STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056237	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace Convalescent Hospital	1240 S Hoover St Los Angeles, CA 90006

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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 - Some	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** 46843 Based on observation, interview, and record review the facility failed to ensure staff did not refer to two of three sampled residents (Residents 101 and 114) as feeders. Residents 101 and 114 required staff assistance with feeding. This deficient practice had the potential for lowered self esteem and depression (a prolonged feeling of sadness, hopelessness, or loss of interest in activities) for Residents 101 and 114. Findings: A review of Resident 114's admission record, indicated Resident 114 was admitted to the facility on [DATE], with diagnoses that included, adult failure to thrive, (AFTT - a complex decline in physical and mental health that can affect the elderly, causing weight loss, decreased appetite, dehydration, and social isolation), chronic obstructive pulmonary disease (COPD) (a lung disease that damages the lungs and makes breathing difficult), hypertension (HTN- High or raised blood pressure), muscle weakness (a lack of physical or muscle strength, throughout the body). A review of Resident 114's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/17/24, indicated Resident 114's cognition (the mental ability to make decisions of daily living) was severely impaired. The MDS indicated Resident 114 required substantial/maximal assistance with bed mobility, transfer, eating, toilet use and personal hygiene. During observation of Resident 114's lunch meal on 10/1/24 at 12:54 pm in Resident 114's room, Resident 114 was lying on his bed in an upright position and Licensed Vocational Nurse 3 (LVN 3) was assisting Restorative Nursing Assistant 2 (RNA 2) feed Resident 114. LVN 3 was encouraging the resident to eat the food. During an interview on 10/1/24 at 1:08 pm, LVN 3 stated Resident 114 eats lunch at the bedside because the resident is a feeder. LVN 3 stated that the feeder residents were part of the RNA feeding program. When asked why the residents that need assistance with feeding are called feeders, LVN 3 stated because the residents are on the RNA feeding list. (continued on next page)

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 - Some	During an interview on 10/1/24 at 1:22 pm, RNA 2 stated, that she was feeding Resident 114 because he is a feeder. RNA 2 stated that all feeders are brought to the dining room and put in one area so the residents can be fed. When asked why Resident 114 is called a feeder, RNA 2 stated because he is on the list to be fed. A review of Resident 101's admission record, indicated Resident 114 was admitted to the facility on [DATE], with diagnoses that included HTN and depression. A review of Resident 101's MDS, dated [DATE], indicated Resident 101's cognition was severely impaired. Resident 101 required substantial/maximal assistance with bed mobility, transfer, eating, toilet use and personal hygiene. During observation of Resident 101's lunch meal on 10/1/24 at 1:11 pm in Resident 101's room, Resident 101 was lying on bed in an upright position and Certified Nursing Assistant 1 (CNA 1) was feeding Resident 101 lunch. During an interview on 10/1/24 at 1:11 pm, CNA 1 stated Resident 101 is a feeder. When asked why CNA 1 called the residents feeders, CNA 1 stated because residents on RNA program are called feeders. CNA 1 stated the residents should not be called feeders because it is disrespectful to them and their family members. During an interview on 10/3/24 at 3:20 pm, RNA 1 stated that the residents that need feeding assistance should treated with respect. During an interview on 10/3/24 at 3:39 pm, the Director of Staff Development (DSD) stated that residents on RNA program are called feeders because they cannot eat independently. During an interview on 10/4/24 at 5:17 pm, the Director of Nursing (DON) stated residents that need of eating assistance should be respected and treated equal to all other residents. The DON stated, residents that need eating assistance should not be addressed as feeders because it is a matter of treating the residents with respect and maintaining their individual dignity during the aging process. During a record review of the facility's In-service lesson plan on Preserving Patient Dignity and Privacy dated 4/30/24 at 2:30 pm, indicated: II. Lesson Body 3. Respect & Dignity a. Every individual should be treated with courtesy and respect. Residents should be addressed with their proper names. You can call them by their first name when permission is given to do so. Never use Honey, Sweetie, or Gramps - they should never be treated like children. During a record review of the facility's policy and procedures (P&P) titled Dignity revised 2/2021, indicated, Policy Interpretation and Implementation. 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 5. When assisting with care, residents are supported in exercising their rights. For example, resident are: e. provided with a dignified dinning experience. 