STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105504	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion and Bernard L Samson Nursing Center	255 59th St N Saint Petersburg, FL 33710

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observation, interview and record review, the facility failed to maintain the dignity of one of one randomly observed resident (#39), who was not properly dressed in the hall way. The findings included: On 03/18/24 at 06:45 AM, when the survey team arrived on the second floor, Resident #39 was near the nurses station in her wheelchair and was wearing an incontinence brief on her lower body. She was holding a denture cup and said that her dentures were missing from the denture cup. There was no staff at the nurses station, but the resident was in direct line sight of a nurse down the hallway. There were four other residents also sitting in the TV room nearby. Resident #39 was originally admitted on [DATE] and readmitted on [DATE]. Her diagnoses included dementia and anxiety disorder. The most recent comprehensive resident assessment, the Minimum Data Set, Significant Change in Status assessment, dated 08/05/23 indicated that the resident had a Brief Interview for Mental Status score of 3, which meant she was severely cognitively impaired. The assessment also did not identify that the resident had any indicators of delirium. This assessment coded the resident as having mood indicators of trouble falling or staying asleep, or sleeping too much for 7 to 11 days; feeling tired or having little energy, 7 to 11 days. The assessment did not identify any resident behaviors. Review of Resident #39's care plan, revealed a care plan focusing on the resident having poor short term memory and requires verbal/physical cues to accomplish simple tasks. Presently Resident #39 requires verbal invitation to group activities that pertain to Resident #39's interest. Resident #39 shows signs of increased anxiety or agitation close to the sundown hours evidenced by wanting to find her mother, her care, going home and is very worried. Date initiated 07/11/18, created 07/11/18, and revised 04/01/23. Resident #39 also had a care plan focus for an ADL (Activity of Daily Living) self-care performance deficit, requires assist with ADL care, dementia, wheelchair for mobility, Hospice for end stage senile degeneration. Date initiated 01/18/19, created 07/30/18, and revised 08/07/23. The goal for this care plan focus stated, Resident #39 will be comfortable and have her dignity maintained through the review date. Date initiated 08/07/23, created 08/07/23, and revised 02/01/24 and 02/07/24. The target date for the goal was 05/07/24. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions for this care plan focus included: -As resident allows, remove dentures at bedtime. Place in Nurse Med Cart for safety. -Staff will assist with dressing as needed. -Staff will assist with oral care daily and as needed. -Staff will assist with personal hygiene daily and as needed. -Staff will assist with dressing as needed. -Staff will assist with oral care daily and as needed. -Staff will assist with personal hygiene daily and as needed. On 03/21/24 at 9:44 AM, the Nursing Home Administrator said that they had no policy on dignity. On 03/21/24 at 11:10 AM, during an interview with the Director of Nursing, she was informed about the observation of the resident as the survey team arrived at the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39866 Based on interview and record review, the facility failed to provide activities of daily living (ADL) related to incontinence care for two dependent residents (#123 and #98) out of three sampled residents. Findings included: 1. Review of Resident #123's Admission Record revealed she was admitted to the facility on [DATE] from an acute care hospital with medical diagnoses of quadriplegia, ataxia, muscle weakness, malignant neoplasm of an unspecified part of the bronchus or lung, and secondary malignant neoplasm of bone. An interview was conducted on 03/18/24 at 8:10 a.m. with Resident #123. She said for the last couple days only, she had not been changed as often. She said she should be changed at least once a shift but the 3:00 p.m. to 11:00 p.m. shift on 3/17/24 did not change her. She said she asked the 11:00 p.m. to 7:00 a.m. on 3/17/24 Certified Nursing Assistant (CNA) to change her when she came on shift, and she did. Resident #123 said she was not soaked thankfully. She said it happened one other time before that, but she could not remember the date or shift, but it was sometime within the last week. Resident #123 said the CNA was honest and said she forgot about me and that she was sorry. An interview was conducted on 3/19/24 at 9:48 a.m. with Resident #123 and she said she was not changed on the 11:00 p.m. to 7:00 a.m. shift last night (3/18/24). Review of Resident #123's Quarterly Minimum Data Set (MDS) dated [DATE] Section C, Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 out of 15 indicating the resident's cognition is intact. Section GG revealed Resident #123 is dependent for Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement . According to