STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095040	A. BUILDING _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HSC PEDIATRIC SKILLED NURSING FACILITY	1731 BUNKER HILL ROAD NE WASHINGTON, DC 20017

(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
F 000	INITIAL COMMENTS	F 000		

An unannounced Long Term Care Survey Recertification Survey was conducted at The Hospital for Sick Children, Skilled Nursing Facility from August 11, 2021, through August 12, 2021. Survey activities consisted of a review of eight (8) sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was seven (7).

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria Allen
TITLE: Administrator
(X6) DATE: 10.21,21

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DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed

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F 000	Continued From page 2 Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of eight (8) sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) to reflect one resident who had a gastrostomy tube. Resident #1. The findings included: Resident #1 was admitted to the facility on 08/27/2019, with multiple diagnoses that included: Gastrostomy, Congenital Malformation Syndrome, Spastic Tetraplegia and Seizure Disorder. Review of the "Nutrition Assessment" dated 05/17/2021, documented, "... continues on GT (gastrostomy tube) feeds... Diet order...	F 641	1. Resident #1's comprehensive assessment conducted on 8/13/21 Is coded with g-tube diagnosis. 2. Audit of most recent MDSs for each resident will be conducted by DON or designee to ensure proper Coding. 3. MDS coding training will be provided to DON and RNs	

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F 641	Continued From page 3 Pediasure peptide (formula for the nutritional needs of children 1 to 13 years of age with malabsorption, maldigestion, and other GI conditions) (30kcal [kilo calories]/oz [ounce]) 660 ml (milliliters) + 925 ml water + 1/8 teaspoon table salt = total volume 1585 ml daily. Give 320 ml via GT bid (twice a day) ..." Review of the MDS with the assessment date of 05/18/2021 in Section I (Active Diagnoses) lacked documented evidence that Resident #1 was coded for her gastrostomy status. During a face-to-face interview conducted on 08/12/2021 at 12:28 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "Yes it should have been coded. Her comprehensive MDS is getting done tomorrow, we will fix it."	F 641	responsible for completing MDSs 4. Second review of MDSs will be conducted for a period of six months by DON or designee and findings will be reported to the QAPI-Sub-Committee for review, recommendations and approval.	10/21/21
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726	.	

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F 726	Continued From page 4 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of eight (8) sampled residents, nursing staff failed to demonstrate the competencies necessary to safely meet the residents ' needs in accordance with professional standards of practice. Resident #7. The findings included: "The ' rights ' of medication administration include right patient, right drug, right time, right route, and right dose." https://www.ncbi.nlm.nih.gov/books/NBK2656/ Resident #7 was admitted to the facility on 06/15/2021, with multiple diagnoses that included: Spasticity, Disorder of Autonomic Nervous System, Encounter for Tracheostomy and Dysphagia.	F 726	1. Nurse will be re-in-serviced as to the proper medication administration, followed by a quiz to verify competency and said action will be documented. 2. Medication passes will be conducted by DON or designee to ensure there are no other residents affected.	

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m DON has developed a quiz to test	095040	A. BUILDING _____ B. WING _____	08/13/2021

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F 726	Continued From page 5 Review of the physician ' s order dated 06/15/2021 at 3:55 PM directed, "Methylphenidate (controlled substance for narcolepsy) HCL (hydrochloride) 10 mg (milligram) tabs (tablets), Dose: 5mg, Route: Gastric tube... twice a day". In a facility reported incident received on 06/18/2021, it documented: "Ordered dose for methylphenidate hcl is 5 mg. Tablets available are 10 mg. Resident was administered entire 10 mg tablet instead of indicated dose of 5mg. No adverse effects were noticed and nurse practitioner on/ duty was notified and she assessed the resident on the same day. No new orders were given. There was not adverse effect on the resident." Review of the warning notice for the medication, Methylphenidate, stipulated: "...Controlled substance for Narcolepsy- causes rapid or irregular heartbeat, Warning: Heart problems warning: may cause stroke, heart attack or sudden death." During a face-to-face interview conducted on 08/12/2021 at 12:45 PM, Employee #1 (Administrator) she stated, "The safety inspections [right drug, patient, route, dose and time] were not done by the nurse which contributed to the error. The nurse involved was counseled and educated."	F 726	3.Interim DON has developed a quiz to test competency to add to the current training materials. This quiz will be used to re-in-service current staff and new staff. 4.DON or designee will conduct medication passes and document findings and report to the QAPI Sub-Committee on a quarterly basis for a six month period for review, recommendations, and approval.	. 10/21/21