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46843 Based on interview and record review, the facility failed to ensure residents advance directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were complete and updated for three out of four sampled residents (Residents 189, 18 and 146) by failing to maintain an accurate and current copy of the resident's advance directives in the resident's clinical record. This failure resulted had the potential to cause conflict with Residents 189, 18 and 146 wishes regarding health care. Findings: 1. A review of Resident 189's admission record, indicated Resident 189 was admitted to the facility on [DATE], with diagnoses that included, chronic obstructive pulmonary disease (COPD - a lung disease that damages the lungs and makes breathing difficult), dementia (a condition characterized by progressive or persistent loss of intellectual functioning especially with loss of memory), hypertension (HTN - high or raised blood pressure), muscle weakness (a lack of physical or muscle strength, throughout the body). A review of Resident 189's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/8/24, indicated Resident 189's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) was severely impaired. The MDS indicated Resident 189 required supervision or touching assistance with bed mobility, transfer, eating, toilet use and personal hygiene. 2. A review of Resident 18's Admission Record indicated the resident was admitted to the facility on [DATE], with the diagnosis of, but not limited to, anxiety disorder, (restlessness, worried, tense or afraid of what may happen in the future), dementia, HTN, and muscle weakness. A review of Resident 18's MDS dated [DATE], indicated Resident 18's cognition was severely impaired and that was dependent on staff for most activities of daily living (ADL - they include bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating). 3. A review of Resident 146's Admission Record indicated the resident was admitted to the facility on [DATE], with the diagnosis of, but not limited to, dementia, HTN, and muscle. A review of Resident 146's MDS dated [DATE], indicated Resident 146's cognition was moderately impaired and required supervision or touching assistance with ADL including bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/3/24 at 0:06 am, the Social Services Director (SSD) stated that when a resident is unable to make life ending or medical decisions, the residen's representative will sign the acknowledgment for the advanced directive and not check the box. Once the resident representative signs the advance directive acknowledgment form, the SSD and the resident's physician wil sign the form. The SSD stated, if the form is not signed by the resident's representative it would be unclear as to the representative's wishes for the resident regarding end-of-life care. During record review on 10/04/24 11:06 am, Residents 189, 18 and 146 advance directive acknowledgment forms did not have the residents representative signature. During a review of the facility's policy and procedures titled Advance Directives undated, indicated, the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with the state law and facility policy. It further indicates prior to or upon admission of a resident, the social service director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directive.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44253 Based on observation, interview, and record review the facility failed to anchor the urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) per physicia's order for one of two sampled residents (Resident 14). This deficient practice had the possibility for Resident 14 to suffer and discomfort pain from potential pulling and dislodgement of the urinary catheter. Findings: A review of the Resident 14's admission record indicated Resident 14 was originally admitted the resident on 4/2/2008 and was readmitted the resident on 4/28/24 with diagnoses that included benign prostatic hyperplasia (BPH - enlargement of the prostate gland), obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from draining properly), and urinary retention (a condition in which urine does not empty completely from the bladder). A review of Resident 14's Physician Orders, dated 4/28/24 indicated to secure the urinary catheter tubing with anchor every day shift to minimize dislodging of catheter. A review of Resident 14's alteration in urinary elimination care plan, initiated 11/20/23, indicated Resident 14 was at risk for complications secondary to blood coming out from the indwelling urinary catheter due to BPH and urinary retention. The care plan goal indicated to empty the resident's bladder to empty adequately without complications. The care plan interventions indicated facility staff to monitor indwelling catheter and change catheter or bag as ordered, reposition for comfort and monitor skin for alteration and to provide urinary catheter care every shift or as ordered. A review of the Quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/29/24 indicated Resident 