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GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

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F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to identify medical symptoms for 2 of 10 sampled residents (residents # 3 and #16) who were observed with restraints. The facility also failed to attempt restraint reduction for 2 of 10 sampled residents (residents # 3 and #16) who were observed with restraints. Findings include: The facility's policy, titled "Restraints," and dated 04/28/06, was reviewed. The policy stated, in part: Physical restraint: any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Medical symptom: an indication or characteristic of a physical or psychological condition. Physical restraints include, but are not limited to: using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising.	F 221		11/8/07

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Restraint use is limited to circumstances in which the resident has medical symptoms that warrant the use of restraint.

Before the use of a restraint, the interdisciplinary team assesses the resident to determine the presence of a specific medical symptom that would require the use of restraints.

Determine how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his of her highest practicable level of physical and psychosocial well-being.

Medical symptoms that would warrant the use of restraints are documented in the medical record, ongoing assessments, and care plan at least quarterly.

The least restrictive device is to be used.

Documentation in the resident's medical record shows evaluation of the effectiveness of least restrictive method of restraint.

A systematic and gradual process to reduce the use of restraints is in effect for each resident whose care plans indicate the need for restraints.

Restraints may not be used...when the restraint is not necessary to treat a medical symptom.

Assess and review at least quarterly and/or with a significant change to determine:

Whether the resident is a candidate for restraint reduction.

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F 221	Continued From page 2 Whether the resident is a candidate for less restrictive restraining measures Whether the resident is a candidate for restraint elimination Design interventions to minimize or eliminate the medical symptom and to identify and address any underlying problems causing the medical symptom Care plan for the least restrictive device that would enable the resident to attain or maintain their highest practicable physical and psychosocial well being A subcommittee of the Performance Improvement Committee meets to review and discuss: If the least restrictive device is being used If the restraint is having a positive effect on the medical symptom If there is a decline in the resident's mental or functional status that is associated with the restraint Development of a plan to reduce the restraint, if applicable If the resident is scheduled for their quarterly assessment to determine continued need for the restraint 1. Resident #3 was admitted to the facility on 06/28/07. Cumulative diagnoses included	F 221		

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F 221	Continued From page 3 diabetes, dementia, congestive heart failure, osteoporosis, allergies, blood clots, and stomach ulcers. A review of the resident's most recent Minimum Data Set, dated 05/20/07, revealed that the resident had long and short term memory problems, was unable to make decisions, was totally dependent on staff for moving in bed, transferring into and out of bed, dressing, eating, toileting and bathing, was unable to walk, and was incontinent of bowel and bladder. A review of the resident's record revealed an order dated 10/13/06 for a self release belt, when the resident is in a wheel chair, for positioning due to poor trunk control and low safety awareness related to dementia. A review of the resident's record also revealed a "Physical Therapy Discharge Summary," dated 01/02/07, which stated, in part, "Pt (patient) is a resident referred to PT (Physical Therapy) for restraint reduction and positioning. Pt is positioned in high back wheel chair with bilateral standard leg rests with lap belt. Pt occasionally leans to right side with shoulders. Right elbow has cushion pillow for support. PT recommends pt remain in current wheel chair for positioning. Also recommends continued use of self release seat belt to keep hips back in wheel chair." A review of the resident's record further revealed a "Physical Restraint Elimination Assessment." The assessment, completed on 11/20/06 and 02/26/07, scored the resident as a "Good Candidate" for restraint reduction/elimination. The assessment on 02/22/07 had an entry under "Action Plan" which stated "PT to evaluate	F 221		

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positioning devise (self release belt). The assessment had "leans forward due to Alzheimer's dementia" as the reason for not attempting a less restrictive measure.

A "Physical Restraint Elimination Assessment" dated 05/26/07 had "continue with current therapy" for the "Action Plan," and had Alzheimer's dementia as the reason for not attempting a less restrictive measure. An entry under "Additional Comments" stated "resident uses self release belt for positioning when in wheel chair. Disoriented times 3."