the Self Care Coding dependent means helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of section H, Urinary Continence revealed Resident #123 is always incontinent of urine and bowel. Review of Resident #123's Toileting Hygiene Certified Nursing Assistant (CNA) documentation revealed on 3/17/24 there was no documentation Resident #123 was provided incontinence care on the 3:00 p.m. to 11:00 p.m. shift. Review of the documentation on 3/18/24 and 3/19/24 revealed no documentation Resident #123 was provided incontinence care for the 11:00 p.m. to 7:00 a.m. shift. Review of Resident #123's care plan revised on 11/8/2023 revealed [Resident #123] has bowel and bladder incontinence r/t [related to] Activity Intolerance, Impaired Mobility, Physical limitations. The goals revealed, The resident will remain free from skin breakdown due to incontinence and brief use through the review date. and The resident's risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. The interventions included: Clean peri-area with each incontinence episode . (continued on next page)

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	105504	A. Building B. Wing	03/21/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/19/24 at 9:00 a.m. with the Assistant Nursing Home Administrator (ANHA)/Risk Manager (RM). She said herself and the Social Worker spoke with Resident #123 and the resident confirmed she was not changed on two separate shifts. The ANHA/RM said she reviewed the documentation and confirmed there was no documentation by the CNA Resident #123 was changed. 43453 2. During an observation of Resident #98 on 03/18/24 at 8:25 a.m., a private paid caregiver, Sitter A was observed in the room sitting by the resident's bed. Resident #98 stated he had sitters to help provide him with care. In an immediate interview, Sitter A stated she was an agency staff member who was employed by the resident's family to provide 1:1 care. She stated she provided this resident with all ADL (activities of Daily Living) care. She stated she worked with the resident 2-3 times a week. Sitter A stated Resident #98 was a 2-person assist and she was waiting for someone to help toilet the resident. On 03/18/24 9:56 a.m., Sitter A stated the resident was still waiting to be changed. She was heard saying, anybody . please help. Review of an admission record for Resident #98 showed the resident was admitted to the facility on [DATE] with diagnoses to include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, ataxia following cerebral infarction, dysarthria, aphasia, dysphagia and other diagnoses. A quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 12, indicating intact cognition. Section GG showed the resident was dependent for ADL's to include toileting hygiene, shower/bath, upper body dressing, lower body dressing, putting on or taking off footwear and personal hygiene. On 03/18/24 at 10:27 a.m., Sitter A was observed standing outside the resident's door looking around. She stated she was still waiting for assistance with toileting for the resident. She stated she had notified a staff member, Staff L, Licensed Practical Nurse (LPN)/Unit Manager. An interview was conducted on 03/18/24 at 11:01 a.m. with Staff L. She confirmed Sitter A came to her and asked for the aide assigned to that hall. Staff L said, Yes, she asked for assistance with toileting. I told her the aide was [Staff Z, Certified Nurse's Assistant (CNA)]. It was not that long ago. I did not check the time. It definitely was not 2 hours ago. Staff L stated she would have to follow-up. During an interview with Staff Z, CNA on 03/18/24 at 10:51 a.m., she stated this resident always had a sitter. She stated the sitter's responsibility was to provide ADL care for this resident. She said, the sitters normally ask for help if needed, but it depends on the sitter. The resident is a one person assist for toileting. She confirmed the private sitters provided care for Resident #98. (continued on next page)

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	105504	A. Building B. Wing	03/21/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/24 at 10:53 a.m., an interview was conducted with Staff AA, CNA. She stated Resident #98 had a private sitter hired by the family. She stated the sitter was supposed to provide all care. She stated the family hired private agency staff. She said, We don't have anything to do with them. They should be providing training for those CNA's regarding caring for this resident. This resident is a 2-person assist, he needs total care, but he can roll in bed and assist during changing. Staff AA stated she did not know the resident was waiting to receive care. She stated the sitter did not mention it. She stated Sitter A had just pulled the call light asking to get him transferred out of bed. Staff AA stated she was assigned to this resident and had assisted Sitter A transfer the resident out of bed. On 03/18/24 at 10:57 a.m., an interview was conducted with Staff W, Registered Nurse (RN). She stated she had not been notified that the resident had waited two hours to be toileted. She stated Sitter A came to her and asked what time the resident's appointment