STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345342	A. BUILDING _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG ELM RETIREMENT AND NURSING CENTERS	1285 WEST A STREET KANNAPOLIS, NC 28081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 10/26/2021 to conduct an unnanounced recertification survey. The survey team was onsite on 10/26/2021 through 10/28/2021. Additional information was obtained offsite on 10/29/2021. Therefore, the exit date was 10/29/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID # MFIZ11	E 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		11/16/21

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

Electronically Signed | 11/18/2021

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F 565	Continued From page 1 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to communicate the facility's efforts to address group concerns verbalized during Resident Council meetings for 3 consecutive months (August 2021, September 2021, October 2021) for 4 of 4 residents (resident #26, #27, #33 and #34) that participated in the Resident Council group meeting. The findings Included: The Resident Council minutes for the period August 2021 through October 2021 were reviewed on 10/26/21 at 2:17 PM. The Resident Council minutes revealed the following: Resident Council minutes dated August 2021 indicated residents had voiced concerns related to menus and staffing on weekends. Resident Council minutes dated September 2021 indicated residents had voiced concerns related to laundry and dietary specifically to food. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.	F 565	1. The facility met with residents #26, #27, #33 and #34 on October 29, 2021 to discuss concerns related to laundry and dietary services. All concerns discussed during Resident Council meetings in August 2021, September 2021, and October 2021 were documented on a Resident Council Concern Form by the Activities Director. Each concern was discussed with the appropriate Department Head and addressed appropriately. The Activities Director followed-up with resident council president to assure that all concerns were resolved satisfactorily. In addition, it was discussed with those residents that ongoing the facility would be addressing concerns voiced in resident council through its concern procedures which will include documenting their concerns and providing feedback to them within Five (5) business days in accordance with the facility concern policy. All concerns will also be discussed by the monthly QAPI Committee. 2. The facility□s Activity Director, who	

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F 565	Continued From page 2 Resident Council minutes dated October 2021 indicated residents had voiced concerns related to soiled linen and clothing being left on the floor, not enough toilet paper or paper towels in the bathroom. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. The facility's concern log was reviewed on 10/26/21 at 3:33 PM which revealed no documented concerns from the Resident Council from August 2021 through October 2021. On 10/26/21 at 4:15pm an interview was conducted with the Resident Council group. Resident #26, #27, #33 and #34 were in attendance. The Residents stated they do not always receive feedback from staff when group concerns were voiced. The Resident Council group stated that concerns with staffing on the weekends, menus specifically to food, not enough toilet paper or paper towels in the bathrooms, laundry and soiled linen and clothing being left on the floor remain on-going with no feedback or resolution reviewed or discussed with the group. The Resident Council group stated that individually they have to ask departments for answers to their concerns that were voiced during the Resident Council meetings. On 10/27/21 at 3:54pm an interview with the Activity Director (AD) revealed that she follows-up with other departments after resident council during QAPI meetings which residents were not allowed to attend. There was no concern form in place to document concerns from Resident Council or how they were resolved. The AD stated that she verbally informed the departments	F 565	conducts monthly resident council, has been in-serviced on October 29, 2021 in regards to documenting concerns voiced during resident council on a Resident Council Concern Form. Concern procedure will include documenting the concern and providing feedback to the resident within five (5) business days. 3. The facility did implement a systemic change to its monthly resident council meeting. The facility was not documenting concerns that were voiced during the resident council meeting on a concern form and there was no way for the facility could show the resident□s concern was addressed and the satisfaction to the resolution. The facility is now requiring the activity director to document concerns voiced during the resident council on a facility concern form. This initiated the concern form procedure where the facility will resolve the concern within five (5) business days. In addition, to ensure the resident council is informed of resolutoion to prior concerns the activity director will review prior concerns and resolution at subsequest resident council meetings. 4. The Assistant Administrator will monitor compliance by reviewing Resident Council Minutes and utilizing QI data Collection Form on business day five (5) after Resident Council Meeting to assure all concerns were resolved. In addition, the facility currently monitors its concerns	