14's cognition (process of acquiring knowledge and understanding) was moderately impaired. The MDS indicated Resident 14 had indwelling catheter and that the resident required supervision or touching assistance with oral and toileting hygiene and upper body dressing. During a concurrent observation and interview on 10/3/24 at 2:03 PM at Resident 14's bedside, Resident 14's urinary catheter was not anchored/secured to the resident's leg to prevent excessive tension to the catheter. Resident 14 stated the urinary catheter used to be secured to his leg and had not been secured for the past two or three days. During a concurrent observation and interview on 10/3/24 at 2:09 PM with Treatment Nurse 1 (TN 1) inside Resident 14's room, Resident 14's urinary catheter was observed. TN1 stated Resident 14's catheter was not anchored/secured to the resident's leg or to the bed. TN 1 also stated the catheter should have an anchor in place to prevent dislodgement or tugging. TN 1 further stated TN 1 will replace Resident 14's anchor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/24 at 2:44 PM, the Director of Nursing (DON) stated staff should ensure a resident's urinary catheter should be anchored to the residents leg. The DON stated, the anchor is in place to ensure the catheter is in place, does not tug and does not cause pain. During a review of the Center for Disease Control and Prevention (CDC) guideline title, Indwelling Urinary Catheter Insertion and Maintenance, indicated one should use a catheter securement device to anchor the catheter and Catheter securement devices act as an anchor to prevent tugging and pulling which can cause irritation and inflammation. When catheters are not secured in male patients, the tugging and pulling can cause pressure sores on the penis tip. (https://www.cdc.gov/infection-control/media/pdfs/Strive-CAUTI104-508.pdf). During a review of the facility's policy and procedures titled, Procedure: Foley Catheter Maintenance, reviewed 5/21/24, indicated, the objective was to maintain a closed drainage system; to prevent bacterial contamination; to prevent backflow. Staff to change the catheter every month as needed or ordered by the physician. Catheter remains secured to reduce friction and movement at the insertion site.

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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** 44253 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of one sampled residents (Resident 142) by failing to label Resident 142's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) with date, time and initials per the facility's Policy: Oxygen Administration. This deficient practice had the potential to cause complications associated with oxygen therapy, including infection. Findings: A review of Resident 142's admission record indicated Resident 142 was originally admitted to the facility on [DATE] and readmitted the resident on 9/6/24 with diagnoses including dementia (a progressive state of decline in mental abilities), cerebral aneurysm (a balloonlike swelling in the wall of an artery in the brain), occlusion and stenosis of carotid artery (narrowing and blockage of arteries in the neck) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). A review of Resident 142's Quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/27/24, indicated Resident 142 had modified independence (some difficulty in new situations only) with their cognitive skills for daily decision making and required supervision or touching assistance with oral and toileting hygiene, showering, dressing and personal hygiene. A review of Resident 142's Physician Orders, dated 9/6/24, indicated the facility to administer oxygen at 2 liters per minute (lpm) via nasal cannula as needed for shortness of breath (SOB) to Resident 142. During an observation on 10/1/24 at 9:24 am, an undated and exposed to air nasal cannula was attached to Resident 142's oxygen concentrator. During a concurrent interview and observation on 10/3/24 at 8:17 AM at Resident 142's bedside, Resident 142's Family Member 1 (FM 1) stated the resident's urinal was attached to Resident 142's concentrator. During a concurrent interview and observation on 10/3/24 at 8:15 am inside Resident 142's room, Licensed Vocational Nurse 1 (LVN 1) stated Resident 142's oxygen tubing was not labeled with the resident's name and was not dated. LVN 1 was not able to state when the oxygen tubing was attached to the concentrator. LVN 1 also stated the oxygen tubing should be dated as it was an infection control issue which could lead to an respiratory infection. During an interview on 10/4/2024 at 2:42 PM, the Director of Nursing (DON) stated oxygen tubing is changed weekly. The DON stated the oxygen tubing should be labeled in order to know that it is clean and to know when to replace it in order to prevent infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Policy: Oxygen Administration, undated, indicated: -The oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer equipment, etc. When not in use, the oxygen tubing should be stored in a clean bag; for example, a Ziplock bag, etc. - The date, time and initials should be noted on oxygen equipment when it is initially used and when changed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when: 1.There were 13 small containers of previously prepared mixed fruits with a use by date of [DATE] expired and stored in the walk-in refrigerator. 