

F882

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§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 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.

INTENT §483.80(b)

The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections.

GUIDANCE

Responsibility for the Infection Prevention and Control Program (including the Antibiotic Stewardship Program)

The facility must designate one or more individuals as the infection preventionist (IP) who is responsible for assessing, developing, implementing, monitoring, and managing the IPCP. The IPCP includes content required in §§483.80(a)(1)-(4), (F880, Infection Prevention and Control and at F881, Antibiotic Stewardship Program (ASP)). While the IP is responsible for the IPCP, other staff play important roles in infection prevention and control as well as antibiotic stewardship. For example, staff must appropriately implement standard precautions such as hand hygiene and transmission-based precautions. Furthermore, ASP development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership and therefore, the IP should utilize and work collaboratively with these team members to also implement the ASP. While an ASP is a team effort, the IP is responsible for ensuring the program meets the requirements for ASPs (at §483.80(a)(3), F881). The IP should review and approve infection prevention and control training topics and content, as well as ensure facility staff are trained on the IPCP (for further information, see §483.95(e), F945, Infection Control Training). However, the IP is not required to perform the IPCP training, since some facilities may have designated staff development personnel.

Primary Professional Training

The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field.

A professionally-trained nurse must have earned a certificate/diploma or degree in nursing.

A professionally-trained medical technologist (also known as clinical laboratory scientist) must have earned at least an associate's degree in medical technology or clinical laboratory science.

A professionally-trained microbiologist must have earned at least a bachelor's degree in microbiology.

A professionally-trained epidemiologist must have earned at least a bachelor's degree in epidemiology.

Examples of other related fields of training that are appropriate for the role of an IP include physicians, pharmacists, and physician's assistants.

Qualifications

The IP must be qualified by education, training, experience or certification. The IP must have the knowledge to perform the role. The IP should remain current with infection prevention and control issues and be aware of national organizations' guidelines as well as those from national/state/local public health authorities (e.g., emerging pathogens). The facility should ensure the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the resident population, such as interpreting clinical and laboratory data. Examples of experience in infection prevention and control may include, but are not limited to, identification of infectious disease processes, surveillance and epidemiologic investigation, and preventing and controlling the transmission of infectious agents. An example of certification is the Certification in Infection Prevention and Control (CIC®) which is conducted by the Certification Board of Infection Control and Epidemiology, Inc. (CBIC®) and accredited by the National Commission for Certifying Agencies (NCCA).

IP Hours of Work

Designated IP hours per week can vary based on the facility and its resident population. Therefore, the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment, conducted according to §483.70(e), to determine the resources it needs for its IPCP, and ensure that those resources are provided for the IPCP to be effective. Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP. A facility should consider resident census as well as resident characteristics, types of units such as respiratory care units, memory care, skilled nursing and the complexity of the healthcare services it offers as well as outbreaks and seasonality of infections such as influenza in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA.

The IP must physically work onsite in the facility. He/she cannot be an off-site consultant or perform the IP work at a separate location such as a corporate office or affiliated short term acute care facility.

Specialized Training in Infection Prevention and Control

Infection prevention and control (IPC) training must be sufficient to perform the role of the IP. Specialized training in IPC may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If a facility's resident population changes, the IP should re-evaluate his/her knowledge and skills, and may need to obtain additional training for the change in the facility's scope of care.

An IP must have obtained specialized IPC training beyond initial professional training or

education prior to assuming the role. Training can occur through more than one course, but the IP must provide evidence of training through a certificate(s) of completion or equivalent documentation.

CMS recommends specialized training include the following topics:

- Infection prevention and control program overview,
- The infection preventionist's role,
- Infection surveillance,
- Outbreaks,
- Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment),
- Principles of transmission-based precautions,
- Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing),
- Water management,
- Linen management,
- Preventing respiratory infections (e.g., influenza, pneumonia),
- Tuberculosis prevention,
- Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions),
- Quality assurance and performance improvement,
- Antibiotic stewardship, and
- Care transitions.

A free online training is available and was developed by a collaboration between CMS and the Centers for Disease Control and Prevention (CDC). The "Nursing Home Infection Preventionist Training Course" is located on CDC's TRAIN website (https://www.train.org/cdctrain/training_plan/3814). Other trainings may be available from entities such as associations, state public health, and universities.