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F 565	Continued From page 3 of their concerns from August 2021 until October 2021. The AD explained that she would verbally update resident council with any information that she received but had no system in place to determine if prior concerns of the Resident Council were resolved. On 10/27/21 at 4:09 PM an interview with Social Worker (SW) revealed she does not attend Resident Council. The AD would come to her if she was not able to resolve an issue, but she had not received any concern forms from Resident Council. On 10/28/21 at 8:59am an interview with the Assistant Administrator revealed that follow up to Resident Council concerns would be discussed and documented in the QAPI meeting to address the voiced Resident Council's concerns and report back to that group. A determination would be made as to whether or not the Resident Council group was satisfied with the resolutions. If there were still problems or concerns, then the facility would need to continue addressing the issue until a resolution was reached. The Assistant Administrator verbalized that residents did not attend the QAPI meeting.	F 565	through its monthly quality assurance and performance improvement (QAPI) meetings. The concerns are monitored for compliance with timeliness and satisfaction of residents and concerns expressed through resident council will be added to this monitoring process to ensure compliance. The administrator is responsible for overall compliance.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		10/31/21

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F 761	Continued From page 4 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure 1 of 1 treatment carts when left unattended by the Medication Technician (Med Tech) #1. The findings included: On 10/26/21 at 11:47 AM during initial facility walk through, observation of the facility treatment cart on the 100 Hall was observed to be unattended and unlocked. During the observation, four staff members passed by the unlocked treatment cart including a staff member escorting a resident down the hall. Med Tech #1 returned to the treatment cart at 11:50 AM to get more supplies and locked the cart. Med Tech #1 was interviewed on 10/26/21 at 11:59 AM about the facility treatment cart. She explained that she was performing wound care on	F 761	1. The facility completed a review of all Medication and Biologicals storage areas (to include the treatment cart) and all medication and biological storage areas were checked to assure they are locked at all times. 2. The facility Director of Nursing, Unit Manager, and Staff Development conducted an in-service on October 26, 2021 for all facility Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Medication Assistants, and Certified Nursing Assistant II (CNAII) on ensuring they lock the treatment carts when not in use and labeling all open medications and biologicals as well as checking expiration dates. 3. No systemic changes are necessary.	

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F 761	Continued From page 5 a resident and when she came back to the treatment cart to get more supplies, she realized the cart was unlocked and she locked it. She was aware the treatment cart was to be locked at all times when unattended and verbalized leaving the treatment cart open was an oversight. Nurse #1 was interviewed on 10/26/21 at 12:43 PM about the process for locking a facility treatment cart. She stated the process was for staff to lock the treatment cart if not within eyesight of the treatment cart. The facility treatment cart was observed with Nurse #1 to contain the following items: triple antibiotic ointment, hydrocortisone cream, hydrogen peroxide, venelex wound dressing cream, iodine swab sticks, dakins solution, biofreeze, ammonium lactate and wound cream. The Director of Nursing (DON) was interviewed on 10/28/21 at 8:55 AM and stated when a nurse needed to step away from the medication cart or treatment cart, the cart was to be locked at all times.	F 761	In this instance the medication assistant made a human error and acknowledged her mistake at the time identified. Facility nursing personnel will be monitored for compliance and violations related to locking the medication and treatment carts will be handled through additional education and the individual must demonstrate competency to securing the medication storage areas. 4. The director of nursing and/or unit supervisor will be responsible to complete visible audits of the treatment carts and her staff's compliance with locking the medication and treatment carts when not in use and not in sight. These audits will be completed at least three times per week for a month then monthly thereafter to ensure compliance. Results of these audits will be documented and reviewed through the facility's quality assurance performance improvement plan where corrective actions taken as necessary.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		11/20/21