In an interview on 10/09/07, at 12:00 noon, Nursing Assistant #1 (NA #!) stated that a seat belt was used whenever the resident was in her wheel chair, as she would scoot out of the chair without the seat belt.

In an interview on 10/11/07, at 8:15 AM, the Director of Nursing stated that her expectations were for the staff to follow the facility's policy regarding restraints.

In an interview on 10/11/07, at 8:15 AM, the Administrator stated that her expectations were for the staff to follow the facility's policy regarding restraints.

2. Resident #16 was admitted to the facility on 04/26/04. Cumulative diagnoses included hypertension, congestive heart failure and depression. A review of the resident's most recent Minimum Data Set, dated 06/17/07, revealed that the resident had long and short term memory problems, was unable to make decisions, was totally dependent on staff for moving in bed, transferring into and out of bed,

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F 221	Continued From page 5 dressing, eating, toileting and bathing, was unable to walk, and was incontinent of bowel and bladder. A review of the resident ' s record revealed an order dated 05/11/07 for a self release belt, when the resident is in a wheel chair. A review of the resident ' s record also revealed a physical therapy restraint elimination referral dated 8/27/07. In an interview on 10/10/07, at 3:00PM, Director of Nursing (DON) stated that a seat belt was used whenever the resident was in her wheel chair, as she would scoot out of the chair without the seat belt. The DON continued, " I am not really sure what the exact medical reason is for the seatbelt. I know that she will slide down and lean to the side when she is in the wheelchair " . The DON added " I would expect that we will follow the facility ' s restraint policy " . In an interview on 10/11/07, at 8:15 AM, the Administrator stated that her expectations were for the staff to follow the facility ' s policy regarding restraints.	F 221		
F 276 SS=B	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed complete quarterly Minimum Data Set (MDS) assessments for 11 of 24 samples residents (residents #1, #3, #4, #7, #8, #11, #12, #14, #16, #17, #19). Findings include: 1. Resident #3 was admitted to the facility on	F 276		11/8/07

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F 276	Continued From page 6 06/28/07. The resident was transferred to the hospital on 08/30/07. It was anticipated that the resident would return to the facility upon discharge from the hospital. The resident returned to the facility on 09/05/07. Cumulative diagnoses included diabetes, dementia, congestive heart failure, osteoporosis, allergies, blood clots, and stomach ulcers. A review of the resident's record revealed an annual Minimum Data Set (MDS) dated 12/04/06, and quarterly assessments dated 02/26/07 and 05/20/07. In an interview on 10/09/07, at 4:20 PM, the MDS coordinator stated that a quarterly assessment should have been completed in August, 2007. The MDS coordinator further stated that she did not know why the assessment was missed. 2. Resident #4 was admitted to the facility on 05/28/07. Cumulative diagnoses included heart failure, high blood pressure, anemia, pressure ulcer, dementia, and diabetes. A review of the resident's record revealed an admitting Minimum Data Set (MDS) dated 06/01/07. In an interview on 10/19/07, at 5:15 PM, the MDS coordinator stated that a quarterly or a significant change MDS should have been completed in September, 2007. The MDS coordinator further stated she did not know why the assessment was missed. 3. Resident #14 was admitted to the facility on 06/19/06. The most recent quarterly Minimum Data Set (MDS) assessment in Resident #14 ' s	F 276		

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medical record was signed as complete on 03/30/07. No other completed MDS assessments located in the resident ' s medical record were dated after the 03/30/07 assessment.

On 10/10/07 at 9:30AM, the MDS coordinator stated she would look for any MDS assessments for Resident #14 dated after 03/30/07.

On 10/11/07 at 8:15AM, the MDS coordinator stated the annual MDS assessment completed in May 2007 had been located. The MDS coordinator added that a quarterly MDS should have been completed in August 2007, but it had been missed.