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F 726	Continued From page 6 When asked to provide evidence of the education, Employee #1 was not able to show any documented evidence that education was provided to the nursing staff.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		

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F 755	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of eight (8) sampled residents, the facility ' s pharmaceutical department failed to label the medication Methylphenidate (controlled substance for narcolepsy) with the appropriate dosing instructions for administration, subsequently the nurse gave the wrong dose of Methylphenidate to Resident #7. The findings included: Resident #7 was admitted to the facility on 06/15/2021, with multiple diagnoses that included: Spasticity, Disorder of Autonomic Nervous System, Encounter for Tracheostomy and Dysphagia. Review of the physician ' s order dated 06/15/2021 at 3:55 PM directed, "Methylphenidate (controlled substance for narcolepsy) HCL (hydrochloride) 10 mg (milligram) tabs (tablets) Dose: 5mg Route: Gastric tube... twice a day". In a facility reported incident received on 06/18/2021, it documented: "Ordered dose for methylphenidate hcl is 5 mg. Tablets available are 10 mg. Resident was administered entire 10 mg tablet instead of indicated dose of 5mg. No adverse effects were noticed and nurse practitioner on duty was notified and she assessed the resident on the same day. No new orders were given. There was not adverse effect on the resident."	F 755	1. Pharmacy staff involved in the error has been counselled, educated, and said action has been documented. 2. Pharmacy Manager has audited/ monitored Methylphenidate to ensure the label includes specific instructions for the nurse to prepare the dose as ordered by the physician/nurse practitioner. 3. Pharmacy Manager has re-in-serviced the pharmacists to add instructions and has tested for competency in the process.	

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F 755	Continued From page 8 Review of the warning notice for the medication Methylphenidate stipulated: "...Controlled substance for Narcolepsy- causes rapid or irregular heartbeat, Warning: Heart problems warning: may cause stroke, heart attack or sudden death." During a face-to-face interview conducted on 08/12/2021 at 11:48 AM Employee #5 (Pharmacist) stated, "We only have the one strength of that medication [Methylphenidate 10mg]. The pharmacist on duty did not put clear instructions on the label to cut the tablet in half before administering it. That pharmacist was counseled, educated and is being monitored. This incident was taken to the Pharmacy and Therapeutics Committee and was given a severity level of "C", indicating the error reached the resident, but it did not cause any harm. No in-service was done with nursing staff. It was reported to the Director of Nursing. We only do in-services with the nursing staff if and when the error occurs more than once or if there are a lot of questions about a medication." When asked to provide evidence of the education, Employee #5 stated that the pharmacist involved was counseled verbally and was not able to show evidence that education was provided. During a face-to-face interview conducted on 08/12/2021 at 12:45 PM, Employee #1 stated they inserviced the nurse but they didn't have documentation.	F 755	4.Pharmacy Manager or designee will report SNF medication errors to the QAPI Sub-Committee on a quarterly basis for a period of six months for review, recommendations, and approval.	10/21/21

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F 812 SS=E	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 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 observation and staff interview, facility staff failed to store and prepare foods in accordance with professional standards of practice for food services safety as evidenced by expired food items such as: four (4) of nine (9) five-pound containers of strawberry yogurt, four (4) of six (6) five-pound container of vanilla yogurt, and one (1) of one (1) container of bacon, food items such as a bag of shrimp, one (1) of one (1) open bag of gelatin that were not labeled, and one of one (1) ten-pound bag of vacuum-packed portions of salmon that were improperly being thawed. The findings included:	F 812		