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F 812	Continued From page 6 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to maintain refrigerator temperatures below 41 degrees Fahrenheit in 1 of 2 refrigerators (the walk-in refrigerator). This practice had the potential to affect the food served to all residents. The findings included: An observation on 10/26/2021 at 11:21am of walk-in refrigerator, noted temperature was 46 degrees Fahrenheit (F). The refrigerator door was not sealed closed. Review of the temperature log located on the outside panel of the refrigerator for 10/26/2021, for October 2021, showed that 23 out of 26 dates had temperatures ranging from 42-50 degrees Fahrenheit. An interview was conducted with the Certified Dietary Manager (CDM) and Assistant Dietary Manager (ADM) on 10/26/2021 at 11:21am. During the interview the CDM and ADM stated that they had submitted a work order to Maintenance Department, for the refrigerator door not sealing correctly. They further stated it would take 10 weeks for a new door to arrive. Observation of refrigerator door at this time, showed that the seal on the right side of the door was hanging off from the top right-hand side of the door. At this time, the CDM provided	F 812	1. The facility has a refrigeration truck as of October 26, 2021 that will be used as a temporary replacement for the refrigerator until the new door, which has experienced atypical delays in completion, will be permanently replaced to ensure desired refrigeration temperatures of forty (40) degrees Fahrenheit or less. The facility dietary supervisor has in-serviced the cooks and dietary aides on November 11, 2021 on the proper refrigerator temperature, keeping a log of temperatures, and what to do in the event the temperature is above the 40 degree requirement and proper reporting procedures. The Registered Dietician has been in-serviced by November 15, 2021 the assistant administrator on her expectations that as a consultant she will review temperatures of the refrigerators and report any concerns related to the refrigerator temperatures. 2. The facility has a refrigeration truck as of October 26, 2021 that will be used as a temporary replacement for the refrigerator	

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F 812	Continued From page 7 documentation of an email showing a new door was ordered on 10/4/21 by the Administrator. An observation on 10/26/2021 at 5:15pm of walk-in refrigerator, showed the temperature was 47 degrees F. Inside were milk, eggs, cheese and juice. A thermometer located inside the refrigerator showed the temperature was 42 degrees F at this observation. Observation on 10/27/2021 at 9:26am of walk-in refrigerator, showed the temperature was 45 degrees F, inside of refrigerator were milk, eggs, cheese and juice. Temperatures were obtained by the CDM with a digital thermometer of two cartons of milk in the refrigerator at this time. One milk observed to be 36.8 degrees F and a second milk was observed to be 41.9 degrees F. Interview with CDM on 10/27/2021 at 9:26am, CDM stated a refrigerator truck had been ordered to use and would be delivered to the facility on 10/28/2021. Interview with the Cook on 10/27/2021 at 9:50am, stated that she was responsible for monitoring refrigerator temperatures and that she had been unaware that the temperatures were too high until 10/27/2021. Review of the temperature log with the Cook for October 2021 showed that 19 out of the 27 days had the Cook's initials for having checked the temperature of the refrigerator when it was above 41 degrees F. When asked if she had reported the 19 high temperatures in October 2021, the Cook was unable to remember when or if she had reported the high temperatures to her Supervisor. Further review of the refrigerator temperature log	F 812	until the new door, which has experienced delays in completion, will be permanently replaced to ensure desired refrigeration temperatures of forty (40) degrees Fahrenheit or less. The facility's dietary supervisor has in-serviced the cooks and dietary aides on November 11, 2021 on the proper refrigerator temperature, keeping a log of temperatures, and what to do in the event the temperature is above the 40 degree requirement and proper reporting procedures. The Registered Dietician has been in-serviced by November 15, 2021 the assistant administrator on her expectations that as a consultant she will review temperatures of the refrigerators and report any concerns related to the refrigerator temperatures. 3. There are no systemic changes necessary, rather re-education on monitoring the refrigerator temperatures by dietary staff, documentation, and reporting /what to do if temperatures are above the required forty degrees Fahrenheit for the refrigerator. The administrator has updated his emergency plan to include a temporary refrigeration company in the event the facility has additional temporary refrigeration needs. 4. The facility’s Dietary Supervisor will review refrigeration temperatures daily for	

