STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105564	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Nursing and Rehabilitation Center	7950 Lake Underhill Road Orlando, FL 32822

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Record Review (PASARR) was correct upon admission, corrected after admission, and/or referred for Level II PASARR if indicated for 3 of 5 residents reviewed for PASARR, of a total sample of 54 residents, (#19, #7 and #30). Findings: 1. Resident #19 was originally admitted to this facility on 9/15/11 with admission diagnoses of type 2 diabetes mellitus, Alzheimer's disease, anxiety disorder, hypertension, and alcoholic cirrhosis of liver. The medical record revealed resident #19's Level I PASARR dated 8/10/09 indicated the resident had no mental illness nor did it include the diagnoses of Alzheimer's disease or dementia. The resident face sheet, revealed additional diagnoses of other seizures dated 4/12/21, major depressive disorder dated 2/21/14, and unspecified psychosis dated 2/21/14 for this resident. No other Level I PASARR was found in the medical record to include these significant diagnoses. On 10/03/24 at 3:13 PM, the Director of Nursing (DON) verified the only PASARR in resident #19's medical record was dated 8/10/09 and its information did not accurately reflect the resident's diagnoses at the time of admission, nor had it been updated to reflect the added diagnoses. She stated the process for Level I PASARR is the hospital who sent the resident to the facility completed the PASARR and the facility's Admission Department uploaded it into the system and the clinical staff member who completed the admission reviewed the PASARR for completion and accuracy. The DON continued, if during the stay at the facility there was a change, for example a new diagnosis, the Minimum Data Set (MDS) Department staff would put any new diagnosis into the charting system and the PASARR should then be reviewed by the DON for any necessary changes. 45646 2. Resident #7 was admitted to the facility on [DATE] with diagnoses including displaced fracture of second cervical vertebra, fracture of right pubis, type 2 diabetes, dementia and seizures. Review of the MDS modified admission assessment with assessment reference date (ARD) of 7/17/24 revealed resident #7 had a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated she had moderate cognitive impairment. The document indicated her active diagnoses included depression and schizophrenia. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #21's electronic medical record (EMR) revealed a diagnosis of other schizophrenia and major depressive disorder with an onset date of 7/10/24. The record contained a Level I PASARR screening form dated 6/30/24 which did not indicate resident #7 had a mental illness (MI) or suspected MI diagnosis. The record did not contain a Level II PASARR screening form. 3. Resident #30 was admitted to the facility on [DATE] with diagnoses including chronic atrial fibrillation, cerebrovascular disease, other seizures and unspecified dementia. Review of the MDS quarterly assessment with ARD of 9/08/24 revealed resident #30 had a BIMS score of 8/15 which indicated he had moderate cognitive impairment. The document indicated his active diagnoses included anxiety disorder, depression and psychotic disorder. Review of resident #30's EMR revealed a diagnosis of major depressive disorder with an onset date of 12/07/22, generalized anxiety disorder with an onset date of 4/01/23 and psychotic disorder with delusions with an onset date of 6/06/23. The record contained a Level I PASARR screening form dated 10/18/22 which did not indicate resident #30 had a mental illness (MI) or suspected MI diagnosis. The record did not contain a Level II PASARR screening form. On 10/03/24 at 3:12 PM, the DON stated she was responsible for completing PASARRs. She clarified the hospital provided the initial PASARR upon resident admission to the facility. She explained the clinical team then reviewed the PASARR for completion and accuracy. The DON stated the PASARR was reviewed again if there were a change in the resident's status such as a new diagnosis. She reviewed the Level I PASARR and current diagnoses for residents #19, #7 and #30. The DON verified an updated Level I PASARR had not been completed for any of the identified residents nor were they referred for a Level II PASARR screening if indicated. The facility's policy and procedure for PASARR dated March 2021 indicated the facility would refer all residents with a newly evident or possible serious mental disorder, intellectual disability or a related condition for Level II resident review.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level II was completed and failed to provide a complete PASARR Level I for 2 of 5 residents reviewed for PASARR, of a total sample of 54 residents, (#71 and #86). Findings A PASARR is a federally mandated evaluation process per the Nursing Home Reform Act . A Level I Pre-Admission Screening is required for all applicants to Medicaid certified nursing facilities, regardless of payor. A Level II Evaluation and Determination must be completed prior to admission if a serious mental illness and /or intellectual disability or related condition is identified through the Level I screening. A Level II evaluation must also be completed when there is a significant change in the resident's physical or mental condition. (Retrieved on 10/07/24, from www.myflfamilies.com). 