STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	**1226 1ST AVE N NEW ROCKFORD, ND 58356**

(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 The standard Medicare/Medicaid recertification and complaint survey started on 07/08/24 and concluded 07/10/24. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		8/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/29/2024

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F 657	Continued From page 1 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the care plans to reflect residents' current status for 1 of 12 sampled residents (Resident #24). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure continuity of care, and may negatively impact the care provided to the resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 07/09/24. This policy, dated August 2022, stated, ". . . Care plans are revised as changes in the resident's condition dictates. . . ." Review of Resident #24's medical record occurred on all days of survey. The current care plan stated, "Transfers with supervision. . . . I like to ambulate throughout the wing but will often refuse staff to walk with me. . . . EZ stand with leg strap. . . . It is recommended that I use a walker to stabilize my gait . . . I ambulate with a stumped over posture and shuffled gait . . . Encourage me to take rest periods after walking as I will walk aimlessly. . . ." The Minimum Data Set (MDS) dated 06/08/24, identified the resident utilized wheelchair for mobility. Observations on all days of survey showed Resident #24 in a wheelchair, moving herself throughout the unit using her feet. During an interview on the afternoon of 07/09/24, an administrative staff member (#1) confirmed the facility failed to update Resident #24's care plan regarding the mobility status.	F 657	1. Immediate corrective action was taken on 7/9/24. The Director of Nursing updated resident #24's care plan immediately to represent her current mobility status. 2. All residents of the facility have the potential to be affected by not having updated care plans. 3. The MDS nurses reviewed and updated all resident's care plans on 7/9/24. Interdisciplinary team members responsible for updating care plans were educated on 7/17/24 and 7/25/24 to assure care plans are revised as changes in the resident's condition dictates. On 07/16/24 & 7/23/24, education was provided through the "Communication to all Staff for Resident Overall Care Needs", document. On 7/17/24 education was provided at a Nursing staff meeting regarding the preliminary survey results. Nursing staff were educated again on the final survey results on 7/25/24 on the facilities policy for Care Plans (Attach 1). Education provided to nursing staff on 7/25/24 was recorded and sent to nursing and agency staff on 7/26/24 via smartlinx for those that could not attend the meeting. Medical records will continue to provide the Director of Nursing or Designee with new orders to ensure care plans are updated with new changes to resident care. 4. The Director of Nursing or Designee(s)	

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F 657	Continued From page 2	F 657	will complete QA checks on a sampling for 5% of current residents weekly X 4, monthly X 3, and quarterly X 2 to assure care plans are updated to a resident□s current level of status. We will continue to re-evaluate for further monitoring and interventions if necessary (attachment #2).	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled residents (Resident #15) observed receiving a topical medication and 1 supplemental resident (Resident #6) observed during medication administration. Failure to obtain a physician's order and to properly administer medications may result in a resident receiving an ineffective dose and/or experiencing adverse reactions. Findings include: Review of the facility policy titled "Administration of Medications" occurred on 07/10/24. This policy, dated March 2023, stated, "1. Medication administration must safely be performed according to the "six rights" of administration. . . .	F 658	1. An order was obtained on 7/10/24 for resident #15 for Nystatin powder (attachment #3) and this was added to her orders (attachment #4). Orders for all residents were reviewed on 7/10/24 for those that have orders to have medications crushed. Medications that cannot be crushed were listed on the resident's profile page. 2. All residents have the potential to be affected by failure to obtain a physician's order and to properly administer medications which can result in receiving an ineffective dose and/or experiencing adverse reactions. 3. Nursing staff education was provided through the "Communication to all Staff for Resident Overall Care Needs",	8/1/24

