	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345365 NAME OF PROVIDER OR SUPPLIER		B. WING	С		
			REET ADDRESS, CITY, STATE, ZIP CODE	02/17/2021	
		NSTON	90	7 CUNNINGHAM ROAD NSTON, NC 28501	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
E 000	Initial Comments		E 000		
F 000	was conducted on 2/2 facility was found in c 483.73 related to E-0	ents for Long Term Care L1S11	F 000		
	Control Survey and c conducted on 2/15/21 facility was found out 483.80 infection contri implemented the CMS	VID-19 Focused Infection omplaint investigation were through 2/17/21. The of compliance with 42 CFR rol regulations and has not S and Centers for Disease on (CDC) recommended or COVID-19.			
F 880 SS=E	1 of 24 complaint alle but did not result in a Infection Prevention & CFR(s): 483.80(a)(1)	& Control	F 880		3/9/21
		blish and maintain an nd control program I safe, sanitary and nent and to help prevent the nsmission of communicable			
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:			
	§483.80(a)(1) A syste	em for preventing, identifying,			
			1		

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				FORI	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345365	B. WING				(17/2021
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF KI	NSTON			907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable 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 isco- resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possil 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	g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ole diseases or can spread to other can spread to other can spread to other can spread to other se or infections should be assission-based precautions ent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable cin lesions from direct a or their food, if direct ne disease; and procedures to be followed rect resident contact.	F	880			

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/23/202 FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345365	B. WING		C 02/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	
010114711			9	007 CUNNINGHAM ROAD	
SIGNATUR	RE HEALTHCARE OF KI	NSTON		KINSTON, NC 28501	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 880	Continued From page		F 880		
	corrective actions tak	en by the facility.			
		le, store, process, and to prevent the spread of			
	IPCP and update the This REQUIREMENT by: Based on observatio interviews, the facility Centers for Disease ((CDC) guidelines for did not perform hand gloves during wound (Resident #1), and a perform hand hygiend after performing incomo other residents room (Resident #1, #2, #3, failed to implement the policy requiring 3 of 6	act an annual review of its ir program, as necessary. is not met as evidenced ns, record review and staff failed to implement the Control and Prevention hand hygiene when a nurse hygiene when changing care for 1 of 1 residents nursing assistant did not e when removing gloves ntinent care before entering for 4 of 4 residents #4). The facility further the facility 's infection control b kitchen staff to wear aring a meal for residents.		F880 1) No residents were found to be affected by the cited deficient prace Education provided with the Licens Nurse on performing hand hygiene changing gloves during wound care Education provided to nursing assi on performing hand hygiene when removing gloves after performing incontinent care before entering ar resident's room. Education provide Dietary Aide #1, Dietary Aide #2, a Dietary Manager on wearing a face while preparing meals for residents education was completed by 3/1/20	tices. sed e when e. istant nother ed to ind emask s. This
	Manager). This failure COVID-19 pandemic Findings included:			 All residents had the potential affected by the deficient practices. Complete in house audit complete current employees to validate that employees were wearing face mass 	d on all
	Providers about Hand dated May 17, 2020 s			appropriately and hand hygiene is performed as per Centers for Dise. Control and Prevention (CDC) guid and according the Signature Health Infection Control Policy as it relates Handwashing. This audit was com	ase delines hcare s
		after removing gloves. The		by 3/3/2021.	