1. Review of resident #71's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses include paranoid schizophrenia, schizoaffective disorder, bipolar type, dementia, depression, and mood disorder. The resident's Level I PASARR form was dated 9/25/18, with diagnoses that included schizophrenia, and anxiety. Page five of the document indicated the resident could not be admitted to a nursing facility and should have a Level II completed because there was a diagnosis or suspicion of a serious mental illness. There was no Level II PASARR in the record and the facility was unable to provide a copy of the Level II PASARR. On 10/03/24 at 3:14 PM, the Director of Nursing (DON) stated the PASARR was completed by the hospital prior to the resident being admitted to the facility. She stated it should be present before the resident was admitted to the facility. The DON stated after admission to the facility she would only review the PASARR if the resident had a diagnosis change. She stated that the Minimum data Set (MDS) nurse input the new diagnosis into the record. She was not able to explain why resident #71 did not have a Level II PASARR. On 10/03/24 at 3:55 PM, the Director of MDS stated that in the morning meeting she discussed any resident who had a new diagnosis. The DON, Social Worker, Unit Managers and MDS staff attended the meeting, so they would all be aware of the new diagnosis. She stated the MDS department also looked at the PASARR when the resident was admitted . She was unable to explain why resident #71 did not have a Level II PASARR. 49840 2. Resident #86 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, schizophrenia, and psychosis. Review of the Quarterly MDS with assessment reference date of 8/22/24, revealed that resident #86 had a Brief Interview for Mental Status score of 11 out of 15, which indicated moderate cognitive impairment. He had diagnoses of psychotic disorder and schizophrenia that were being treated with antipsychotics. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #86's medical record, revealed a Level I PASARR dated 12/02/21 that was missing the diagnosis page and therefore was incomplete. Further review of the care plan for resident #86 showed he had behaviors such as hoarding and was being monitored for antipsychotic therapy. On 10/03/24 at 03:21 PM, the DON verified the Level I PASARR was incomplete in the electronic medical record, and she was unable to find the completed paper copy of the PASARR. She stated she was the person responsible for completing PASARRs and confirmed a new Level I PASARR should have been completed due to the resident's serious mental health conditions. Review of the Policy and Procedure for PASARR issued 3/21 read it was the policy of the facility to assure all residents admitted to the facility received a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations. The procedure included staff to incorporate the recommendations from the PASARR Level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. The procedure described staff should refer all Level II residents and all residents with newly evident or possible serious mental disorders, intellectual disability, or a related conditions for Level II resident review upon a significant change in status assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50401 Based on observation, interview and record review, the facility failed to obtain a physician's order to provide treatment to a non-pressure wound and failed to apply non-pressure wound treatments per professional standards for 1 of 1 resident reviewed for non pressure wounds, of a total sample of 54 residents, (#19). Findings: On 9/30/24 at 1:36 PM, resident #19 was observed being assisted with his lunch. There was an undated bandage on the resident's left arm near his elbow. On 9/30/24 at 2:10 PM, the Memory Lane Unit Manager (UM) verified the resident had an undated bandage and confirmed nurses should always date a wound dressing to allow staff to know when the dressing was applied. Review of the medical record on 9/30/24 revealed no physician orders for a wound treatment to resident #19's left arm. Review of the medical record on 10/01/24, revealed a new physician order was placed at 1:13 PM, for treatment to the skin tear to resident #19's left elbow. The order indicated staff should cleanse with normal saline, pat dry, apply triple antibiotic ointment and cover with non-adherent dressing every day shift. On 10/01/24 at 3:45 PM, the resident was observed in the day room wheeling his wheelchair to a table to work on a puzzle. On his left arm near the elbow, an undated white bandage was again observed. In interviews on 10/01/24 at 5:01 PM, and on 10/03/24 at 2:10 PM, the Director of Nursing (DON) was informed an undated dressing was observed on resident #19's left arm on 9/30/24 and again on 10/01/24. She acknowledged she was aware the resident's skin tear on his left arm did not have a physician's order for the treatment when it was initially observed and verified with the UM on 9/30/24. She confirmed the physician's order for treatment was not obtained until after it was observed by the surveyor. The DON stated she expected nurses who saw a skin tear or wound on a resident, would assess the wound and notify the physician for any treatment