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F 658	Continued From page 3 e. The medication is given by the right route. . . . 3. Physician orders are obtained through faxing or calling physician for either written or verbal orders. . . . " Mosby's "2023 Nursing Drug Reference," 36th ed., Elsevier, Inc., Missouri, page 1046, stated, ". . . Administer Drugs Safely, Accurately, and Professionally . . . Do not break, crush, or chew ext rel [extended release] tabs [tablets] . . ." - Observation on 07/09/24 at 8:54 a.m., showed a medication aide (#3) applied Nystatin powder to Resident #15's perineal area while completing cares. Review of Resident #15's medical record occurred on 07/09/24. The record lacked a physician's order for Nystatin powder. The medication aide (#3) applied a topical medication without an order. - Observation on 07/10/24 at 8:23 a.m., showed a nurse (#2) crushed and administered a Potassium Chloride tablet in pudding to Resident #6. Review of Resident #6's medical record occurred on 07/10/24. A physician's order stated, "Potassium Chloride ER [extended release] oral tablet . . . give 1 tablet by mouth one time a day . . ." During an interview on the afternoon of 07/10/24, an administrative staff member (#1) confirmed the nurse (#2) administered the tablet incorrectly, and confirmed that all medications	F 658	document on 07/16/24 & 07/23/24 (attachment #10). On 7/17/24 education was provided at a Nursing staff meeting regarding the preliminary survey results. Nursing staff were educated again on the final survey results on 7/25/24 on the "Administration of Medications" policy (attachment #5) and medications not suitable for crushing (attachment #6). Education provided to nursing staff on 7/25/24 was recorded and sent to nursing and agency staff on 7/26/24 via smartlinx for those that could not attend the meeting. 4. The Director of Nursing or Designee(s) will complete QA checks on a sampling for 5% of current residents weekly X 4, monthly X 3, and quarterly X 2 on administration of medications. The Director of Nursing or Designee(s) will complete QA checks on a sampling for 5% of current residents weekly X 4, monthly X 3, and quarterly X 2 of residents receiving crushed medications to assure medications are appropriate for crushing. We will continue to reevaluate for further monitoring and interventions if necessary (attachment #7).	

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F 658	Continued From page 4 should have a physician's order.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to ensure an environment free from accident hazards on 1 of 1 special care unit. Failure to ensure residents do not have access to laundry and soiled utility rooms placed them at risk for exposure to chemicals and other accident hazards. Findings include: - Observation on 07/08/24 at approximately 2:10 p.m. showed Resident #23 opened the door to an unlocked laundry room on the special care unit, and the door closed behind her. A few minutes later, an unidentified staff member entered the laundry room to redirect the resident. Observation showed containers of bleach and laundry detergent next to the washing machine. A cupboard contained other laundry detergents, Sani-Cloth disinfecting wipes, and hair spray. Observation on 07/08/24 at 4:08 p.m. showed this door remained unlocked. During an interview on the morning of 07/09/24,	F 689	1. Observations were immediately started on 07/09/24 of the laundry and soiled utility rooms in the special care unit to ensure doors were kept locked (attachment #8). Maintenance was notified on 7/09/2024, after the concern was presented to us, and repaired the laundry room door, which was not shutting tightly. The bypass locks were removed from the inside of the soiled utility and laundry room doors on 7/12/24 on the special care unit. 2. All residents have the potential for exposure to chemicals and other accident hazards when the laundry and soiled utility rooms are not locked. 3. Nursing staff education was provided through the "Communication to all Staff for Resident Overall Care Needs", document on 07/9/24 & 07/23/24 (attachment #9 & 10). On 7/17/24 education was provided at a Nursing staff	8/1/24

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F 689	Continued From page 5 an administrative nurse (#1) reported the laundry room door, when closed tightly, should automatically lock. -Observations on 07/08/24 from 4:07 p.m. until 5:37 p.m. showed the door of the soiled utility room on the special care unit unlocked. The room contained Comet disinfecting cleaner with bleach, Clorox urine remover, mop detergent, four bottles of antibacterial liquid hand soap, two containers of hand sanitizer, and Sani-Cloth germicidal disposable wipes. On 07/09/24 at 8:25 a.m., observation showed the soiled utility room door locked. A housekeeping staff member (#7) stated the door "should always be locked." During an interview on 07/09/24 at 4:04 p.m., an administrative staff member (#8) stated she expected staff to keep the soiled utility room door locked at all times. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate assistance and/or assistive devices for 1 supplemental resident (Resident #25) observed during a toileting transfer. Failure to use a gait belt and provide appropriate assistance during a transfer placed residents at risk for accidents, falls, and/or injuries. Findings include: Review of the facility policy titled "Transfers with use of Transfer Belts/Mechanical Lifts" occurred on 07/10/24. This policy, dated January 2018,	F 689	meeting regarding the preliminary survey results. Nursing staff were educated again on the final survey results on 7/25/24 on the expectation that soiled utility and laundry doors are to always remain locked (attachment #6). Observations were started immediately to assure doors in the special care unit remained locked. Bypass locks were removed on 7/12/24 from the soiled utility and laundry rooms on the special care unit. Keypad locks without a bypass lock were placed on the laundry rooms on Grace and Faith wing on 7/24/24. Education provided to nursing staff on 7/25/24 was recorded and sent to nursing and agency staff on 7/26/24 via smartlinx for those that could not attend the meeting. 4. The Director of Nursing or designee(s) will complete random audits of all soiled utility and laundry room doors to assure they are locked. This will be conducted weekly X 4, monthly X 3, and quarterly X 2. We will continue to re-evaluate for further monitoring and interventions if necessary. 1. Corrective action was accomplished for residents found to be affected by this practice with initial education to nursing staff on 7/17/24. 2. All residents requiring a gait belt and assistance during a transfer can potentially be affected if proper use of the gait belt is not used during a transfer.	