2. Resident cups that were removed from the dish machine had red color stains and were stored to air dry on the racks. 3.Wet kitchen wiping cloths/towel were stored on the kitchen counters and were reused to clean and wipe food contact surfaces and food preparation equipment such as the stove, blenders, and food storage carts. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 195 out of 195 residents who received food from the facility. Findings: 1. During an observation in the kitchen on [DATE] at 9 am, there were 13 single containers of mixed fruits stored in the walk-in refrigerator with a date of [DATE]. During a concurrent interview with cook (cook1), cook1 stated the containers of mixed fruits was prepared to serve the residents on [DATE] and its now expired. Cook1 stated the containers of fruits should be discarded and cook1 removed the mixed fruits to discard. Cook1 stated it is important to follow the dates on the food, to make sure expired food is not served to residents because residents can get sick. During an interview with Dietary Supervisor (DS) on [DATE] at 10:35 am, DS stated food should be labeled and dated. DS stated the mixed fruit containers should be discarded following the use by date of [DATE] on the label to prevent expired food being served to residents. A review of facility policy titled Refrigerator/Freezer Storage (undated) indicated, No food item that is expired or beyond the best buy date are in stock .Leftovers will be covered, dated, labeled, and discarded within 72hours. 2. During an observation in the kitchen on [DATE] at 11 am, clean resident cups were stored on racks. One cup on the rack was observed with red color stains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with facility Registered Dietitian RD on [DATE] at 11 am, RD stated the cups are washed and disinfected, then they are stored on the racks for air drying. RD stated the red stain could be thickened cranberry juice stains. RD stated it should have been rewashed and not placed on racks for air drying. RD stated the cup is dirty and could cross contaminate resident beverage. During an interview with Dishwasher (DW) on [DATE] at 11:05 am, DW stated when the dishes are removed from the dish machine, they are checked for cleanliness and rewashed if there are still stains. DW stated this cup was missed during the checking process. A review of facility's policy and procedures (P&P) titled Dish washing Procedures-Dish Machine (undated) indicated, Remove gross particles by spraying, scraping and prerinsing in water, use appropriate chemicals to wash, sanitize, de-stain, and rinse dishes. A review of facility's (P&P) titled Sanitizing equipment and surfaces (undated) indicated, Dietary staff should ensure that all equipment, shelves, serving utensils, and surface areas are clean and in good condition. 3. During an observation in the kitchen on [DATE] at 10:15AM, Dietary Aide 2 (DA2) picked up a kitchen cloth that was on the counter. DA2 was using the kitchen wiping cloth/towel to wipe and clean the counter for food preparation. After DA2 was done with cleaning the counters, DA2 left the kitchen towel on the food preparation counter. During the same observation, DA4 picked up the same kitchen towel and started wiping surface of the food blender, and the counters. DA4 then left the kitchen towel on the counter. During an interview with DA2 on [DATE] at 10:30AM, DA2 stated the kitchen towels are soaked with sanitizer. The kitchen towels are to clean and disinfect the counters and equipment after food preparation. DA2 stated the towels are from a red bucket with sanitizer solution. DA2 stated the red bucket is on a rack around the corner from the preparation area and DA2 got it out of the bucket but did not return it. During a concurrent interview with DA2 and DA3 on [DATE] at 10:35AM, DA3 stated the kitchen towels should be returned and stored in the red bucket with sanitizer, but there is no red bucket with sanitizer solution in the food preparation area and the kitchen towels are left on the counters and reused. DA3 stated the kitchen towels are not clean and it is contaminating the counters. During an interview with DA1 on [DATE] at 10:40AM, DA1 stated DA1 assists the other Dietary aides and cooks and fills the red bucket with sanitizer solution. DA1 stated there should be a red bucket in the food preparation area to store the kitchen towels. DA1 stated the red bucket is filled with sanitizer solution and it is changed every two hours. During a concurrent observation and interview with RD on [DATE] at 10:45AM, Cook2 had a kitchen towel in his pocket and was using to wipe the stove. There was another towel stored on the food cart next to the steam stable. RD stated kitchen towels should be stored in the sanitizer solution when not in use and the sanitizer solution is changed every two hours to prevent cross contamination of the counters and kitchen equipment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedures titled Food Preparation (undated) indicated, Work surfaces are cleaned and sanitized after each use. (Red bucket is used for sanitizer). Wiping cloths are stored in an approved sanitizing solution and laundered daily. A review of the 2022 U.S. Food and Drug Administration Food Code, Code ,d+[DATE].14 Wiping Cloths, use Limitation, indicated, (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S ,d+[DATE].114; and (2) Laundered daily as specified under ,d+[DATE].11(D). (C) Cloths in-use for wiping surfaces in contact with raw animal FOODS shall be kept separate from cloths used for other purposes.