orders. She stated it was her expectation for nurses to follow physician's orders for wound care, and confirmed all dressings were to be dated when they were applied. The facility's Wound Care policy dated 4/20/20 described wound care procedures and treatments should be performed according to physician orders using proper wound care technique. The document detailed that nurses should then document in the clinical record when treatments were performed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview, and record review the facility failed to provide wound care to heel pressure ulcers/injuries per physician order and plan of care for 1 of 3 residents reviewed for pressure ulcers/injuries, of a total sample of 54 residents, (#48). Findings: Review of the medical record indicated resident #48 was admitted to the facility on [DATE] from acute care hospital with diagnoses including unstageable pressure wounds bilateral heels, dementia, muscle weakness, muscle wasting and atrophy. Unstageable pressure injuries are widely understood to be full-thickness pressure injuries in which the base is obscured by slough and/or eschar. Correct identification of these pressure injuries can be challenging among health care professionals and, although treatments vary .(Retrieved on 10/04/24 from www.pubmed.ncbi.nlm.nih.gov). The resident's five-day modification minimum data set assessment dated [DATE] indicated resident was moderately cognitively impaired, required partial to moderate assistance from staff with his toileting, bathing, dressing, bed mobility and he was always incontinent of urine and bowel. The resident was at risk for developing pressure ulcers and had a stage three pressure ulcer/injury present on admission as well as 4 unstageable facility acquired pressure wounds/injuries. The assessment indicated the skin and ulcer treatments that applied were pressure reducing device for bed/chair, nutrition or hydration intervention to manage skin problems and pressure ulcer care. A wound care observation was conducted on 10/02/24 at 2:25 PM, with the wound care nurse. The resident was pleasantly confused and lying in bed with his lower extremities elevated on pillows with his heels off the bed. The nurse explained to resident what he was doing regarding changing the dressings on his heel wounds. The nurse removed the soiled dressings from both heels and exposed wounds which were as per the wound physician documentation dated 10/01/24. The right heel measured 0.7 centimeters (cm) by 1.3 cm by unknown depth, wound appearance with 60% granulation (pink/red tissue), 40% slough (yellow dead tissue), and moderate amount of serous (clear, watery) drainage. The left heel measured 1.3 cm by 1 cm by unknown depth and had 50% granulation 30% slough, 20% connective tissue and moderate amount of serous drainage. The wound nurse performed hand hygiene and proceeded to clean the left heel wound with dermal wound cleanser, applied skin prep peri-wound, then a pea sized amount of Santyl (debriding wound ointment) to the wound bed and covered with border dressing. He performed hand hygiene, then proceeded to do the same procedure to the right heel. Review of the physician orders dated 8/27/24 for the right heel wound and 9/25/24 for the left heel wound read, Cleanse with NS [normal saline], pat dry, skin prep peri wound, apply Santyl-moist gauze to wound bed and cover with gauze and Abd [abdominal pad], wrap with Kerlix and secure with tape every day shift for wound and as needed for soiled/dislodges. The medical record contained a care plan for pressure injury wounds to bilateral heels dated 8/21/24 and listed an intervention for wound care as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 4:18 PM, an interview was conducted with the Director of Nursing (DON) and wound care nurse. The wound care nurse acknowledged he cleaned the heel wounds with dermal wound cleanser instead of normal saline and failed to apply Santyl moist gauze to wound bed or cover with gauze, Abd pad, and wrap with Kerlix as ordered by the physician. The wound nurse confirmed he did not check the physician orders prior to doing the resident's wound care and the DON said, the nurse must follow the orders when providing wound care. The DON verified it was best practice for nurses to bring a copy of the physician order for wound care into the room when performing wound care to ensure it was done as per the physician orders. Review of the facility policy and procedures for Wound Care issued 4/20 read, Wound care procedures and treatments should be performed according to physician orders .