was. She said. She did not ask me about toileting. Many of the sitters that care for this resident do it independently. They only ask for help if transferring him. Review of a bowel and bladder elimination task log for this resident dated 03/08/24 to 03/21/24, showed there was no CNA documentation related to toileting all morning on 03/18/24. The review showed one incontinence documentation time stamped 1:27 p.m. There was no documentation for toileting between 03/17/24 at 4:29 p.m. and 03/18/24 at 1.27 p.m. Review of Resident #98's Care Plan dated 11/13/23 showed the resident was not care planned to receive ADL assistance from paid private care givers/sitters. The care plan showed an ADL focus indicating the resident has an ADL self-care performance deficit related to history of CVA with left hemiplegia, wounds on admission, non- ambulatory wheelchair user. Interventions included all staff to converse with resident while providing care, Invite the resident to scheduled activities. Offer a la carte activities such as books, magazines, cards, word puzzles, newspaper, or games. Provide with activities calendar. Notify resident of any changes to the calendar of activities. Review resident's activation needs with the family/representative. When the resident choose not to participate in organized activities, the resident prefers to watch television and visits for social and leisure activities. Assist with all ADLs as ordered/needed. Staff to assist with all ADL needs as necessary. On transfers, the resident requires assistance from staff, vanderlift x2 assist. Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use bell to call for assistance. The CNAs are to monitor/document/report PRN (as needed) any changes, any potential for improvement. reasons CNA for self-care deficit, expected course, and declines in function. A follow-up interview was conducted on 03/20/24 at 12:11 p.m. with the Director of Nursing (DON). The DON confirmed the facility CNA's were responsible for providing care, including toileting/changing, giving showers/baths, ultimately all care. She said, It is not our expectation that the sitters provide personal care. The DON said, We will provide education to the sitters and resident to utilize the call light. I will initiate education for our staff. They are responsible for all care. Staff E, Assistant NHA stated regarding the companion waiting for assistance, she did not use the call light. The resident is alert. He should have utilized the call light. I will investigate and initiate education. On 03/20/24 at 01:42 p.m., The NHA stated they did not have a policy on ADLS to include toileting.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01800 Based on observations, staff interviews, and medical record reviews, the facility failed to ensure that seven (#555, #28, #43, #87,#37, #58, and #96) seven randomly observed residents who received respiratory care, had their respiratory equipment (e.g., oxygen tubing, nebulizers) properly stored while not in use, and dates on the residents' oxygen tubing. The findings included: 1. On 03/18/24 at 12:25 p.m., Resident #555, who had pneumonia, was receiving oxygen via nasal cannula at 1.5 liters/minute according to the flow meter on the standard oxygen concentrator (a machine that uses room air to make oxygen for people who need supplemental oxygen). There was no date on oxygen tubing, so that the staff would know how long the tubing has been in use. Resident #555 current physician's orders included the following related to respiratory care: -Has/is the resident experienced shortness of breath while lying flat? If yes, please create a health status note stating shortness of breath while lying flat and any interventions put in place. every shift for monitoring, start date: 01/29/24 at 2300 hours (11:00 p.m.) , discontinued on 03/15/24 at 1636 hours (4:36 p.m.), and restarted 03/15/24 at 2300 hours (11:00 p.m.). -Take and record vital signs every shift, or at other frequencies, as needed. Start date: 03/15/24 at 2300 (11:00 p.m.). -Albuterol Sulfate (a medication used to treat wheezing and shortness of breath caused by breathing problems) Inhalation Nebulization Solution (a liquid medicine that turns into a fine mist to breathe in through a mask or mouthpiece) (2.5 mg/3 ml) 0.083% 1 vial inhale orally every 6 hours related to pneumonia, start date, 02/01/24 at 0600 hours (6:00 a.m.), discontinued on 03/15/24 at 1636 hours (4:36 p.m.). -Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 ml) 0.083%, 3 milliliters inhale orally every 6 hours as needed for shortness of breath/wheezing, start date, 03/15/24 at 2100 (9:00 p.m.) hours. -Mucinex Oral Tablet Extended Release 12 Hour 600 mg (Guaifenesin) (a cough medication that loosens congestion in the chest and throat), give 600 mg by mouth every 6 hours as needed for congestion/cough, start date on 03/15/24 at 2100 hours (9:00 p.m.) . There were no orders for oxygen administration. Review of Resident #555's March 2024 vital signs in the medical record, indicated Resident #555's oxygen saturation rates (the percentage of oxygen in a person's blood) ranged from 95 to 96% (normal range - 95% to 100), and the resident's respirations ranged from 17 to 18 breaths/minute (normal range - 12 to 20 breaths per minute). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was recently admitted on [DATE], and the most current Minimum Data Set, a Discharge Assessment, return not anticipated, dated 02/20/24 and OBRA (Omnibus Budget Reconciliation Act) Admission assessment dated [DATE] indicated no shortness of breath and no oxygen use. Resident #555 had a care plan for ineffective airway clearance, initiated and created on 03/15/24. The care plan goal was for Resident #555 to be free of respiratory distress, with a target date of 06/13/2024. The care plan interventions included: encourage use of incentive spirometer (a medical device that helps a person take slow deep breaths to prevent lung problems after surgery); evaluate capillary refill (a simple test used to evaluate blood circulation in peripheral tissue); evaluate for cough; evaluate for shortness of breath; evaluate lung sounds; evaluate pulse oximetry (measurement of blood oxygen levels); evaluate respiratory rate and effort; and head of the bed elevated. On 03/21/24 at 11:18 a.m., the Director of Nursing (DON) was interviewed and informed about Resident #555's oxygen tubing that was not dated. She confirmed in the resident's medical record that the resident was on oxygen via nasal cannula at 1.5 L/min. The DON stated that the nurse should have dated that [oxygen tubing]. 43453 During facility tours on 03/18/24 at 10:03 a.m., 03/19/24 at 2:05 p.m. and 03/20/24 at 10:11 a.m., observations were made of Resident #28's nebulizer and mask on top of a chair. The nebulizer was not in a bag. The nebulizer was observed exposed to the elements during three of three days of observations. Review of an admission record for Resident #28 revealed she was admitted to the facility on [DATE]. Review of physician orders for Resident #28 dated 03/21/24 showed there were no orders for the nebulizer machine, and it's use. During a facility tour on 03/20/24 at 10:04 a.m., an observation was made of Resident #43's oxygen tubing and nasal cannula placed on her wheelchair seat. The tubing and cannula were not stored in a bag. They were exposed to the elements. Review of physician orders for Resident #43 dated 03/21/24 showed Oxygen 2 liters via NC (nasal cannula) to keep saturation greater than 88% may use with humidifier as needed every shift for SOB (shortness of breath) dated 01/24/24. On 03/20/24 at 10:36 a.m., an interview was conducted with Staff L, Licensed Practical Nurse (LPN). She stated respiratory equipment should be secured in a bag to prevent contamination. It should be cleaned after each use, labeled, and stored in a bag. She stated the facility had a respiratory therapy team that did rounds and ensured equipment such as oxygen and nebulizers were stored appropriately. On 03/20/24 at 12:27 p.m., an interview was conducted with the Director of Nursing (DON). She stated respiratory equipment should be cleaned after each use and stored in a clean dated bag. The DON said, respiratory equipment should not be left exposed to the elements. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview was conducted on 03/20/24 at 1:54 p.m. the Assistant Director of Nursing (ADON) and the current Infection Preventionist (IP) and the former IP. The ADON/IP stated related to the facility's infection control practices, the respiratory team changes all tubing every Monday. She stated everything was to be stored in a plastic bag. She stated nebulizers were to be cleaned and air dried, stored in a bag that was labeled and dated. 48223 On 3/18/2024 at 7:44 a.m., Resident #87's nebulizer machine was observed on the bedside table. The tubing and mask were sitting on the machine, unbagged. (Photographic Evidence Obtained) On 3/18/2024 at 8:14 a.m., Resident #37's nebulizer machine was observed on the bedside table. The tubing and mask were lying on the floor, next to the bedside stand, unbagged. (Photographic Evidence Obtained) On 3/18/2024 at 8:35 a.m., Resident #58's nebulizer machine was observed on the bedside table. The tubing and mask were sitting on the machine, unbagged. (Photographic Evidence Obtained) On 3/18/2024 at 8:55 a.m., Resident #96's nebulizer machine was observed on the bedside table. The tubing and mask were sitting on the machine, unbagged. (Photographic Evidence Obtained) An interview was conducted with Staff K, Certified Nursing Assistant (CNA) on 3/19/2024 at 11:25 a.m Staff K stated the tubing and mask should be in a bag. An interview was conducted with Staff O, Registered Nurse (RN) on 3/20/2024 at 2:00 p.m Staff O stated nebulizer masks should be placed in a bag after use. Staff O validated that many on the floor were not in bags, review of photo confirmed they should be in bags and anyone could the mask place in bag. Staff O stated, you were too early, I noted the masks just after you had toured the unit. An interview was conducted with the Director of Nursing (DON) on 3/21/2024 at 10:24 a.m The DON stated, I expect the tubing to be changed, dated and bagged. The facility did not provide the requested policy and procedure for oxygen equipment storage prior to survey exit.