INVESTIGATIVE PROCEDURES

Use the Infection Prevention, Control & Immunizations Facility Task, along with the above interpretive guidance, when determining if the facility meets the requirements for, or when investigating concerns related to, compliance with the infection preventionist requirement at §§483.80(b)(1)-(4) (i.e., role, qualifications, training, and allowed time for the position).

Instances of the facility not implementing transmission-based precautions when indicated should be cited at F880. These findings may support citing F882 as well, in which case the surveyor must also show that the facility did not ensure requirements at §483.80(b) were met. For example, F882 should be cited if the IP was not available to assist staff on multiple occasions with their questions on when transmission-based precautions should be initiated for a resident due to lack of sufficient time to perform the IP role, and this led to noncompliance with F880.

The facility may be cited at an infection control tag such as F880, but not at F882. For example, F882 should not be cited if all requirements at §483.80(b) are met, but a staff member did not clean and disinfect reusable resident care equipment (e.g., blood pressure cuff, thermometer) after use on a resident on transmission-based precautions and it was then used on the next resident, despite proper policies and procedures, staff training, and process surveillance of staff practices addressing this concern.

Conversely, the facility can be cited at F882 although not at F880, F881, or F945 in cases where a surveyor's investigation began with an infection control concern leading to a review of the IP, but in the end did not result in evidence of noncompliance at another infection control tag (e.g., F880, F881) or F945. For example, during the investigation, the surveyor found through record review that the IP did not have specialized training.

Surveyors should utilize the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review Facility Task to determine compliance with §483.80(c), IP participation on QAA committee.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F882, the surveyor's investigation will generally show that the facility failed to ensure that the IPCP was overseen by a qualified individual, who:

- Meets the requirement for professional training; or*
- Adequately assesses, develops, implements, monitors, and manages the IPCP; or*
- Has the appropriate knowledge and skills to care for the IPC needs of the facility's resident population and to be responsible for the IPCP; or*
- Has time to perform IP responsibilities; or*
- Performs IP duties in the facility; or*
- Completed specialized training in IPC.*

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health and safety includes, but is not limited to:

- The facility failed to ensure the IP was qualified by education, training, experience or certification to identify a gastrointestinal outbreak in the facility and implement appropriate control measures. Surveyors identified that the IP did not ensure that appropriate control measures (e.g., transmission-based precautions, environmental cleaning and disinfection) and reporting to public health occurred. As a result, several residents became seriously ill with diarrheal illnesses resulting in dehydration.*

An example of Level 3, actual harm that is not immediate jeopardy includes, but is not limited to:

- The facility failed to ensure the IP implemented the IPCP appropriately for a case of pediculosis (i.e., head lice) and the resident's roommate also became infested. Per the IPCP and CDC recommendations, the resident should have been placed*

on contact precautions until 24 hours after the application of an effective treatment. The IP participated in an interview and confirmed that she was aware of the diagnosis but did not ensure contact precautions were initiated.

An example of Level 2, no actual harm with potential for more than minimal harm, that is not immediate jeopardy includes, but is not limited to:

- *The facility failed to ensure the IP was performing the duties of the position and was qualified to perform the role. The IP did not ensure the facility had an antibiotic stewardship program. Based on record review, the facility could not provide documentation for an antibiotic stewardship program. During the interview, the IP demonstrated a lack of understanding of an effective program and how to implement an antibiotic stewardship program. Additionally, during the interview, the IP confirmed that she did not have training in antibiotic stewardship.*

An example of Level 1, no actual harm with potential for minimal harm includes, but is not limited to:

- *The facility failed to ensure the IP had appropriate time to perform IP responsibilities. Record review and interview(s) revealed that the IP failed to ensure that the IPCP was reviewed annually. The IP verified that she did not have enough time onsite to update the IPCP by its annual deadline and two months had passed since an update was required. There were no infection control findings outside of annual review and documentation.*

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

- *F838: for concerns related to the facility assessment;*
- *F867: for concerns related to the QAA committee's responsibility to identify or correct quality deficiencies, which may include systemic infection control concerns;*
- *F868: for concerns related to the QAA committee to include the IP's participation;*
- *F880: for concerns related to infection prevention and control;*
- *F881: for concerns related to the antibiotic stewardship program; and*
- *F945: for concerns related to staff training on the standards, policies, and procedures of the infection prevention and control program.*