4. Resident #11 was admitted to the facility on 12/5/06 and has diagnoses that include Atrial Fibrillation, Congestive Heart Failure, Non-healing back wound secondary to Basal cell and Squamous cell Carcinoma, Bilateral Pleural Effusion, Pulmonary Hypertension, Mitral Valve Regurgitation, Dysphagia, Anemia, and a Depressive Disorder.

Review of the resident's medical record revealed an initial Minimum Data Set (MDS) assessment completed on 12/12/07, and two quarterly MDS assessments completed on 2/26/07 and 5/24/07 respectively. There were no further MDS assessments found in the resident's medical record.

In an interview with the MDS Coordinator on 10/10/07 at 1:30 PM, she stated that an MDS assessment was due for Resident #11 by the end of August, 2007, but that it had not been done. The MDS Coordinator stated that it had been a very busy summer and that she was behind on

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the MDS assessments and was trying to catch up.

5. Resident #12 was admitted to the facility on 4/28/05 and has diagnoses that include Dementia, Anemia, Hypothyroidism, Hypertension, Dehydration, Glaucoma, and Anorexia.

Review of the resident's medical record revealed an annual MDS assessment completed on 6/5/07. There were no further MDS assessments found in the resident's medical record.

In an interview with the MDS Coordinator on 10/9/07 at 5:05 PM, she stated that an MDS assessment was due for Resident #12 in September, 2007, but that it had not been done. The MDS Coordinator stated that she had gotten behind on the MDS assessments.

6. Resident #16 was admitted to the facility on 04/26/04. The most recent quarterly Minimum Data Set (MDS) assessment in Resident #16's medical record was signed as complete on 06/17/07. No other completed MDS assessments were located in the resident's medical record were dated after the 06/17/07 assessment. On 10/10/07 at 2:15PM, the MDS coordinator stated she would look for any MDS assessments for Resident #16 dated after 06/17/07. On 10/11/07 at 9:15AM, the MDS coordinator stated the quarterly MDS assessment due to be completed in September 2007 had not been located. The MDS coordinator added that a quarterly MDS should have been completed in September 2007, but it had been missed.

7. Resident #17 was admitted to the facility on

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F 276	Continued From page 9 06/02/06. The most recent quarterly Minimum Data Set (MDS) assessment in Resident #17's medical record was signed as complete on 06/25/07. No other completed MDS assessments were located in the resident's medical record were dated after the 06/25/07 assessment. On 10/10/07 at 2:15PM, the MDS coordinator stated she would look for any MDS assessments for Resident #17 dated after 06/17/07. On 10/11/07 at 9:15AM, the MDS coordinator stated the quarterly MDS assessment due to be completed in September 2007 had not been located. The MDS coordinator added that a quarterly MDS should have been completed in September 2007, but it had been missed. 8. Resident #7 was admitted to the facility on 02/07/06. Record review of resident #7's chart revealed that an annual MDS (Mimnimum Data Set) assessment had been done on 01/17/07 and a quarterly assessment had been done on 04/19/07. No further quarterly assessments were on the resident's chart. The MDS nurse stated during an interview on 10/10/07 at 3:30 pm, that no additional quarterly assessments had been done for resident #7. 9. Resident #8 was admitted to the facility on 03/22/06. Record review of resident #8's chart revealed that an annual MDS (Mimnimum Data Set) assessment had been done on 03/23/07 and a quarterly assessment had been done on 06/27/07. No further quarterly assessments were on the resident's chart. The MDS nurse stated during an interview on 10/10/07 at 3:30 pm, that no additional quarterly	F 276		

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assessments had been done for resident #8.

10. Resident #19 was admitted to the facility on 05/18/07. Record review of resident #19's chart revealed that an annual MDS (Mimnimum Data Set) assessment had been done on 05/31/07. There were no quarterly assessments on the resident's chart.

The MDS nurse stated during an interview on 10/10/07 at 3:30 pm, that no quarterly assessments had been done for resident #19.