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F 812	Continued From page 10 During an environmental walkthrough of the facility ' s kitchen on 08/11/2021, at approximately 10:00 AM, food items in one (1) of two (2) walk-in refrigerators were inadequately stored as follows: 1. Four (4) of nine (9) five-pound containers of strawberry yogurt were expired as of 08/09/2021. 2. Four (4) of six (6) five-pound container of vanilla yogurt was expired as of 08/04/2021. 3. One (1) of one (1) container of bacon had a use-by-date of 08/02/2021. 4. Shrimp pieces, stored in a plastic storage bag, were not clearly marked to indicate the date the original container was opened, and/or the date to be discarded. 5. One (1) of one (1) open bag of gelatin was not labeled to indicate the date it was opened, and/or the date to be discarded. 6. One (1) of one (1) ten-pound bag of vacuum-packed portions of salmon, labeled by the manufacturer to "keep frozen," was thawing in the walk-in refrigerator. During a face-to-face interview conducted at the time of the observation, Employee #6 acknowledged the findings. 7. Employee #7 (Director of Environmental Services) arrived to facility ' s kitchen on 08/11/2021 at 10:44 AM and stated, "There is a crack in the pipeline coming off the grease trap, which causes a leak and floods the kitchen. The dish washing machine has been down since February [2021]. I ' m not sure if it was reported to	F 812	1. Five-pound containers of expired strawberry yogurt with expired dates were disposed of. Five pound container of expired vanilla yogurt were disposed of. Bacon with expired use-by-date was disposed of. Shrimp pieces in plastic bag without clear open date was disposed of. Gelatin lacking date as to when it was opened was disposed of. One ten-pound bag of vacuum-packed portions of salmon was disposed of. HSC submitted a comprehensive plan to DOH in regards to the project to fix the pipeline coming off the grease trap. 2. Nutrition Manager will walk through refrigerated coolers and freezers to assess dating and labeling process adherence and dispose of any expired product. Engineering Manager and Administrator will review equipment and systems to ensure there is no	

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F 812	Continued From page 11 the Department of Health." He added that the machine is used "periodically, and when not in use, the staff has been washing dishes by hand." When asked if he could show the training records for staff on how and when to use the dishwasher, Employee #7 indicated that there was no formal training of staff. He also acknowledged that the Department of Health should have been informed of the issue with the dishwasher. During a face-to-face interview conducted on 08/11/2021, at approximately 11:00 AM, Employee #1 stated the she had not reported the drain concerns to the Department of Health.	F 812	malfunction which affects SNF operations and needing DOH reporting. 3. Nutrition services manager will conduct documented education to review policy and procedures for dating and labeling and monitoring of product expiration. Nutrition services manager will conduct rounds of refrigerated coolers and freezers to ensure adherence with dating and labeling of product expiration. Manager will document findings.	
F 880 SS=E	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	F 880	Administrator and Engineering Manager will review systems and equipment at least monthly to ensure timely reporting and properly functioning systems/equipment. 4. Nutrition services manager will report findings to the QAPI Sub-Committee on a quarterly basis for a period of six months for review, recommendations and approval. Administrator will report on a quarterly basis to the QAPI Sub-	

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F 880	Continued From page 12 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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.	F 880	(cont. F812) Committee as to any reporting to DOH in regards to systems or equipment malfunction for a period of six months for the sub-committee's review, recommendations, and approval.	10/21/21

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	095040	A. BUILDING _____ B. WING _____	08/13/2021

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F 880	Continued From page 13 §483.80(e) Linens. 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 observation, record review and staff interview, for one (1) of eight (8) sampled residents, facility staff failed maintain infection control and prevention practices evidenced not maintaining clean technique and not performing hand hygiene while providing tracheostomy care. Resident #7. The findings included: "Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves... and preventing direct contamination of materials and supplies." https://journals.lww.com/jwocnonline/fulltext/2012/03001/clean_vs__sterile_dressing_techniques_for.7.aspx Resident #7 was admitted to the facility on	F 880	1. Nurse and respiratory therapist will be re-in-serviced in maintaining infection control and prevention practices while providing trach care; maintaining sterile and clean technique as required; maintaining the sterile and clean field; proper use, removal and disposal of gloves; hand hygiene in between dressing. Training will be documented and it will be followed by competency checks.	

