STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555442	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAPITAL TRANSITIONAL CARE	**6821 24TH STREET SACRAMENTO, CA 95822**

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, record review, and facility policy review, the facility failed to implement ongoing infection control protocols to control the spread of infection when staff were tasked to care for both COVID-19 (coronavirus disease 2019, the name of a respiratory illness that can spread from person to person) positive and COVID-19 negative residents in the same assignment. This failure had the potential to spread the respiratory illness to other vulnerable residents in the facility, for a census of 93 residents. Findings: A facility document titled Admission Record, indicated Resident 1 was admitted to the facility in August of 2010. Further review of Resident 1's clinical record indicated the resident was tested for COVID-19 on 6/30/20 and resulted positive. A facility document titled Admission Record, indicated Resident 2 was admitted to the facility in February of 2019. Further review of Resident 2's clinical record indicated the resident was tested for COVID-19 on 6/23/20 and resulted positive. A facility document titled Admission Record, indicated Resident 3 was admitted to the facility in January of 2009. Further review of Resident 3's clinical record indicated the resident was tested for COVID-19 on 7/14/20 and resulted negative. In an interview with the Infection Preventionist (IP), on 7/10/20 at 2:52 p.m., the IP confirmed the designated COVID-19 Certified Nurse Assistant (CNA) did not show up for work for the 7/9/20 night shift. The IP reported facility staff called the IP and the Director of Nurses (DON) to provide care in the COVID-19 unit, and they stayed until about three or four in the morning. The IP indicated Resident 1 and Resident 2 were both in the COVID-19 unit at this time. When asked if there was a point in the shift where staff were caring for both COVID-19 positive and COVID-19 negative residents in one assignment, the IP stated, yes. An interview was conducted with CNA1, at 4:16 p.m. on 7/15/20. CNA1 indicated on the night shift of 7/9/20, she was assigned to care for residents in the non-COVID-19 unit. CNA1 further indicated the staff member assigned to the COVID-19 unit did not show up. CNA1 stated the IP and DON arrived to provide resident care in the COVID-19 unit. CNA1 reported when the DON and IP left later in the shift, CNA1 was given instructions by the IP and DON to check on the residents in the COVID-19 unit. CNA1 stated care was provided to a Resident 1 in the COVID-19 unit by assisting the resident to the bathroom. CNA1 further stated care was then provided for her assigned resident (Resident 3) in the non-COVID-19 unit. CNA1 reported the care provided to all residents was documented in the electronic medical record. A concurrent interview and record review was conducted with the IP and Assistant Director of Nurses (ADON) at 1:22 p.m. on 7/16/20. IP confirmed a bowel and bladder report was present in Resident 1, Resident 2, and Resident 3's clinical record to indicate care was provided to COVID-19 positive residents prior to care provided to non-COVID-19 residents by the same CNA. A facility policy titled COVID 19 Mitigation Plan, dated June 2020, indicated COVID positive cohorts will be housed in a separate area (unit or wing) of the facility (Containment Unit) and will have dedicated HCP (Health Care Personnel) who do not provide care for residents in other cohorts .

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.