11. A record review for Resident #1 revealed the resident was admitted to the facility on 05/04/07. The resident had diagnoses to include Congestive Heart Failure, End Stage Renal Disease with HemoDialysis with Right Arm Shunt, Anemia, Hypertension, Arthritis, Gastroesophageal Reflux Disease, Hypothyroidism, Degenerative Joint Disease, Coronary Artery Disease, Myocardial Infarction, Peripheral Vascular Disease, Fracture of the Left Hip, and Decubitus to Coccyx and Sacral Area (Stage III). A record review of the Admission Minimum Data Set (MDS dated 05/22/02) was done. A record review of the chart revealed there was no quarterly assessment on the chart for 08/07.

An interview on 10/09/07 at 3:47 PM was done with Nurse #2 regarding a review of the chart for Resident #1 with no Rap Summary for the Admission Assessment 05/07. The interview also revealed the quarterly assessment due 08/07 was not on the chart. Nurse #2 revealed she would go look for it. An interview on 10/09/07 at 3:47 PM was done with Nurse #2 regarding the review of the chart with no quarterly MDS on the chart and

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F 276	Continued From page 11 no RAPS Summary. At 3:55 PM Nurse #2 returned with the RAPS Summary. The MDS nurse revealed she was unable to locate the quarterly assessment, but she would continue to look. An interview on 10/10/07 was done with Nurse #2 regarding the review of the chart with no quarterly MDS on the chart. The MDS nurse stated, "I still can't find it." An interview on 10/11/07 at 11:15 AM was done with Nurse #2 at the end of the survey. Nurse #2 revealed she did not find a quarterly assessment for Resident #1.	F 276		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record reviews, and review of facility policy, the facility failed to ensure proper care and services for 1 of 3 residents (Resident #1) with an indwelling catheter. The facility failed to secure the catheter causing the catheter to be pulled taut. The facility failed to give catheter care when the catheter was visibly soiled with blood. The findings include: A review of the facility policy, " Indwelling Urinary Catheter (Revised 04/28/06) " included, " Care	F 315		11/8/07

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F 315	Continued From page 12 of a catheter is provided to prevent infection and/or reduce irritation. " The equipment/supplies include, · " Basin with warm water and soap · Towel and washcloth · Disposable gloves · Catheter care kit · Antiseptic ointment as ordered " The procedure included, " 1. Identify and explain procedure to resident and provide for privacy. 3. Wash hands, and put on gloves. 9. Wash perineum well with soap and water or a no rinse cleansing solution and cleaning from front to back. If resident has had an involuntary bowel movement, clean this area first to eliminate contamination. 10. Cleanse area well and remove debris from catheter at insertion site. Do not pull on catheter or advance it further into the urethra. 11. Rinse well with warm water, unless a no rinse cleansing solution and pat dry gently with a clean towel. Observe for catheter related complications such as reduced urine output that may indicate blockage or signs and symptoms of infection such as cloudy urine, sediment, strong odor, dark color, blood in urine, complaints of pain. 12. Apply ointment, if ordered. 13. Validate the catheter is anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter. 14. Validate that catheter is secure to facilitate flow of urine. To reduce the incidence of reverse flow, avoid kinks in the tube and secure the urinary bag to hang below the resident ' s bladder and cover as indicated. 15. Remove the gloves. 21. Observe the resident for signs and symptoms of catheter related complications: a. Urinary Tract Infection, b. Bacteremia c. Febrile Episodes d. Bladder stones e. Fistula formation f. Erosion of the Urethra h. Chronic Renal Inflammation i. Pyelonephritis j.	F 315		

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Blocked Catheters 24. Check and validate the catheter every 30 days or as needed for indicators that the indwelling catheter needs to be changed. Rationales that may indicate the need to change the catheter include, but are not limited to: a. Contamination of the catheter b. Blockage of the catheter c. Persistent leakage around the catheter d. Irritation by a larger balloon e. Irritation by the catheter materials." Documentation guidelines included in the policy for Indwelling Urinary Catheter included, "Nursing interventions, notification, and update the resident's care plan as needed."