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F 812	Continued From page 8 on 10/28/2021 showed the temperature for the October 27th was 50 degrees F and on the October 28th the temperature was 43 degrees F. An interview with the Registered Dietitian (RD) on 10/28/2021 at 2:00pm, indicated she was not aware that the temperature in the walk-in refrigerator was out of range until 10/26/2021, when the CDM called her and reported it. She advised the CDM to discard the food in the refrigerator, purchase new food and place it in the food truck. RD stated that she was new to her role and made observations on 8/21 and 9/21 and did not recall the temperatures being above 41 degrees F until it was reported on 10/26/2021. RD stated that staff should have notified her prior to 10/26/2021 to get direction on whether to replace the food. RD stated that the facility had replaced parts of the door and ordered a new door. A follow up interview with CDM on 10/28/2021, at 4:14pm, she stated that she was new to the position and that prior to her, the ADM was in charge of the kitchen. CDM stated the food from the refrigerator should not have been served. She stated that staff monitored the temperature of food and milk in the refrigerator, but she was unable to produce documentation to support that. CDM stated that the food in the walk-in refrigerator has been discarded on 10/28/2021 and that the process would be to check the food temperature prior to serving and if the temperature was too high, to not served it. Interview with the Administrator and Executive Director on 10/28/2021 at 4:52pm, both stated that they were aware of the temperatures of the walk-in refrigerator and they were working to	F 812	three weeks, weekly for one month, and then monthly thereafter to ensure that refrigeration temperatures are compliant. Results of these audits will be reviewed through the facility quality assurance and performance improvement (QAPI) committee to ensure that refrigerator temperatures are compliant. The administrator is responsible for overall compliance.	

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F 812	Continued From page 9 replace the door. Stated they became aware that the walk-in unit door was not working and had the refrigeration company service the unit and ordered new door on 10/4/2021. Administrator stated that staff checked the milk prior to serving, but could not provide documentation of any temperatures, she further stated that the milk temperature had been checked a couple of weeks ago (beginning of October) and that the milk temperature was fine. Administrator stated that the staff probably did not know that they should report the temperatures were too high. Both the Administrator and Executive Director stated that the staff should obtain temperatures inside of the refrigerator, log the temperature and then report to the Supervisor any temperatures outside of 41 degrees Fahrenheit.	F 812		
F 880 SS=F	Infection Prevention & Control 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) 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		11/20/21

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F 880	Continued From page 10 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 11 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, local health department representative interview, staff interviews and the Centers for Disease Control (CDC) COVID-19 Data Tracker for Rowan county transmission rate, the facility failed to follow CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 1 of 1 staff members (Activities Director) failed to wear eye protection when conducting a Resident Council meeting with 4 of 4 residents (Resident # 26, Resident #27, Resident #33, and Resident #34), when 3 of 3 staff members (Infection Preventionist, Medication Technician (MT) #1 and MT #2) failed to wear eye protection when providing care to 3of 3 residents (Resident #33 and Resident #7, Resident #1) and when 1 of 1 staff members (NA #1) failed to wear eye protection when providing snacks to 3 of 3 residents (Resident #2, Resident #13, Resident #31). These practices had the potential to affect all residents who receive care from the facility staff. This failure occurred during a COVID-19 pandemic. The findings included: On 10/25/21 and 10/26/2021 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed. The CDC	F 880	1. A Root Cause Analysis was completed and it was determined that the event occurred as a result of misinterpretation of the CDC Recommendations regarding PPE use during substantial or high county transmission rates. The Facility developed a policy regarding required eyewear related to community transmission rates. The Administrator, assistant administrator, Director of Nursing and Infection Preventionist obtained education via CDC website and CMS updates on proper PPE (eyewear requirement) during times of substantial or high county transmission rates. 2. All facility staff were educated on the above policy by the Director of Nursing and Infection Preventionist on November 10, 2021. Staff verbalized understanding on the policy and performed a return demonstration of proper donning and doffing of eyewear. Goggles and faceshields were distributed to each staff member during the in-service. 3. There are no systemic changes necessary. The facility took the CDC recommendations on 10/21/2021 as a	

