STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555459	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAMERCY COURT	**2200 GRAMERCY DRIVE SACRAMENTO, CA 95825**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on interview and record review, the facility failed to fully implement their infection prevention and control program when the Infection Preventionist (IP) did not implement an ongoing system of surveillance designed to identify infection risks, and prevent the spread of communicable diseases in the facility. This failure had the potential to increase the risk of not identifying and stopping the spread of possible communicable infections to others in the facility. Findings: During an interview with the IP, on 9/1/20, at 11:05 a.m., the surveyor asked the IP to describe her process for surveillance of infections in the facility. The IP stated that each day she generated a report of the residents who started an antibiotic in the last 24 hours, she would attach a log of those residents for that day and indicated if the infection was present on admission or acquired while at the facility, if the physician ordered diagnostic tests, etc. The IP stated she compiled the data into one report at the end of each month and share the reports with the Director of Nursing (DON). When asked if she maintained an ongoing list of the infections in the facility, she stated she did not. The IP stated she created a map of where infections were located in the facility for May 2020. When asked if she mapped locations of infections in the facility since May 2020, she stated she did not. When asked if she investigated the root causes of how residents may have acquired infections in the facility, she stated she did not have documentation of such investigations. When asked if she knew the present number of infections, their locations, and their type, she stated she did not have that information on hand. When asked if she performed audits on staff compliance with infection prevention and control practices, she provided monthly audits on staff compliance with hand hygiene practices. When asked if she performed audits on other infection prevention and control practices, the IP stated she did not. The IP confirmed she did not have a surveillance process in place to identify, analyze, track, and monitor infections in the facility in real-time to detect and manage potential outbreaks. The IP stated, for the past two months, she has spent most of her time doing Covid-19 tests on staff each week, and has not had the time to dedicate to her usual infection prevention and control activities. Review of the facility's Antimicrobial Stewardship Meeting/Infection Control Meeting Minutes, dated 5/29/20, indicated data for the months of March and April. The minutes indicated an agenda item for Healthcare-Associated Infections (HAIs, infections acquired at the facility). The action plan for HAIs indicated the rate had increased. The minutes did not have documented evidence of investigative results on the root causes of the HAIs, the upward trend, or the interventions used. The action plan for HAIs included, CAUTI (catheter-associated urinary tract infection) maintenance bundle audit shared with IP - will start using during rounds for audit for CAUTI prevention. The minutes indicated an agenda item for Hand Hygiene/PPE (personal protective equipment) Observation, and the action plan included, PPE observation to start June 2020. Review of the facility's Antimicrobial Stewardship Meeting/Infection Control Meeting Minutes, dated 6/30/20, indicated data for the month of May. The minutes indicated the HAIs rate had decreased. The minutes did not have documented evidence of investigative results on the root causes of the HAIs, the downward trend, or the interventions used. The action plan for HAIs included, CAUTI (catheter-associated urinary tract infection) maintenance bundle audit shared with IP - will start using during rounds for audit for CAUTI prevention. The action plan for the agenda item Hand Hygiene/PPE Observation included, PPE observation to start June 2020. A facility policy and procedure titled Infection Prevention and Control Program, dated 8/16, indicated, The infection prevention and control program is coordinated and overseen by the infection prevention specialist (infection preventionist) .The infection prevention and control committee, Medical Director, Director of Nursing Services, and other key clinical and administrative staff review the infection control policies at least annually. The review will include .Assessment of staff compliance with existing policies and regulations .Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications .The information obtained from infection control surveillance activities is compared with that from other facilities and with acknowledged standards (for example, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices .Data gathered during surveillance is used to oversee infections and spot trends .Important facets of infection prevention include .educating staff and ensuring that they adhere to proper techniques and procedures

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.