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F 689	Continued From page 6 stated, ". . . If a resident needs hands on assistance of trained staff for balance or lifting and maintaining standard position, transfer belt/gait belt must be used, unless otherwise care planned. . . ." -Review of Resident #25's medical record occurred on 07/10/24. The care plan stated, ". . . Will ambulate but requires walker, staff using gait belt with hands on assist. Transfers with one assist and FWW [front wheeled walker]. . . ." Observation on 07/08/24 at 4:15 p.m. showed two certified nurse aides (CNAs) (#5 and #6) assisted Resident #25 from the wheelchair to a standing position by lifting under the resident's arms and transferred the resident to the toilet without the use of a gait belt. After toileting the resident, both CNAs (#5 and #6) lifted Resident #25 under the arms, and without the use of a gait belt, transferred Resident #25 back to the wheelchair. During an interview on the afternoon of 07/10/24, an administrative staff member (#1) confirmed staff should be following policy and resident care plans.	F 689	3. Nursing staff education was provided through the "Communication to all Staff for Resident Overall Care Needs", document on 07/16/24 & 07/23/24 (attachment #10). On 7/17/24 education was provided at a Nursing staff meeting regarding the preliminary survey results. Nursing staff were educated again on the final survey results on 7/25/24 and educated on proper use of gait belts for those that require assistance with transfers. A review was completed on the Safe Operating Procedures (Resident Transfer) Policy (attachment #11). The Occupational Therapist was present to demonstrate proper use of the gait belt and its indications for use. 4. The Director of Nursing or Designee(s) will complete QA checks on a sampling for 5% of current residents, who require transfer assistance with the use of a gait belt. This will be conducted weekly X 4, monthly X 3, and quarterly X 2. We will continue to reevaluate for further monitoring and interventions if necessary.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		8/1/24

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F 761	Continued From page 7 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to label medications in accordance with professional standards for 2 of 4 supplemental residents (Resident #8 and #22) observed during medication pass. Failure to ensure appropriate labeling of medications placed residents at risk for medication errors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 834, stated, ". . . Check Three Times for Safe Medication Administration . . . First Check . . . Read the MAR [medication administration record] and remove the medication(s) from the	F 761	1. Immediate corrective action was taken by assuring a name was placed on the eye drops of resident #8. Orders were verified by the pharmacy and resident #22□s nasal spray was returned to pharmacy for proper labeling. 2. All residents have the potential to be affected if appropriate labeling of medications does not occur. 3. On 7/10/24 all residents with medications designed for multiple administration which include eye drops and nasal sprays were checked to assure the resident□s name and date opened were placed on the container. Nursing staff education was provided through the	

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F 761	Continued From page 8 client's drawer. Verify that the client's name and room number match the MAR. . . ." Page 838 stated, ". . . Compare the label of the medication container or unit-dose package against the order on the MAR or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. If there is still a discrepancy, check with the pharmacist. . . ." - Observation on 07/08/24 at 4:06 p.m. showed a nurse (#4) prepared medications for Resident #8. The nurse removed a bottle of artificial tears from the drawer. The box/bottle lacked a label with identifying information (such as the resident's name). The nurse administered the eye drops to Resident #8. - Observation on 07/09/24 at 8:27 a.m. showed a nurse (#9) removed nasal spray from the medication cart for Resident #22. The label on the medication identified two sprays to each nostril twice daily; however, the MAR and the physician's order identified two sprays each nostril once daily. During an interview on the morning of 07/09/24, an administrative nurse (#1) identified she would clarify the nasal spray order, and staff should label over the counter medications with the resident's name and the date they opened the medication.	F 761	Communication to all Staff for Resident Overall Care Needs, document on 07/16/24 & 07/23/24. Nursing staff were educated during a staff meeting on 7/17/24 and 7/25/24 on labeling of medications. Medications are to have date medication was opened & name of resident. This is for mediations that are used for multiple administration such as eye drops and nasal sprays. The "Administration of Medication" policy was reviewed on 7/25/24 which includes the labeling of medications used for multiple administrations (attachment #5). Education provided to nursing staff on 7/25/24 was recorded and sent to nursing and agency staff on 7/26/24 via smartlinx for those that could not attend the meeting. 4. The Director of Nursing or Designee(s) will complete random audits of sampling for 10% of residents weekly X 4, monthly X 3, and quarterly X 2 to assure proper labeling of medications used for multiple administrations.	
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		8/1/24

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F 880	Continued From page 9 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 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,	F 880		