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	345342	A. BUILDING _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 Covid-19 Data Tracker revealed that the county where the facility was located had a high level of community transmission for COVID-19. CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 9/10/2021 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): * If SARS- CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), Healthcare Personnel (HCP) working in facilities working in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The facility did not have a policy that corresponded to the 9/10/21 Centers for Medicare and Medicaid Services (CMS) memo related to using community transmission rate and what PPE would be required. An initial Director of Nursing (DON) interview on 10/26/2021 at 10:55 AM revealed staff were to wear a surgical mask while in the facility. If a resident was on transmission-based precautions, then staff should have full PPE in place based on precautions. During a Resident Council meeting on 10/26/2021 at 4:15 PM, the Activities Director was	F 880	recommendation and not a requirement. The facility administrator has instructed the director of nursing, infection preventionist, and assistant administrator to follow the CDC recommendations as a requirement. 4. The Facility developed a QI Data Collection Form to monitor compliance. This form was distributed to all Department Managers. Audits will be performed by the department managers daily for four (4) weeks, weekly for three (3) weeks, monthly for three (3) months. Results will be reported and reviewed during monthly Quality Assurance and Performance Improvement (QAPI) Committee where results of these audits will be reviewed and corrective actions taken as necessary.	

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observed to be within 6 feet of 4 residents (Resident #26, Resident #27, Resident #33, and Resident #34) without wearing eye protection.

The Infection Preventionist was observed on 10/27/2021 at 8:47 AM in a Resident #33's room assisting the resident with oxygen. The Infection Preventionist was within 6 feet of the resident without wearing eye protection.

During an observation and interview on 10/28/2021 at 9:39 AM with Medication Technician (MT) #1, the MT was observed providing wound care to Resident #7 without wearing eye protection. The MT indicated she only wore eye protection when she was irrigating a wound or if there was a chance body fluid would be splashed in her eyes.

During an observation and interview with Nursing Assistant (NA) #1 on 10/28/2021 at 10:14 AM, NA #1 was observed to be providing snacks to Resident #2, Resident #13 and Resident #31 without wearing any eye protection. NA #1 indicated that she only wore eye protection when there was a COVID outbreak or when she was providing resident care.

An observation and interview with MT #2 on 10/28/2021 at 10:19 AM during medication administration revealed MT #2 was not wearing any eye protection while administering medications to Resident #1. MT #2 indicated that she would wear eye protection if there was a Covid outbreak or if there was a chance body fluid would get in her eyes.

An Infection Preventionist interview on 10/28/2021 at 6:15 PM revealed she was aware

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of the most recent CDC guidance regarding wearing eye protection in a COVID-19 high transmission rate county. The Infection Preventionist verbalized the CDC guidance was a recommendation and was not mandated.

The Activities Director was interviewed on 10/29/2021 at 12:20 PM. She revealed she was not wearing eye protection when she was within 6 feet of residents because there was not a COVID-19 outbreak in the facility. The Activities Director further indicated the facility was following CDC guidance which was that staff were to wear surgical masks.

An interview with the Rowan County Health Department Director of Nursing (DON) on 10/29/2021 at 1:36 PM confirmed the facility was in Rowan County and the transmission rate for COVID-19 was high.

An interview with the DON was completed on 10/29/2021 at 2:57 PM. The DON revealed the facility read the CDC guidelines as recommendations not mandates. The DON further indicated the staff were advised to wear eye protection only when doing procedures that body fluids could be splashed into their eyes such as irrigation of wounds, nebulizer treatments and suctioning.