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	S FOR MEDICARE &				OMB NO. 0938-03 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
					С	
		345365	B. WING		02/17/2021	
NAME OF P	ME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CC			
SIGNATURE HEALTHCARE OF KINSTON				907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIC	
F 880	Continued From pag	e 3	F 88	n		
F 880	guidance further stat perform hand hygien moving from work on body site on the sam indication for hand hy On 2/15/2021 at 1:22 changing Resident # shoulder blade dress #1 removed the off-lo extremity and remove performing hand hyg pair of gloves. Using removed the dressing soaked 4x4 dressing with a kerlix dressing gloves and reapplied left lower extremity. A reposition the right le appeared on her ung into the bathroom an applied a pair of new inner aspect of the ri- abrasion was observ- right ankle, and a sili She removed her glo of gloves without per #1 exposed and clear normal saline gauze zinc cream to the sac gloves and reapplied performing hand hyg gloves and did not pe exiting the room to of the wound cart in the	ed to change gloves and e during patient care if a soiled body site to a clean le patient or if another clinical ygiene occurs. 2pm, Nurse #1 was observed 1's left heel, sacral and left sing. With gloves on Nurse boading boot on the left lower ed her gloves without iene before reapplying a new a pair of scissors, she g on the left foot. A betadine was applied and secured and tape. She removed her the off-loading boot to the When Nurse #1 reached to eg, a liquid substance gloved hands, and she went d washed her hands. She g gloves and examined the ght lower leg. An open ed on the inner aspect of the cone dressing was applied. wes and reapplied a new pair forming hand hygiene. Nurse insed the sacral area using a and applied a Silvadene and cral area. She removed her I a new pair of gloves without iene. Nurse #1 removed her I a new pair of gloves		3) Education on the Infection O Policy as it relates to the wearing mask. Additionally, the facility sh provide staff education on the im of hand hygiene. This education provided to all staff by 3/5/2021. training will also be provided to a upon hire and during orientation 4) The Root Cause Analysis w conducted by the Infection Preve QAPI Team and Governing Boar root cause of the cited deficient was determined to be need for ff education regarding proper PPE proper wearing of face masks, th facilities infection control policy of performing hand hygiene. The Fi revealed there is a need for mor observations to ensure staff are Infection Control guidelines to in previously stated concerns. Due findings of the RCA, the above of will be completed and then ongo will be conducted by the Directo Nursing, Infection Preventionist, Assistant Director of Nursing for observations and review to ensu are wearing face masks appropri following the infection control po relates to handwashing for prevent the spread of Covid 19. These and observation rounds will be of 5 x weekly for 4 weeks on various weekly x 4 weeks on various weekly x 4 weeks on various shi then monthly x 3 months. Any sinot in compliance with Infection	g of a face hall hportance will be This all staff factors entionist, rd and the practices urther is usage, he on RCA also e frequent following clude the e to the education bing audits r of and/or ure staff riately and licy as it ention of audits conducted us shifts, 3 shifts, fts and taff found	

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	A. BUILDING		
345365		B. WING	B. WING		
IAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		02/17/2021	
SIGNATURE HEALTHCARE OF KINSTON			907 CUNNINGHAM ROAD KINSTON, NC 28501		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMPLETIO	
prep, removed her gle hand hygiene and ap the left shoulder blad repositioned for comf the bathroom and wa exiting the room. On 2/15/2021 at 1:43 Nurse #1, when aske between removing gle new pair of gloves, sh washing." She stated or had hand sanitizer hygiene after removir reapplying a new pair interview on 2/16/202 stated she received e personal protective e performing hand hygi She stated she shoul the room, but she did Resident #1. She stat hands before applying gloves. On 2/15/2021 at 4:07 Director of Nursing (E on the type of resider their hands or use ha before applying new gloves 2. On 2/15/2021 at 2: was observed applying providing incontinent	oves without performing plied a silicone dressing to e. Resident #1 was ort, and Nurse #1 entered shed her hands before pm in an interview with d what was performed oves and before reapplying a ne answered, "Hand d she should wash her hands available to perform hand ng gloves and before r of gloves. In a phone 21 at 3:03pm, Nurse #1 education of the use of quipment that included ene after removing gloves. d have had hand sanitizer in n ' t want to walk away from ted she usually washed her g gloves and after removing pm in an interview with the DON), she stated depending nt care provided, staff wash nd gel after removing gloves gloves.	F 880	 noncompliance will result in emploid disciplinary action and subsequent termination of employment. All dates summarized and presented to a facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any or trends identified will be address the QAPI committee as they arise, the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator and Director of Social Services. 5) The Administrator and Director Nursing is responsible for implementary and the planeta of the Compliance. 	t ta will the g vissues ed by and trator, and trator, or, Director	
