STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245621	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folkestone	100 Promenade Avenue Wayzata, MN 55391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48299 Based on observation, interview, and document review, the facility failed to ensure required nurse staff data was posted daily before each shift, including over the weekend, and the accuracy of the posted nurse staffing information. This had potential to affect all 29 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 10/14/24 at 2:23 p.m., the PHS-Daily Hours Posted was in a holder on the wall near the nursing station and administrators' office. The posting was dated 10/11/24. The clinical administrator (director of nursing; DON) confirmed the posting was for 10/11/24 and stated they sometimes pulled the weekend information and reviewed before placing the posting back in holder. The facility staff posting dated 9/16/24, indicated the evening shift had no licensed staff and four non licensed staff. The daily roster dated 9/16/24, indicated the evening shift had one licensed practical nurse (LPN) from C.S. (central staffing) and five non licensed staff. The facility staff posting dated 9/24/24, indicated the evening shift had one licensed registered nurse (RN) and four non licensed staff. The daily roster dated 9/24/24, indicated the evening shift had one licensed RN and six non licensed staff. The facility staff posting dated 9/25/24, indicated the day shift had two RNs with one RN who worked 8:30 a. m. to 9:30 a.m The daily roster dated 9/25/24, indicated the day shift had one RN. The facility staff posting dated 9/16/24, 9/19/24, 9/24/24, 9/25/24, 10/1/24, 10/3/24 and 10/8/24, indicated the night shift had two registered nurses (RNs). The daily roster dated 9/16/24, 9/19/24, 9/24/24, 9/25/24, 10/1/24, 10/3/24 and 10/8/24, indicated the night shift had one RN. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 10/16/24 at 4:44 p.m., the care center administrator (administrator) stated they gave nursing copies of the facility staff posting for them to post over the weekend. The administrator stated they placed the facility staff posting in the wall holder each morning when they were here and did not switch posting on 10/14/24. There was a white board nursing updated in real time and visible for residents and family members but did not list specific hours. The administrator reviewed staffing information for 9/16/24 and confirmed there were six staff present, including one LPN, and the posting coded four staff. The administrator reviewed staffing information for 9/24/24 and stated the posting had not included the staffing coordinator (SC) who worked on the floor or the staff who was completing TMA or RN training. Staff postings were to include staff in training on the floor. The administrator reviewed staffing information for 9/25/24 and stated one RN should not be included in the posting since they were completing nondirect hours at an in-service. The administrator reviewed the night shifts which were coded as two RNs on the facility staff postings and daily rosters which indicated one RN. The administrator confirmed there was one RN who worked the night shifts on those days, and the other RN was on a leave and their shift showed up on the Dayforce (platform which helps manage payroll and workforce management) schedule. The administrator stated the human resources team who coded the RN in the system fixed the RN's status to reflect accurately. On 10/17/24 at 10:50 a.m., the SC stated they printed the daily schedule and changed the schedule to reflect call-ins or staff who switched shifts, and the nurses put the schedule on the board. The SC stated the weekend schedules were printed up until Monday morning, and the nurses made them aware of any staff changes and were responsible for updating the paper schedule on the weekends. The Nurse Hours Posting Policy dated 10/2022, indicated nursing staff data was posted on a daily basis at the beginning of each shift, reflected the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and was updated by the staffing personnel to include the actual hours worked by direct nursing staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview, observation, and document review, the facility failed to accurately transcribe a medication order, and failed to check the medication administration record (MAR) against the medication label and clarify administration instructions prior to giving medication for 1 of 1 resident (R4) who received an anticoagulant (also known as blood thinners; medication used to prevent or reduce blood clots) during medication administration observation. Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact and had diagnoses of atrial fibrillation (a heart condition which causes an irregular, often rapid, heartbeat), heart failure (heart muscle does not pump blood as well as it should), hypertension (high blood pressure), kidney failure (loss of kidney function which normally removes waste and excess fluid from blood), and diabetes mellitus [condition which affects how the body uses blood sugar (glucose)]. R4's undated care plan, identified R4 was at risk for side effects of anticoagulants due to anticoagulant use and directed staff to complete labs per provider orders and monitor for side effects, which included bruising, bleeding, CVA (cerebrovascular accident, also known as stroke; blood supply to part of the brain is blocked or reduced), heart attack (flow of blood to heart is severely reduced or blocked), and blood clots (clumps of blood which change from a liquid to a gel and controls bleeding). On 10/15/24 at 8:30 a.m., trained medication assistant (TMA)-A stated they prepared medication while reviewing the medication rights and checks. R4's apixaban (an anticoagulant) 2.5 mg (milligram) medication pack was observed, and the label instructed to give one tablet orally two times daily. TMA-A placed one 2.5 mg tablet of apixaban in R4's medication cup, prepared R4's other medications, and administered medication to R4. During subsequent document review, R4's Order Review Report signed by provider on 9/26/24 and MAR, directed staff to give 2.5 tablet of apixaban 2.5 mg orally two times a day with order start date of 3/20/24. During interview on 10/15/24 at 1:51 p.m., TMA-A confirmed R4's apixaban label directed to give one tablet of 2.5 mg apixaban and the MAR directed to give 2.5 tablet. TMA-A stated someone typed the order wrong and would let the nurse know. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/15/24 at 2:12 p.m., registered nurse (RN)-A stated providers filled out order forms and the first nurse would enter the order and a second nurse completed a second check. Providers also gave orders through the telephone and nurses would write the order and have providers sign the orderp; or providers would fax the orders. Once orders were processed, they were placed in the resident binder. RN-A stated they would check residents for signs and/or symptoms of side effects and update the provider and family member or other representative if medication given incorrectly. RN-A verified R4's apixaban order, which reflected on MAR, directed to give 2.5 tablets of apixaban 2.5 mg instead of 1 tablet of apixaban 2.5 mg. RN-A stated orders entered incorrectly could lead to medication errors and was the reason nursing completed a second check after an order was entered. On 10/16/24 at 8:10 a.m., the clinical administrator (director of nursing; DON) stated a medication variance report was completed for the apixaban, the pharmacy had sent apixaban 2.5 mg tablets and no others for R4. The order was reviewed with the provider and changed to reflect 2.5 mg instead of 2.5 tablets of apixaban 2.5 mg. The DON provided R4's orders from M Health Fairview Southdale electronically signed 7/1/24, and the orders directed to give apixaban 2.5 mg, 1 tablet by mouth two times daily and had two initials written by the order. During interview on 10/16/24 at 12:44 p.m., TMA-A stated the pharmacy label on medication and MAR were supposed to match, and they followed the pharmacy label or called the DON when directions did not match. During interview on 10/16/24 at 1:02 p.m., RN-A stated they followed the rights of medication administration and reviewed provider orders in the resident binder when there was a discrepancy between medication labels and the MAR. During interview on 10/16/24 at 1:04 p.m., the DON stated they clarified the transcription of R4's apixaban order and believed R4 received the right medication and right dose. The DON expected staff to follow medication protocols and review the electronic MAR and medication packaging and follow provider orders. The Medication Administration Procedures dated 1/27/19, directed staff to verify the medication label matched the MAR with the right resident, medication, dose, time, route, reason, form of drug, and documentation. The Medication Administration Error Policy dated 5/2021, indicated a medication error occurred when there was failure to compare doctors' orders with pharmacy labels and medication administration record. The Order Processing Policy dated 5/2024, indicated staff obtained telephone, verbal, or written orders from providers and orders included the name, strength, dosage, time and frequency of medication, diagnosis for medication, and route of administration. Each order was noted and processed and received a second check by a qualified staff. The Medication Administration Policy dated 5/2021, indicated accurate transcription of medication orders was the responsibility of licensed nursing staff, and medications were transcribed from the physician order sheet to the MAR in the electronic MAR.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and manufacturer guidelines for 3 of 9 residents (R4, R17, and R15) observed to receive medication. A total of four (4) errors out of 29 opportunities were identified which resulted in a medication error rate of 13.79%. Findings include: R4: R4's significant change Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact and had diagnoses of atrial fibrillation (a heart condition which causes an irregular, often rapid, heartbeat), heart failure (heart muscle does not pump blood as well as it should), and hypertension (high blood pressure), kidney failure (loss of kidney function which normally removes waste and excess fluid from blood), and diabetes mellitus [condition which affects how the body uses blood sugar (glucose)]. R4's Order Review Report signed 9/26/24, identified R4 required polyethylene glycol 3350 oral packet 8.6 gram by mouth in the morning for constipation with order date of 5/9/24. On 10/15/24 at 8:30 a.m., trained medication assistant (TMA)-A stated they prepared medication while reviewing the medication rights and checks. R4's polyethylene glycol 3350 oral container had a sticker which directed there was a change in the medication's directions. R4's electronic medication administration record (MAR) directed staff to give 8.6 gram (gm) by mouth in the morning. TMA-A took the cap off the polyethylene glycol container, poured the powder into the cap until the line which read 17 gm, and poured the powder into a plastic beverage cup. TMA-A prepared R4's other medications, locked the MAR screen and medication cart, and walked towards R4's room with medication and polyethylene glycol in hand. TMA-A was stopped and asked to verify the polyethylene glycol. TMA-A returned to the medication cart and confirmed the powder was poured to the 17 gm line and the order was for 8.6 gm. TMA-A dumped out the polyethylene glycol, filled the cap half-full of powder, and poured the powder into a plastic beverage cup. On 10/15/24 at 2:12 p.m., registered nurse (RN)-A stated they would check residents for signs and/or symptoms of side effects and update the provider and family member or other representative if medication given incorrectly. RN-A stated R4 had a history of intestinal obstruction, and R4 was at risk for excessive bowel movements and dehydration if given more polyethylene glycol than ordered. R17: R17's significant change MDS dated [DATE], identified R17 had moderate cognitive impairment and diagnoses of dementia, hypertension, coronary artery disease (also called atherosclerotic heart disease; a condition of narrowing or blockage of coronary arteries which supply blood and oxygen to the heart), and kidney failure. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17's Order Review Report signed 9/26/24, identified R17 required brimonidine tartrate ophthalmic solution 0.2% one drop in left eye two times a day for ocular hypertension (condition where the pressure inside the eye is higher than normal) with an order date of 11/22/23. On 10/15/24 at 8:54 a.m., TMA-A prepared an eye drop for R17. R17's brimonidine 0.2% eye drop label instructed to give one drop into left eye two times daily. TMA-A entered R17's room, performed hand hygiene, and donned gloves. R17 was laying in bed and TMA-A administered one drop to R17's left eye and one to R17's right eye. TMA-A confirmed one drop to both eyes were given and verified the MAR and label directed to give one drop to left eye. TMA-A stated R17 had other eye drops which instructed to give to both eyes. On 10/15/24 at 2:12 p.m., registered nurse (RN)-A stated staff followed orders for how many eye drops to give and which eye to give the drops in. RN-A stated follow-up for giving eye drops differently than ordered depended on which kind of eye drop was given, such as an eye drop for an eye condition like glaucoma. R15: R15's quarterly MDS dated [DATE], indicated R15 had moderate cognitive impairment and diagnoses of hypertension, kidney failure, and diabetes mellitus. The MDS indicated R15 had orders for insulin and received insulin injections seven days out of the last seven days of the MDS look back period. R15's Treatment Administration Record (TAR) for October 2024, indicated R15 required 8 units subcutaneously of insulin lispro injection solution 100 unit/mL (milliliter) three times a day for diabetes mellitus type two before each meal and hold if blood glucose less than 150 with start date of 9/17/24. R15 required 20 units subcutaneously of insulin glargine subcutaneous solution 100 unit/mL in the morning for diabetes mellitus type two with start date of 10/2/24. On 10/16/24 at 7:53 a.m., RN-A checked R15's blood glucose level, and the result was 186. RN-A removed gloves, completed hand hygiene, placed on new gloves, and stated R15 received eight units of insulin lispro before each meal and was held if blood glucose was less than 150, and 20 units of insulin glargine in the morning. RN-A placed needle on Humalog KwikPen (insulin lispro) 100 units/mL without wiping tip of pen with an alcohol swab and dialed pen to two and set aside. RN-A placed needle on Lantus Solostar (insulin glargine) without wiping tip of pen with an alcohol swab and dialed pen to two and set aside. RN-A wiped R15's abdomen with alcohol wipe, dialed Humalog KwikPen to eight units, and administered to R15's abdomen. RN-A wiped the other side of R15's abdomen with alcohol wipe, dialed Lantus Solostar from two units to 20 units, and was questioned about priming technique. RN-A stated the needle was primed when the pens were dialed to two units, verified they did not press the pen plunger before dialing from two to required units, and then administered to R15's abdomen. RN-A returned supplies to the cupboard in R15's room, removed gloves, performed hand hygiene, and exited R15's room. RN-A verified they did not wipe the tip of the insulin pens prior to attaching the needle, since they took the pen cap off and inserted needles without touching the tip of the pens. RN-A stated they wiped the top of insulin vials before withdrawing medication with needle, because the chances of touching the top of the vial was high. RN-A stated ensuring the pen tip was clean before needle attachment was important for infection purposes, and insulin pens were primed as part of instructions to administer the correct dosage. