted on 8/26/2020 through 8/27/2020. There were a total of 2 complaint allegations investigated; 1 allegation was not substantiated and 1 allegation was substantiated as a result of the survey. Event ID #91TJ11. F 880 Infection Prevention & Control F 880 SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and ransmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 000	was conducted on 8/ The facility was found §483.73 related to E- Subpart-B-Requireme Facilities. Event ID#	26/2020 through 8/27/2020. d in compliance with 42 CFR 0024 (b)(6), ents for Long Term Care 91TJ11.	F 00	10				
F 880 SS=D Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) F 880 9/25 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals F 880 9/25		Control Survey and c conducted on 8/26/20 There were a total of investigated; 1 allega and 1 allegation was	omplaint investigation were 020 through 8/27/2020. 2 complaint allegations tion was not substantiated substantiated as a result of						
 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 		Infection Prevention	& Control	F 88	0	9/25/20			
program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals		§483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environm development and tran	ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable						
reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals		program. The facility must esta and control program	blish an infection prevention (IPCP) that must include, at						
providing services under a contractual		reporting, investigatir and communicable d staff, volunteers, visit	ng, and controlling infections iseases for all residents, ors, and other individuals						

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/21/2020 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		345142	B. WING		_	08/2	27/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER		200 GLENWATER DRIVE CHARLOTTE, NC 28262	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and durat depending upon the in involved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens.	pon the facility assessment to §483.70(e) and following ndards; a standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other can spread to other can spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct a or their food, if direct ne disease; and procedures to be followed rect resident contact.	F 880				
	§483.80(e) Linens.	le, store, process, and					

Facility ID: 923015

If continuation sheet Page 2 of 7

			0.00				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY
			A. BUILDI	NG_			с
		345142	B. WING			08/27/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	21/2020
				92	200 GLENWATER DRIVE		
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		С	HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From page	a 2	E S	880			
1 000		s to prevent the spread of		000			
	infection.	s to prevent the spread of					
	§483.80(f) Annual rev	view					
		ict an annual review of its					
	IPCP and update the	ir program, as necessary.					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
	Based on observatio			University Place Nursing and			
	interviews, and review			Rehabilitation Center acknowledges	_		
	Usage, the facility fai dialysis resident while			receipt of the Statement of Deficiencies and proposes this Plan of Correction a			
	lobby area for a dialy			required by Federal and State regulation			
		(1) reviewed for infection			and statutes applicable to long term ca		
	control. Additionally,	-			providers. This plan does not constitut		
	-	specified in the All Staff			an admission of liability on the part of t		
	Update related to ma			facility, and such liability is hereby			
	staff members failed	to wear facemasks while			specifically denied. The submission of	this	
	they worked in the kit			plan does not constitute an agreement			
	occurred during a Co	vid-19 pandemic.			the facility that the surveyor's findings		
					conclusions are accurate, that the findi		
	Findings included:				constitute a deficiency, or the scope or		
	A facility policy titled	"Cuidalina an Maak Llaaga"			severity regarding any of the deficienci	es	
		"Guideline on Mask Usage", 20 was reviewed. The policy			cited are correctly applied.		
	read in part:				F880		
	roud in part.				Corrective action has been accomplish	ned	
	We are recommendir	ng the use of surgical			for the alleged deficient practice regard		
		hen a patient is going to the			resident #1 and 2 of 4 dietary staff	-	
	emergency room, to				members. On 08/26/2020 a face mask	‹	
	readmitted into our fa	acility.			was placed on resident #1 by the		
					receptionist. All residents that have		
	•	tion titled "All Staff Update",			outside appointments or return to the	_	
	dated 4/9/2020 was r				facility from outside appointments have		
	communication read	in part.			the potential to be affected by the sam		
	Residents going out t	to an appointment must wear			alleged deficient practice. On 08/26/20 an audit was completed to ensure that		
	a mask.	o an appointment must wed			residents that had appointments and	all	
							1

Facility ID: 923015

If continuation sheet Page 3 of 7

		MEDICAID SERVICES	<i>a</i>			D. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	SURVEY PLETED
			A. BUILDING	3		С
		345142	B. WING			27/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		21/2020
				9200 GLENWATER DRIVE		
UNIVERSI	TY PLACE NURSING AN	ID REHABILITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN (OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETIO DATE
F 880	Continued From page	e 3	F 88	30		
	All staff must wear a			mask in place. All other	residents were	
				compliant with mask use.		
	1. Resident #1 readm	nitted to the facility on		an audit was completed v		
	10/11/2019. His diag	noses included end stage		staff to monitor compliane	ce of face mask	
	renal disease.			use and no other issues		
	· ·	rly Minimum Data Set (MDS)		In-service was conducted		
	dated 8/9/2020 revea			Nursing (DON), Assistant		
		. He required extensive ved dialysis services. No		Nursing (ADON) and Sta Coordinator (SDC) for all	•	
	behaviors indicated.	ved dialysis services. No		included CDC guidelines		
				compliance and resident		
	Resident #1 had a dia	alysis plan of care reviewed		mask use when leaving t		
		ncluded interventions for		upon return to the facility	-	
	dialysis services on N	londay, Wednesday and				
	Friday.			Measures put into place		
				alleged deficient practice		
		g progress notes were		include: Face Masks we	•	
		20 through 8/26/2020 which		medication carts for quick		
		ntation of Resident #1		access. Face masks we		
	refusing to wear his n	nask.		stored in the Dietary Man quick and easy access.	•	
	An observation was c	completed on 8/26/2020 at		education was conducted		
		t #1 being transported in his		Nursing, Assistant Direct		
		y area by Nurse Aide (NA)		and Staff Development C		
		his dialysis bag resting on		08/26/2020 for all staff th		
	his lap. Resident #1	had no mask in place. NA		guidelines for mask comp	bliance and	
		n face-shield, mask and		resident guidelines for ma		
	-	transporting Resident #1.		leaving the facility and up		
	Continued observatio			facility. In-service to be o		
		1. She stated she was		09/01/2020. Employees		
		as a dialysis recipient and obby area by 10:15 AM for		allowed to work next sche in-service acknowledged		
		lized she had received				
	· ·	control and Covid-19. NA #1		An audit was initiated on	08/26/2020 bv	
	-	ent #1 should have a mask		the Director of Nursing, A	-	
	on. She stated she w	vas rushed and going back		of Nursing and/or Staff D		
		mask. NA #1 explained		Coordinator to ensure that	-	
	Resident #1 should h	ave had a mask on prior to		were wearing face masks		
	leaving his room.			go to outside appointmer	nts and upon	