competency check through quizzes and

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F 880	Continued From page 14 06/15/2021, with multiple diagnoses that included: Encounter for Tracheostomy, Dysphagia, Spasticity, and Disorder of Autonomic Nervous System. Review of the Minimum Data Set dated 06/25/2021 revealed in Section O (Special treatments, procedures, and programs), "Suctioning, Tracheostomy care ..." During an observation on 08/12/2021, from 9:50 AM to 10:15 AM, the following was observed: Employee #3 (Respiratory Therapist) was performing a respiratory treatment and tracheostomy tie change on Resident #7. Employee #3 provided privacy, turned off the fan, placed the ambu bag (a hand-held device used to provide positive pressure ventilation to patients) on the bed, applied gloves, placed the "Tri-Flo Cath-N-Glove Kit 10 Fr (French)" directly on top of the resident ' s bed linens. Next, the employee removed one glove from the kit and applied it on top of the already gloved right hand. Employee #3 then picked up the tubing with her right hand and began to adjust the equipment/tubing with her left hand while still holding the tubing in her right hand, at times bending over to adjust the suction tubing with her left hand. Employee # 3 then began to suction Resident #7. After suctioning the resident, Employee #3 discarded the Cath-N-Glove kit contents into the trash receptacle located in the resident ' s room. Employee #3 then placed two piles of dry gauze on Resident #7 ' s bed linen (knee area of the resident) and sprayed Micro Klenz (wound cleanser) on one pile of gauze. At this point, Employee #4 entered the room to assist with	F 880	2.Infection Preventions (IP) or designee will observe trach care to residents to ensure nursing and respiratory staff follow proper infection control practices. 3.Nursing and respiratory staff will be re-in-serviced and competency verified via quizzes and observations as to how to follow proper infection control practices while providing trach care. Written plan for infection surveillance will be reviewed/revised by IP to ensure monitoring of nursing practices and correction of quality deficiencies. COVID-19 policy will be reviewed and and revised by Administrator as needed but at least monthly to ensure compliance with frequent guideline changes. trach care policy/procedure will be revised by IP to reflect findings from root cause analysis.	

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F 880	Continued From page 15 removing and replacing the tracheostomy collar. Employee #4 picked up the wet gauze off the bed linen with gloved hands and proceeded to clean the tracheostomy site, the employee then placed the gauze with visible soiled contents back on the resident ' s bed linens in a different area of the bed. Employee #4 then picked up a dry gauze off the bed linens and used it to pat dry the trach area of the resident and placed the used gauze in the same pile with the other wet, soiled pieces of gauze. Employee #3 then picked up a wet gauze off the bed, cleaned the resident ' s neck area, then discarded the gauze on the bed with the other pile of soiled gauze. During the observation, Employee #3 and Employee #4 failed to maintain clean technique and failed to perform hand hygiene in between removing the old dressings, cleaning and applying the new clean dressing to the tracheostomy site. During a face-to-face interview conducted at the time of the observation, Employee #3 and Employee #4 acknowledged the findings.	F 880	4. IP or designee will conduct trach observations on a monthly basis, document findings and report findings on a quarterly basis for a 12 month period to the QAPI Sub-Committee for review, recommendations, and approval. IP or designee will present revised surveillance plan and trach policy to the QAPI Sub-Committee on a quarterly basis for a six month period for review, recommendations, and approval. Administrator will present revised COVID-19 policy changes to the QAPI Sub-Committee for review, recommendations, and approval on a quarterly basis for a six month period.	10/21/21
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training	F 882		

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F 882	Continued From page 16 in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility staff failed to have a designated Infection Preventionist who completed specialized training in infection prevention and control. The findings included: During a face-to-face interview conducted on 08/12/2021, at 2:46 PM, it was revealed that Employee #2 (Director of Nursing), who is the designated staff responsible for the facility's Infection Prevention and Control Program (IPCP), has not completed the specialized training in infection prevention and control as required by the Center for Medicaid and Medicare Services (CMS).	F 882	1.Interim DON completed certification on 9/12/2021. She will serve as the IP. 2.New DON is required to be IP certified. 3. DON and at least one RN will receive training to become IP certified. 4. Administrator will document and report to the QAPI Sub-Committee as to IP certification on a quarterly basis for a period of six months.	10/21/21

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F 882	Continued From page 17 At the time of the interview, Employee #2 acknowledged the finding and stated, "The previous Director of Nursing was certified in infection prevention and control. I am working on getting certified but I am just the Interim Director of Nursing." .	F 882		