	Continued From page prep, removed her glu hand hygiene and ap the left shoulder blad repositioned for comf the bathroom and wa exiting the room. On 2/15/2021 at 1:43 Nurse #1, when aske between removing glu new pair of gloves, sl washing." She stated or had hand sanitizer hygiene after removir reapplying a new pair interview on 2/16/202 stated she received e performing hand hygi She stated she shoul the room, but she did Resident #1. She sta hands before applyin gloves. On 2/15/2021 at 4:07 Director of Nursing (E on the type of resider their hands or use ha before applying new pair she stated she shoul the room, but she did Resident #1. She sta hands before applyin gloves.	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: SCORRECTION 345365 ROVIDER OR SUPPLIER 345365 RE HEALTHCARE OF KINSTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 prep, removed her gloves without performing hand hygiene and applied a silicone dressing to the left shoulder blade. Resident #1 was repositioned for comfort, and Nurse #1 entered the bathroom and washed her hands before exiting the room. On 2/15/2021 at 1:43pm in an interview with Nurse #1, when asked what was performed between removing gloves and before reapplying a new pair of gloves, she answered, "Hand washing." She stated she should wash her hands or had hand sanitizer available to perform hand hygiene after removing gloves. In a phone interview on 2/16/2021 at 3:03pm, Nurse #1 stated she received education of the use of personal protective equipment that included performing hand hygiene after removing gloves. She stated she should have had hand sanitizer in the room, but she didn ' t want to walk away from Resident #1. She stated she usually washed her hands before applying gloves and after removing	IDENTIFICATION NUMBER: A BUILDING. 345365 B. WING ROVIDER OR SUPPLIER B. WING RE HEALTHCARE OF KINSTON ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 4 F 880 prep, removed her gloves without performing hand hygiene and applied a silicone dressing to the left shoulder blade. Resident #1 was repositioned for comfort, and Nurse #1 entered the bathroom and washed her hands before exiting the room. F 880 On 2/15/2021 at 1:43pm in an interview with Nurse #1, when asked what was performed between removing gloves and before reapplying a new pair of gloves, she answered, "Hand washing." She stated she should wash her hands or had hand sanitizer available to perform hand hygiene after removing gloves. In a phone interview on 2/16/2021 at 3:03pm, Nurse #1 stated she received education of the use of personal protective equipment that included performing hand hygiene after removing gloves. She stated she should have had hand sanitizer in the room, but she didn 't want to walk away from Resident #1. She stated she usually washed her hands before applying gloves and after removing gloves. On 2/15/2021 at 4:07pm in an interview with the Director of Nursing (DON), she stated depending on the type of resident care provided, staff wash their hands or use hand gel after removing gloves before applying new gloves. 2. On 2/15/2021 at 2:46pm, Nurse Aide (NA #1) was observed applying a pair of gloves before providing incontinent care to Resident #2. After	PERCIENCIES CORRECTION (X1) PROVIDERSUPPLIER/LIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 345365 B WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 CUNNINGHAM ROAD KINSTON, NC 28501 SUMMARY STATEMENT OF DEFICIENCIES (REAP DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (REAP CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) Continued From page 4 prep, removed her gloves without performing hand hygiene and applied a silicone dressing to the bathroom and washed her hands before exiting the room. F 880 On 2/15/2021 at 1:43pm in an interview with hygiene after removing gloves and before reapplying a new pair of gloves, he answered, "Hand washing." She stated she should wash her hands or had hand sanitizer available to perform hand hygiene after removing gloves. Stated she should have had hand sanitizer in the room, but she didn 1' twant to walk away from Resident #1. She stated she usually washed her hands before applying gloves and after removing gloves. F RAMINISTON - CORRECT PREFIX On 2/15/2021 at 4:07pm in an interview with hygiene after removing gloves and before reapplying a new pair of gloves. In a phone interview on 2/16/2021 at 3:03pm, Nurse #1 interview on 2/16/2021 at 4:07pm in an interview with the Director of Nursing (DON), she stated depending on the type of resident care provided, staff wash ther hands or use hand gel after removing gloves before applying new gloves. Sinceta before applying new gloves. 