Facility ID: 923015

If continuation sheet Page 4 of 7

	S FOR MEDICARE &	MEDICAID SERVICES			CONSTRUCTION	(X3) DATE	D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	PLETED
		345142	B. WING		C 08/27/2020		
	ROVIDER OR SUPPLIER	010112			TREET ADDRESS, CITY, STATE, ZIP CODE	08	27/2020
					200 GLENWATER DRIVE		
UNIVERS	TY PLACE NURSING AN	ID REHABILITATION CENTER			CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 4	F	380			
	received training on 8 usage and Covid-19. An interview was com 8/26/2020 at 10:13 A #1 should have had a NA #1 should have pl #1 prior to exiting his to the lobby area. An observation was c Receptionist on 8/26/ lobby area. She was Resident #1 while he A telephone interview Assistant Director of I served as the Infectio 8/26/2020 at 11:01 Al residents should have leaving their rooms. had received education practices and Covid-1	2020 at 10:15 AM in the observed placing a mask on waited for dialysis transport. was completed with the Nursing (ADON), who also on Preventionist, on M. She explained all e a mask in place when She communicated all staff on on infection control 19.			return to the facility and to ensure tha dietary employees were wearing face masks while working in the kitchen. Audits will be completed on residents dietary employees three times per week 4 weeks, then two times per week 4 weeks, then weekly for 4 weeks. Th audit will be documented on the face mask audit tool. The Director of Nurs or Assistant Director of Nursing will present the findings and recommendations at monthly QI committee meeting. QAPI/QI committ will evaluate for continued compliance 3 months.	and ek for ne ing ee	
	Worker on 8/26/2020 explained Resident # refusal of care but wa	1 exhibited behaviors of as not aware of Resident #1 nask. She communicated ed a plan of care for					
	explained Resident # wear his mask. She	npleted with the 5/2020 at 12:09 AM. She 1 had periods of refusal to explained agency staff he would wear his mask and					

If continuation sheet Page 5 of 7

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345142	B. WING				C /27/2020
NAME OF P	ROVIDER OR SUPPLIER		ł	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
UNIVERS	ITY PLACE NURSING AN	D REHABILITATION CENTER			0200 GLENWATER DRIVE CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 880	he stated "no". The <i>A</i> was agreeable with R proceeded to transpo The Administrator cor readily available Resi mask in place unless An interview was corr on 8/26/2020 at 12:26 familiar with Resident Resident #1, on his d when he entered the his dialysis transport. recall Resident #1 no 2. An observation of t completed on 8/26/20 observation revealed a mask while she pre Covid unit. Further of revealed Dietary Aide while he washed dish An interview was corr AM with Dietary aide received in-service tra and Covid-19 inclusiv times. Dietary aide # hanging off her ear ar was observed with he nose and mouth. Review of Dietary Aid revealed she received related to mask usage An interview was corr AM with Dietary aide	Administrator verbalized staff tesident #1's refusal and rt him to the lobby area. mmunicated if masks were dent #1 should have had a he refused. appleted with the Receptionist 5 pm. She stated she was t #1. She expressed ialysis days, wore a mask lobby area and waited for The receptionist could not t wearing a mask. The Dietary Department was 20 at 9:50 AM. The Dietary Aide #1 not wearing pared to plate food for the bservation of the kitchen the #2 not wearing a mask es. appleted on 8/26/2020 at 9:55 #1. She revealed she had aining on infection control te of wearing a mask at all 1 stated her mask was and had just came off. She er mask now covering her e #1's education record d training on 4/09/2020 e and Covid-19. appleted on 8/26/2020 at 9:57	F	880			

Facility ID: 923015

If continuation sheet Page 6 of 7

PRINTED: 09/21/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/21/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		345142	B. WING				C 27/2020
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSI	TY PLACE NURSING AN	D REHABILITATION CENTER			200 GLENWATER DRIVE HARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	on infection control ar wearing mask at all ti should have had his r difficult to breath. Review of Dietary Aid revealed he received related to mask usage An interview was com 10:00 AM with the As (ADM). She explaine training on infection c inclusive of wearing n staff were aware that all times. An interview was com Administrator on 8/26 communicated dietar masks the way they he A telephone interview 8/27/2020 at 11:15 Al (DM). He stated staff	2 stated he received training nd Covid-19 inclusive of mes. He communicated he mask on but it was hot and e #2's education record training on 4/09/2020 e and Covid-19. npleted on 8/26/2020 at sistant Dietary Manager d all staff had received ontrol and Covid-19 masks. The ADM verbalized masks should be in place at npleted with the /2020 at 12:15 PM. She y staff should wear their had been in-serviced.	F 8	80			
	fresh air to go outside employee area. He v educated on infection inclusive of wearing n	erbalized staff had been control and Covid-19					

If continuation sheet Page 7 of 7