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 38740 Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster areas was maintained in sanitary manner. One of two garbage dumpster was overfilled with cardboard boxes and uncovered. The floor area around the trash dumpsters was not clean, there was plastic utensils, gloves, plastic bags, disposable lunch tray and plates. This deficient practice had the potential for harborage and feeding of pests. Findings: During a concurrent observation and interview with Dietary Supervisor (DS) on 10/2/24 at 12 pm, there was one dumpster outside of the kitchen at the back exit that was not covered. The dumpster was overfilled with cardboard boxes and not covered. There was trash on the floor including plastic bags, Styrofoam cups, disposable paper trays, plates and paper including resident meal ticket (includes resident diet and food preferences). During a concurrent interview with DS and Maintenance Supervisor (MS), DS stated the cardboard boxes should be made flat so they can fit in the dumpster and lids can close. DS stated the trash company picks up trash every day. MS stated the housekeeping staff clean the trash on the floor everyday at 2 pm. MS stated the trash should always be covered and the trash cleaned from the floors to prevent flies and other pests from coming around the trash and then to the facility. During an interview with the facility Administrator (ADM) on 10/2/24 at 3 pm, ADM stated the trash should always be covered. ADM also stated facility will add locks on the trash to secure facility trash. During a review of the facility's policy and procedures titled, Food-Related Garbage and refuse Disposal (revised 10/2017) indicated, Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. During a review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056237	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace Convalescent Hospital	1240 S Hoover St Los Angeles, CA 90006

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to implement its infection control policy and procedures by failing to ensure a urinal (a contianer to pass/collect urine), was not hanging on the oxygen concentrator (is a medical device that gives extra oxygen) and did not touch the oxygen tubing for one of one sampled residents (Resident 142). These deficient practice had the potential for cross contamination and infection. Findings: A review of Resident 142's admission record indicated Resident 142 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), cerebral aneurysm (a balloonlike swelling in the wall of an artery in the brain), occlusion and stenosis of carotid artery (narrowing and blockage of arteries in the neck) and peripheral vascular disease (PVD - narrowing of the blood flow to the arms and legs). A review of Resident 142's Quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/27/24 indicated Resident 142 had modified independence (some difficulty in new situations only) with their cognitive skills for daily decision making and required supervision or touching assistance with oral and toileting hygiene, showering, dressing and personal hygiene. A review of Resident 142's Physician Orders, dated 9/6/24, indicated the facility to administer oxygen at 2 liters per minute (lpm) via nasal cannula as needed for shortness of breath (SOB) to Resident 142. During a concurrent interview and observation on 10/3/24 at 8:17 AM at Resident 142's bedside, Resident 142's Family Member 1 (FM 1) stated that Resident 142's urinal was attached to the resident's oxygen concentrator and was touching the oxygen nasal cannula. During a concurrent interview and observation on 10/3/24 at 8:15 AM inside Resident 142's room, Licensed Vocational Nurse 1 (LVN 1) stated Resident 142's urinal was hanging from the resident's oxygen concentrator and nasal cannula. LVN 1 stated the urinal should not touch Resident 142's oxygen tubing. LVN 1 also stated the urinal should not touch the concentrator and the oxygen tubing should be dated as it was an infection control issue and can lead to an respiratory infection. During an interview on 10/4/24 at 2:42 PM, the Director of Nursing (DON) stated urinals should not be attached to oxygen concentrator, it is also an infection control issue. A review of the facility's policy and procedures titled, Policies and Practices - Infection Control, reviewed 5/21/24, indicated it was the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.