Summary of CDC Major Recommendations for Catheter care http:www.cdc.gov/ncidod/hip/guide/uritract.htm included, "Educate personnel in correct techniques of catheter insertion and care. Secure catheter properly. Periodically re-educate personnel in catheter care. Refrain from daily meatal care with either of the regimens discussed in text (ointments, etc. unless ordered by physician)."

Medline Plus Urinary Catheters included, "HOW TO CARE FOR YOUR CATHETER-Most experts advise against routine changing (replacing) of the catheters. If the catheter is clogged, painful, or infected it may require immediate replacement. Routine care of the indwelling catheter MUST include daily cleansing of the urethral area (where the catheter exits the body) and the catheter itself with soap and water. The area should also be thoroughly be cleansed after all bowel movements to prevent infection. Experts no longer recommend using antimicrobial ointments around the catheter as they have not been shown to actually reduce infections." Potential

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F 315	Continued From page 14 Complications included, "Bleeding into or around the catheter." A record review for Resident #1 revealed the resident was admitted to the facility on 05/04/07. The resident had diagnoses to include Congestive Heart Failure, End Stage Renal Disease with HemoDialysis (Monday, Wednesday, and Friday) with Right Arm Shunt, Anemia, Hypertension, Arthritis, Gastroesophageal Reflux Disease, Hypothyroidism, Degenerative Joint Disease, Coronary Artery Disease, Myocardial Infarction, Peripheral Vascular Disease, Fracture of the Left Hip, and Decubitus to Coccyx and Sacral Area (Stage III). A record review of the Admission Minimum Data Set (dated 05/22/07) was done. The Admission Minimum Data Set (05/22/07) included the resident had an indwelling catheter and Stage 4 Pressure Ulcer. A record review of the residents care plan updated 05/22/07 included a problem, "Urinary Elimination, Altered Pattern related to Indwelling Catheter." The goal included, "Maintain Patent Catheter Drainage times 90 days. Will be free from signs of infection." A review of the physician 10/07 orders included, " 16F Indwelling Foley Catheter due to Sacral Pressure Ulcer Stage 3. May change 1st of every month and when needed for dislodging and clogging per Facility Standing Order (start date 09/18/07). A review of the 10/07 Treatment Administration Record included, · (start date 09/18/07) 16F Indwelling Foley Catheter due to Sacral Pressure Ulcer Stage 3. · May change 16F Indwelling Foley Catheter	F 315		

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PRN for dislodging and clogging.
A review of the documentation in the Treatment Administration Record, Medication Administration record, and chart did not reveal documentation that catheter care was being done or that the catheter was being anchored to prevent undue tension/irritation of the urinary meatus/dislodgement.

A record review of the physician orders, treatment administration records, medication administration records, and nurses' notes, care plan, and entire chart did not reveal documentation of care of the catheter, use of a securing device to secure catheter, and ongoing monitoring of catheter even after 2 past incidents of dislodgement.

A record review of the nurse's notes dated 08/11/07 at 6PM revealed, "Resident's foley catheter came out this PM when transferring chair to bed - balloon inflated. No trauma noted to urethra, no bleeding or pain. Replaced Foley with #18F 5cc foley. Resident tolerated well." Record review revealed the resident is currently medicated with Tylenol #3 for complaints of back pain."

A record review of the nurse notes dated 08/14/07 at 7:00 AM included, "Resident pulled out foley catheter. Replaced with #18 French- draining yellow urine. Medicated with Tylenol #3. No signs of discomfort."