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:19 a.m., the clinical administrator (director of nursing; DON) stated they completed a medication variance report for the eye drops which were given in both eyes rather than the left eye. On 10/16/24 at 1:04 p.m., the DON stated R4 was focused on their bowels, and correct administration of bowel medications helped maintain R4's baseline and avoided loose stools or constipation. DON stated R17's brimonidine eye drop was intended for R17's left eye and not both eyes, and staff completed follow-up observations on R17. The DON referred to manufacturer instructions and facility competencies related to the need to wipe insulin pen tips or not prior to needle insertion and how to prime needles and insulin pens. The DON stated priming removed air from needles, and infection control was important for set-up of insulin administration. The DON expected staff to follow medication protocols and review the electronic MAR and medication packaging and follow provider orders. On 10/16/24 at 2:22 p.m., the DON confirmed priming occurred when insulin pens were dialed to two and plunger pressed to zero, and then the pens were redialed to administered amount. The DON also verified staff were to wipe the tip of insulin pens prior to attaching needle. Lantus Prescribing Information which contained Instructions for Use dated 12/2020, instructed to wipe the rubber seal with alcohol prior to attaching new needle and to perform a safety test before each injection to ensure an accurate dose by ensuring the pen and needle work properly and removing air bubbles. The directions to perform a safety test included turning the dosage selector to two units, holding the pen with needle pointing upwards and tapping insulin reservoir so air bubbles rise up towards the needle, pressing the injection button all the way in and checking if insulin comes out the needle tip. The dose window should show 0 (zero) following the safety test before selecting the dose. The Medication Administration Policy dated 5/2021, directed staff to follow the 8 rights of drug administration which included right drug, dose, and route. The Medication Administration Procedures dated 1/27/19, directed staff to remove the cap from the insulin pen and wipe the rubber stopper with an alcohol wipe and then attach a new needle to the insulin pen following manufacturer's guidelines. Further, the procedure directed staff to turn dose selector to two units, hold pen with the needle pointing up and tap the cartridge to move collected air to the top of the cartridge, press the injection button all the way in until the dose selector is back to zero, observe for a stream or drop of insulin at the tip of the needle or follow specific pen guidelines for additional testing if no drop appears, and select dose by turning the dose selector to the number of units to be administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure food items were properly stored, labeled, and dated, and kitchen fans were kept in clean condition. Also, the facility failed to ensure that staff with facial hair wore beard nets while in the kitchen and plating food. This had the potential to affect all 29 residents , staff, and visitors who consumed food from the main and/or fourth floor kitchen. Findings include: During the initial kitchen tour with executive chef (EC) on 10/14/24 at 12:53 p.m., the walk-in refrigerator on the main kitchen was reviewed. EC stated an unopened cooked corned beef package came from the freezer Friday and was for sandwiches and added date to the package. Unopened packaged ground beef was in a cardboard box with the date 9/30/24 typed on its packaging and/or delivery sticker, and EC marked the box for next use. Other unopened packages of ground beef were thawing next to the box and not in drip-proof container. EC stated the packages of ground beef next to the box were taken from the freezer this day. EC stated they received an order today and was in the process of moving food around. The walk-in freezer of the main kitchen had uncovered pastries on a cart for breakfast. A plastic bag had breaded fish without a label and date. EC removed and asked staff to label and date the fish. The fourth floor serving kitchen area for the nursing home had a stove which was used to make items such as scrambled eggs. Above the stove was an exhaust fan which had gray, fuzzy particles on the lower boarder. EC wiped finger on area of exhaust fan and had grayish colored, fuzzy particle which came off area onto finger. Pans were placed upside down and one pan was right side up on a flat surface above the stove and below the exhaust fan. The flat surface with the pans had small particles which were removed when fingers wiped across. EC stated the fan would be cleaned, and they cleaned the fans in the main kitchen weekly. The small dish washing room connected to the kitchen area but separated by a door had a fan with scattered grayish, fuzzy particles. On 10/14/24 at 5:04 p.m., meal service on the fourth floor was observed. Dietary aide (DA)-A plated multiple plates with pulled pork sandwiches, beans, fruit, and other food items. DA-A had facial hair which covered face from side burn of face by ears to chin and upper lip and was approximately a quarter-inch thick. On 10/14/24 at 5:20 p.m., DA-A stated they wore hair nets for food service and in the kitchen. DA-A verified they did not have