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35086 Based on observation, interview, and record review, the facility failed to administer oxygen (O2) therapy as ordered by the physician for 2 of 4 residents reviewed for respiratory care, of a total sample of 54 residents, (#36, #152). Findings: 1. Resident #36 was admitted to the facility on [DATE] from an acute care hospital. His diagnoses included metabolic encephalopathy, acute and chronic respiratory failure, pneumonia, heart failure and chronic obstructive pulmonary disease (COPD). Review of the medical record for resident #36 revealed (AHCA) Agency for Health Care Administration Form 5000-3008 form dated 9/06/24 with Treatment Devices for O2 2 L [liters] NC [nasal cannula] and a physician order dated 9/07/24 that read, Respiratory: Oxygen 2 L via NC continuous. On 10/01/24 at 9:55 AM, and later at 2:10 PM, resident #36 was observed lying in bed wearing a NC attached to the O2 concentrator set at 3.5 liters per minute (LPM). Review of resident #36's care plan initiated on 9/24/24 for altered respiratory status and difficulty breathing related to shortness of breath, obesity, congestive heart failure, sleep apnea, COPD, history of respiratory failure and pneumonia had goals that he would have no signs or symptoms of poor oxygen absorption, maintain normal breathing pattern and no complications related to shortness of breath. The interventions included to administer medications as ordered. Oxygen is a medication that requires a prescription from a healthcare provider. You should only use oxygen therapy as a medical treatment. If you take in more oxygen than your body needs, it can slow your breathing and heart rate to dangerous levels. Too much oxygen can lead to oxygen toxicity or oxygen poisoning . (Retrieved on 10/04/24 from https://my.clevelandclinic.org). On 10/01/24 at 2:12 PM, resident #36's nurse was at lunch and the [NAME] Unit Manager (UM) checked the medical record for the resident and confirmed he was supposed to get O2 at 2 LPM continuously. The unit manager then went into the resident's room and verified the oxygen concentrator was currently set at 3.5 LPM via NC. The UM then adjusted the O2 concentrator setting to 2 LPM. The UM verbalized the assigned nurse should check the settings every time they went into the resident's room to ensure they were getting the oxygen as ordered. On 10/01/24 at 5:03 PM, the Director of Nursing (DON) said the nurses were supposed to check the residents' oxygen settings at least once per shift and it was best practice to check it every time they went into the room. 50875 2. Resident #152 was admitted to the facility on [DATE]. His diagnoses included pulmonary fibrosis, COPD, asthma, respiratory failure with hypoxia, dependence on supplemental oxygen, type 2 diabetes mellitus and glaucoma. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set assessment with reference date 8/20/24, revealed resident #152 was cognitively intact, had no behaviors, nor refused care, and required the use of O2. The assessment indicated resident #152 required supervision with activities of daily living and used a wheelchair for mobility. Review of resident #152's physician orders for continuous O2 was 2 LPM via nasal cannula. Resident #152 had a baseline care plan for required use of O2 therapy and an ineffective breathing pattern care plan related to COPD, shortness of breath and wheezing. Interventions included Licensed Nurse to administer O2 as ordered. On 9/30/24 at 11:57 AM, resident #152 was observed in bed, alert and oriented. He wore a nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator showed it was set at 5 liters of oxygen per minute. Resident #152 stated he did not know how many liters of oxygen he needed nor the number the concentrator was set at. Resident #152 stated the machine did not work all the time and he thought it was set at 3 LPM. He explained he did not change the setting on the concentrator himself. On 9/30/24 at 1:41 PM, assigned Registered Nurse (RN) A, stated she verified the physician orders at the beginning of her shift but did not remember the amount of oxygen resident #152 received. RN A was accompanied to resident #152's room where she confirmed the flow rate on the oxygen concentrator was currently set at 5 LPM. A few minutes later, RN A was asked to verify the physician orders in the electronic record. She stated the physician's order was for 2 LPM of continuous O2. RN A confirmed resident #152 was not on the physician ordered flow rate of O2 and proceeded to resident #152's room to correct it. Upon exit of resident #152's room to the nurse's station, Licensed Practical Nurse (LPN) B, the UM for Sunflower, was informed of the situation and stated physician orders were verified per shift by the nurses to ensure residents received the correct amount of oxygen. On 10/01/24 at 5:06 PM, the DON stated for residents on oxygen, it was the responsibility of nurses to verify the orders and adjust the oxygen flow rates according to the physician orders at least once per shift. She confirmed resident #152's nurses should have validated the amount of O2 given per the physician order. She stated resident #152 monitored his O2 status and would have changed the flow rate, however, it was the responsibility of the nurses to have reeducated the resident and checked the concentrator more often than once per shift. On 10/02/24 at 9:40 AM, resident #152 was observed with O2 at 2 LPM with a nebulizer treatment running and stated he needed more air. LPN C assigned to resident #152, was made aware of the resident's statement of not getting enough air. The O2 tubing was connected to a new oxygen concentrator. On 10/02/24 at 12:14 PM, assigned LPN C stated she was aware the resident did not receive oxygen as prescribed on 9/30/24 and explained she always checked the concentrator and verified the flow rate with the physician order. She confirmed the resident felt as though he was not getting enough oxygen and spoke with the Nurse Practitioner about the resident's condition who said there was no need to increase the flow rate because resident #152's oxygen saturation was within normal limits. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Oxygen Administration Policy not dated revealed oxygen was administered to residents who need it consistent with professional standards of practice, the resident's care plan and the resident's choice. It also stated as part of the compliance guidelines that oxygen was administered under orders of a physician except in emergencies and once the situation was under control, orders for oxygen were obtained as soon as practicable.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 48878 Based on interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented timely and appropriate plans of action to prevent repeat deficient practices related to pre-admission screening and resident review (PASARR) and Quality of Care. Findings: Review of the facility's survey history revealed repeated concerns for accuracy of Level I PASARRs, referral for Level II PASARRs, obtaining of non-pressure wound care orders and application of dressings per professional practice during the last annual recertification survey from March 2023 and again during the current recertification survey. On 10/02/24 at 4:00 PM, the Administrator stated he had been working at the facility since April 2024 and was unaware of the previous recertification survey deficiencies due to the change of ownership. He confirmed the facility did not currently have any Performance Improvement Plans at that time for the areas of concerns regarding PASARRs and Quality of Care. The Administrator conveyed the QAPI process should address and or prevent the facility from having repeated deficiency concerns by instituting a plan of correction and ensuring it was followed consistently throughout the year. On 10/03/24 at 3:50 PM, a white notebook accessible to all visitors was located in the main lobby of the facility. Inside the notebook were the nursing home guide and the 2567 Statement of Deficiencies with the plan of corrections from the March 2023 recertification survey. Review of the facility Quality Assurance and Performance Improvement Plan date 6/10/21 read, The QA committee shall be interdisciplinary and shall develop and implement appropriate plans of action to correct identified quality deficiencies .and act on available data to make improvement .monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.

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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. 50401 Based on observation, interview, and record review, the facility failed to follow Contact Precautions for 1 of 3 residents reviewed for Transmission Based precautions, (#17), and failed to ensure use of a clean nasal canula for 1 of 4 residents reviewed for oxygen use, (#117), of a total sample of 54 residents. Findings: 1. On 10/01/24 at 2:10 PM, Certified Nursing Assistant (CNA) I was observed entering resident #17's room without performing hand hygiene and without the required personal protective equipment (PPE) . CNA I was then observed as he placed a food item on this resident's tray and left the room, going straight back to food cart to continue passing meals, again without performing hand hygiene. A sign on resident #17's door indicated the resident was on Contact Isolation and anyone entering the room should wear a gown and gloves and should perform hand hygiene. A few minutes later in the hallway CNA I stated he donned a gown and gloves earlier when he entered the room but acknowledged during three separate other trips into resident #17's room he had not worn the required PPE. CNA I explained he didn't have time to don gown and gloves for each visit and was unaware of why the resident was on Contact Precautions. He stated he got report when he started his shift but was not told about why the resident was on isolation. He stated he understood the importance of wearing the appropriate PPE with residents on Contact Isolation to prevent the spread of infection to other residents. On 10/01/24 at 5:17 PM, the Director of Nursing (DON) stated she expected staff to follow the Contact Precaution instructions listed on the residents' door. She added the CNA's were supposed to get report from the prior shift's CNA and the shift nurse regarding the needs of the residents for which they are caring for. She confirmed the CNAs had received education regarding infection control requirements and the wearing of PPE. 2. On 9/30/24 at 2:30 PM, resident #117's oxygen tubing and nasal canula were observed on the ground in his room with the Memory Lane Unit Manager (UM). The UM asked the resident why his oxygen tubing was on the ground, and the resident replied staff had left it there. The UM then asked the resident if he needed the oxygen on right now and he stated, No Ma'am, so the UM turned off the oxygen concentrator and left the dirty nasal canula and tubing on top of the oxygen concentrator machine, and left the room. On 10/01/24 at 5:17 PM, the DON confirmed oxygen tubing that had been on the floor should be promptly disposed of. She explained she expected staff who observed a nasal canula on the floor to throw it away so it would not be picked up and placed on the resident. The policy entitled, Transmission-Based (Isolation) precautions dated 2024 by The Compliance Store, LLC, revealed a facility who implemented the policy would provide signage with instructions and personal protective equipment (PPE) near the entrance of the resident's room.