STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165513	A. BUILDING _____ B. WING _____	**10/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHER MANOR COMMUNITIES	**3131 HILLCREST ROAD DUBUQUE, IA 52001**

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews and observations the facility failed to follow appropriate infection control practices in regards to gloving for 1 of 1 meal observed. The facility reported a census of 72. Findings include: According to Resident #1's face sheet dated 10/26/20 indicated the resident had [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed the resident had a BIMS score of 15 which indicated the resident alert and oriented. The resident walked with supervision and ate independently. Review of the Care Plan dated 10/12/20 revealed the physician ordered the staff to place the resident into droplet isolation related to a positive COVID 19 [DIAGNOSES REDACTED]. The resident denied any COVID 19 symptoms. The staff transferred the resident to the COVID unit at Grand(NAME)Asbury for isolation. The notes indicate the resident transferred back to Hillcrest campus on 10/23/20. Observation out side of Resident #1's door way is an isolation cart which contained: gowns, gloves, goggles, masks. A sign sits on top of the cart which directs staff how to don/doff isolation personal protective equipment, which includes gown, masks, goggles and gloves. The sign directs staff to use only the articles required for each isolation level: contact, droplet or airborne. Observation on 10/26/20 at 9:26 a.m. revealed Staff A, Dietary Aide enter Resident #1 room, with gloves on. The staff walked into the resident's room to retrieve his Styrofoam breakfast dishes. She exited the room with the dishes, placed the dishes in the garbage but failed to remove her gloves after touching the Styrofoam dishes. The DA then proceeded down the hall to the kitchen. Observation on 10/26/20 at 9:32 a.m. Staff B-Dietary Aide entered the resident's room with gloves on, she proceeded to wash off the top of his tray table, left the room but failed to remove her gloves after exiting the room. The staff walked down the hall. During an interview with the Director of Nurses on 10/26/20 at 9:32 a.m., the D.O.N. stated she would have expected the dietary staff to remove their gloves after they leave a resident's room on isolation . The D.O.N. re-educated the staff on the proper use of gloves and how they need to change gloves after leaving each resident room. During an interview with Staff B-Dietary Aide on 10/26/20 at 1:35 p.m, Staff B stated the Director of Nurses provided re-education on the use of gloves and when to change gloves after leaving an isolation room. Staff B stated she wore the same gloves this morning when she cleaned the tray tables all residents. She stated she was never told she needed to remove/change her gloves in between residents. Review of an Infection Control COVID 19 policy dated 3/11/2020, the policy directs the staff to follow standard precautions which include hand hygiene. The policy directs staff to wash hands or use alcohol based hand rub before and after putting on and removing gloves. To use personal protective equipment such as gloves when there is an expectation of possible exposure to infectious material.

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.