their beard covered and stated they do not do anything different around beards but then stated they had beard bags. On 10/15/24 at 11:06 a.m., cook (C)-A verified pastries and cinnamon rolls were uncovered on sheet slid into a cart in the freezer of the main kitchen and stated they were for the next day. On 10/15/24 at 11:07 a.m., the cardboard boxes of ground beef and unopened ground beef packages next to the box remained on the bottom shelf on the refrigerator and not contained. On 10/15/24 at 11:14 a.m., DA-A had no beard cover and temped the cold food over ice and hot food on the steam table on the fourth-floor nursing home area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/15/24 at 11:38 a.m., DA-A dished up multiple plates from the steam table, which staff brought to residents, and did not have a beard cover. On 10/16/24 at 8:48 a.m., the packages of ground beef remained on the bottom shelf and not in a container. On 10/16/24 at 9:10 a.m., C-A browned ground beef. C-A stated they were not aware of a protocol for kitchen staff with facial hair and would either follow the three-day rule for use of opened items in the refrigerator or consult with EC. C-A stated food in the refrigerator and freezer should be covered and dated. C-A stated they placed food into refrigerator from freezer a day or two before it was needed, so it would be thawed out by the time of use. If unopened items were not dated, they used the first in line. C-A stated they had a certain container for thawing chicken in the fridge and raw meat was placed on the bottom shelf to thaw. C-A continued to brown ground beef, and C-B checked on muffins in the oven and took out and placed on table. A fan was on and blew into the kitchen area where the muffins and ground beef were, and the fan had speckles of grayish colored particles and hair-like substance which blew approximately two to three inches away from where it was connected to the fan. C-B stated they all cleaned the fans, and there was not a schedule for the fans, but they cleaned in their down time when they saw the need. C-B stated they saw dust on the fan and would clean. C-A stated they usually tried to clean the fan once a week and did not document and confirmed the fan needed to be cleaned. On 10/16/24 at 9:44 a.m., the fan previously noted in the dish washing room of the fourth nursing home area with scattered grayish particles was on. DA-B stated they left dishes in the rack they were washed in and placed the rack on top of the dish machine to dry. On 10/16/24 at 12:54 a.m., DA-B confirmed the fan was on and needed to be cleaned. DA-B stated they cleaned what they were able to on the outside but did not have the parts fully clean the fan. DA-B stated they had verbally told a maintenance worker the fan needed to be cleaned about a couple weeks previously. On 10/16/24 at 1:26 p.m., the culinary director (CD) stated the pastries in the freezer were prepped for next days use, and C-B stated they had not covered the cart with the pastries in the freezer in the past. CD stated uncovered food was at risk for cross contamination. CD stated they rotated food in the refrigerator to know what to use first based on their five-week menu. CD stated food had dates when delivered and expected food to have dates when out of packages delivered in. In the walk-in refrigerator, CD wrote a date on unopened, cooked chicken label. The ground beef was now in a pan with a date, and CD stated the ground beef should be in pan and dated like it was now. CD stated they had a daily and quarterly cleaning list they used, and culinary cleaned the fans when dirty. The exhaust fan was cleaned by an outside company. Fans were important to clean to serve safe food. On 10/16/24 at 3:54 p.m., regional engineering manager stated there was an inspection sticker which showed the hood fan above the oven was cleaned twice a year by an outside company, and culinary cleaned in between. A facility maintenance technician (MT)-A stated staff notified them on concerns through TELS (web-based platform which helps with building operations communication), calling, using radio, or calling the receptionist who then communicated to the maintenance department. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[NAME] Weekly Sanitation Checklist undated, directed cooks to take down hood vents and send through the dish washer and replace when clean. The facility did not provide checklist documentation of completed hood vent cleaning but provided documentation to show Brothers Industrial Cleaning cleaned the kitchen exhaust system 7/16/24. Cleaning checklists did not include fans. Facility policy Labeling and Dating Ready to eat and/or Potentially Hazardous Food Items dated 1/28/14, indicated ready to eat and potentially hazardous food items were to have labels to specify date prepared, date frozen, and date thawed of any refrigerated, ready-to-eat, potentially hazardous foods. Facility policy Food Receiving and Storage dated 5/14/17, directed staff to cover, label, and date all foods stored in the refrigerator or freezer, and uncooked and raw animal products and fish were stored in drip-proof containers. Nutrition and Culinary Uniform Policy dated 9/2024, directed staff to wear hair coverings while preparing food in prep areas, such as kitchenettes where staff served food, and beard nets for beard hair half an inch or longer.