An observation on 10/10/07 at 8:36 AM was made of Resident #1. The observation revealed Nurse #3 performing treatments for Resident #1. Nurse #3 log rolled the resident (turned the resident over) to the right side. The resident was rolled over onto the catheter pulling the catheter

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F 315	Continued From page 16 taut. The catheter was pulled tight enough over the thigh causing an indentation over the resident's thigh. The resident had brownish-red blood oozing out from the catheter area. No catheter secure was in use. Interview at this time with the treatment nurse included, "I do catheter care when I notice dirtiness. Routinely we look at the catheter every day. I saw the catheter secured last Friday." The resident was rolled back and forth while doing the dressing change and putting a clean brief on the resident. An observation was made of the catheter dropped off the side of the bed when positioning the resident and performing care. The old brief had blood on it. Nurse #3 removed the dirty brief and put the clean brief on the resident without performing catheter care and cleaning the blood from around the resident's perineal area and catheter. At 9:00 AM Nurse #4 came into the room to look at the perineal area and catheter insertion site. Nurse #4 stated, "It's swollen" pointing to the labia majora and labia minora (catheter insertion area and perineal area. The resident revealed she had bleeding there before, since she had been at the facility with the catheter. An interview on 10/10/07 at 3:42 PM was done with Nurse #1 regarding the facility practice regarding indwelling catheters. The interview included it was the facility practice to do catheter care with soap and water. The interview also revealed the catheter should be secured. Nurse #4 revealed the care should be on the TARS (Treatment Administration Record). Nurse #4 came back later and said it was the facility standard to clean with soap and water as part of the bath and incontinent care.	F 315		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	F 371		11/8/07

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F 371	Continued From page 17 The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain dinnerware free of chips, store dinner plates dry when stacked together, and cover all hair on the head with hair restraints. Findings include: 1. The facility policy titled Dishwashing: Dishmachine dated 11/18/05 read " Rationale: Proper sanitation of dishware and re-usable foodservice supplies and equipment is essential to prevent foodborne illness. 23. Stack like items together, e.g. plates, bowls, trays, etc., in the appropriate storage location. Dishes should be dry when stored or stored in a manner that allows air to circulate and air drying to continue. " On 10/09/07 at 2:50PM, the Dietary Manager removed 31 dinner plates from the cart where they were being stored, stacked together, for use in meal service. Of the 31 plates, 11 were observed with wet surfaces. The Dietary Manager removed the wet dishes and directed staff to rewash and allow to dry before storing. 2. The facility policy titled Dishwashing: Dishmachine dated 11/18/05 read " Rationale: Proper sanitation of dishware and re-usable foodservice supplies and equipment is essential to prevent foodborne illness. 26. Separate out any dishes with cracks, chips, or missing glaze,	F 371		

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and report types and quantities to the Nutrition Services Manager/Supervisor. "

On 10/09/07 at 2:50PM, the Dietary Manager removed 31 dinner plates from the cart where they were being stored for use in meal service. Of the 31 plates, 12 were observed to be chipped. The Dietary Manager discarded the chipped dinner plates. The Dietary Manager then removed 120 saucers from the cart where they were being stored for use in meal service. Of the 120 saucers, 5 were observed to be chipped. The Dietary Manager discarded the chipped saucers.

3. The facility policy titled Principles of Safe Food Handling dated 10/31/06 read " 1. Practice good personal hygiene. C. Restrain hair appropriately. Hair restraints such as hats, hair covering or nets are worn to effectively keep hair from contacting food and keep food handlers from touching their hair. "

On 10/09/07 at 11:48AM, the Dietary Manager was observed plating food from the noon meal tray line. The managers bangs were protruding from the front of the managers hair net. When brought to her attention, the manager adjusted the hair net to cover all the hair on her head, including the bangs.

On 10/09/07 at 3:00PM, a dietary staff member was observed preparing food for the evening meal. The staff members pony tail was observed extending down below the staff members hair net. When brought to the attention of the Dietary Manager, the manager directed the staff member to cover all the hair on her head with a hair net. The staff member explained the second hair net

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F 371	Continued From page 19 used for her ponytail had slipped off. The staff member then placed a hair net over her head to cover all the hair, including the pony tail.	F 371		