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F 880	Continued From page 10 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. §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, review of manufacturer's instructions, and staff interview, the facility failed to follow infection control standards for 3 of 3 residents (Resident #7, #8, and #41) observed during blood glucose testing. Failure to properly disinfect glucometers may result in the spread of bloodborne pathogens between residents. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ)	F 880	1. Immediate action included disinfecting all patient assigned glucometers with the PDI Germicidal disposable wipes. Resident #7 was provided with their own glucometer. All staff responsible for performing blood sugar checks were notified by phone, in person, by use of the communication board, or through Smartlinx text on 7/8/24. They were provided with correct instructions on how to disinfect glucometers using PDI wipes	

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	355041	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 situation existed on 07/08/24 at 5:55 p.m. The IJ resulted from a staff member improperly cleaning a glucometer and attempting to use it with another resident. This finding placed residents in immediate danger due to the potential for exposure to bloodborne pathogens. *07/08/24 at 6:27 p.m., The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ. *07/09/24 at 9:44 a.m., The survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Immediate disinfection of all glucometers using an approved method (i.e., Sani-Cloths) *Ensured all residents requiring blood glucose checks (accuchecks) were assigned individual glucometers *Education provided to all staff who complete accuchecks on proper disinfecting process *07/09/24 at 10:04 a.m., The survey team verified the implementation of the removal plan as of 07/08/24 and the IJ removal. The deficient practice remained at a "D" scope and severity following the removal of the IJ. Findings include: Review of the manufacturer's instructions for the "Assure Prism" blood glucose meter (glucometer) identified, ". . . Cleaning and Disinfecting . . . The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of	F 880	as well as the expectation that residents have their own glucometers and are not shared between residents. The policy on Glucometer Cleaning and Disinfection was posted to the facility message board within point click care for all nursing staff to see (attachment 19). 2. All residents that have blood glucose testing have the potential to be affected. 3. Nursing staff education was provided through the "Communication to all Staff for Resident Overall Care Needs", document on 07/09/24, 07/16/24 & 07/23/24 on the proper steps on cleaning and disinfecting glucometers (attachment #9, #10, #20). On 7/17/24 education was provided at a Nursing staff meeting regarding the preliminary survey results. Nursing staff were educated again on the final survey results on 7/25/24. Education was provided during both meetings pertaining to the proper steps on cleaning and disinfecting glucometers and the expectation of each resident having their own glucometer to avoid the sharing of glucometers. Glucometer disinfecting observations were started immediately and continue. Education provided to nursing staff on 7/25/24 was recorded and sent to nursing and agency staff on 7/26/24 via smartlinx for those that could not attend the meeting. 4.The Director of Nursing or Designee(s) will conduct random audits of proper procedure of cleaning and disinfecting of	

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F 880	Continued From page 12 the meter and lancing device before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood-borne pathogens. The meter should be cleaned and disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed. . . . We have validated . . . PDI Super Sani-Cloth Germicidal Disposable Wipe for disinfecting the Assure Prism multi meter. . . . Only wipes with EPA [Environmental Protection Agency] registration numbers listed in the previous tables have been validated for use in cleaning and disinfecting the meter. . . ." The manufacturer's instructions did not list isopropyl alcohol wipes as an approved cleaner/disinfectant. - Observation on 07/08/24 at 4:06 p.m. showed a nurse (#4) checked Resident #8's blood sugar with a glucometer labeled with the resident's name. The nurse then cleaned the meter with an alcohol wipe and placed it back in the case. The nurse stated she normally used a Sani-Cloth to clean the meter but there were none in the cart, and each resident had their own individual glucometer. - Observation on 07/08/24 at 4:18 p.m. showed a nurse (#4) checked Resident #41's blood sugar with a glucometer labeled with the resident's name. The nurse then cleaned the meter with an alcohol wipe and placed it back in the case. - Observation on 07/08/24 at 4:27 p.m. showed a nurse (#4) attempted to check Resident #7's	F 880	glucometers following blood glucose checks. This will be done weekly X 4 weeks, every other week X 2 months, monthly X 3 months, and quarterly X 2 to assure proper procedure if followed. We will continue to evaluate for further monitoring an intervention if necessary.	

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F 880	Continued From page 13 blood sugar using Resident #8's glucometer. The nurse stated, "She's [Resident #7] not one we do routinely [check blood sugars], so we use someone else's [glucometer]." Observation showed the nurse took Resident #8's glucometer from the medication cart and attempted to enter Resident #7's room. The surveyor intervened and requested the nurse disinfect the glucometer with a Sani-Cloth. During an interview on the afternoon of 07/08/24, an administrative nurse (#1) stated she expected staff to clean glucometers with Sani-Cloths and not share meters between residents.	F 880		