2. On 2/15/2021 at 2:46pm, Nurse Aide (NA #1) was observed applying a pair of gloves before providing incontinent care to Residen	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345365	B. WING				C / 17/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SIGNATU	RE HEALTHCARE OF KI	NSTON			907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 880	entering Resident #1' Resident #2's room w hygiene. She applied changed Resident #1 repositioning Resident removed her gloves a room without perform On 2/15/2021 at 3:05 entering Resident #3' Resident #1's room w hygiene and applied a Resident #3 declined that moment. NA #1 r exited Resident #3's r hand hygiene. On 2/15/2021 at 3:06 entering Resident #4' Resident #3's room w hygiene. After Reside incontinent care, she bed controls and Res the resident for incom new pair of gloves. N to the hallway and rer performing hand hygi containers were obse On 2/15/2021 at 3:08 #1, she stated she ne after removing gloves needed to put sanitize soap and water in the also. She stated she fast, she just forgot to removing her gloves. interview on 2/17/202	s room after exiting vithout performing hand a pair of gloves and 's adult brief. After at #1 in the bed, she and exited Resident #1's ing hand hygiene. pm, NA #1 was observed s room after exiting vithout performing hand a new pair of gloves. needing incontinent care at emoved the gloves and room without performing pm, NA #1 was observed s room after exiting vithout performing hand ent #4 consented to was observed touching the ident #4 's hand to prepare tinent care before applying a A #1 walked out of the room noved her gloves without ene. Hand sanitizer rved on the hallway. pm in an interview with NA beded to sanitize her hands a. She further stated she er in her pocket to use, but bathroom could be used provided resident care so perform hand hygiene after	F	880			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345365	B. WING				C / 17/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SIGNATU	RE HEALTHCARE OF KI	NSTON			907 CUNNINGHAM ROAD KINSTON, NC 28501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	months ago that inclu protective equipment hygiene after removin On 2/15/2021 at 4:07 DON, she stated whe care, the nurse aide s removing the gloves. 3. The facility 's infect Coronavirus updated duration of the state of pandemic, all direct c wear a surgical face r Non-direct care worke resident care areas m mask. On 2/15/21 at 4:25pm observed standing ins silverware on residen observed wearing a c exposing her mouth at An interview was con 2/15/21 at 4:30pm. SI worn over the mouth stated she had been wear a mask while in On 2/15/21 at 4:25pm kitchen wearing a cloi exposing her mouth at food for the residents An interview was con 2/15/21 at 4:33pm. D be worn covering the	ded the use of personal and performing hand ag gloves. pm in an interview with the n conducting incontinent should wash her hands after ction control policy for Novel on 2/4/21 stated for the of emergency/COVID-19 are stakeholders were to mask while in the facility. ers (such as dietary) out of nay utilize an antimicrobial n, Dietary Aide (DA) #1 was side the kitchen placing t meal trays. DA #1 was loth mask below her chin and nose. ducted with DA #1 on he stated masks were to be and nose at all times and trained on how and when to the facility. n DA #2 was observed in the th mask below her chin and nose while pureeing in the facility.	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345365	B. WING		_	C 02/17/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	•=======	
SIGNATUR	RE HEALTHCARE OF KI	NOTON	9	907 CUNNINGHAM ROAD			
				KINSTON, NC 28501			
(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 TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		
F 880	Continued From page	97	F 880				
	On 2/15/21 at 4:40pm observed standing in with no mask on his fr observed in his hand. An interview was con Manager on 2/15/21 a Manager stated he sh but he was talking to Dietary Manager state how and when to wea the facility. He further exceptions for DA #1 from wearing a mask. An interview was con Nursing (DON) on 2/1 stated all staff were re	the Dietary Manager was the kitchen behind DA #1 ace. His cloth mask was ducted with the Dietary at 4:40pm. The Dietary hould have had his mask on, the kitchen staff. The ed he has been trained on ar his mask while he was in stated there were no and DA #2 to keep them					

Facility ID: 923213

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