STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165218	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Point Nursing and Rehabilitation	801 28th Avenue North Clinton, IA 52732

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 25855 Based on observation, record review, resident and staff interview, the facility failed to maintain a homelike environment for resident rooms for six out of six rooms reviewed. (Residents #5, #6, #31, #40, #45). The facility reported a census of 52 residents. Findings include: Observations of residents' rooms revealed the following: a. On 6/3/24 10:31 AM, Resident #5's bathroom door had approximately 40% of the paint missing from the bottom. Resident #5 reported the door to her bathroom looked that way since she moved in 3 years ago. In addition, the wall outside the door on the left side didn't have a baseboard. b. On 6/4/24 at 7:29 AM, Resident #40's bathroom door had splintering noted to bottom portion of the door. c. On 6/4/24 at 8:04 AM, Resident #45's bathroom door had paint missing to the lower portion, a baseboard missing to left side of the door, and corner covers peeled off with exposed plaster which measured approximately 4 feet in length. d. On 6/5/24 at 8:12 AM, Resident #6's bathroom door had paint missing to top portion of the door and the wall to right side of the bathroom door had an area without plaster which measured approximately 8 inches long and 2 inches wide with exposed metal. e. On 6/5/24 8:23 AM, Resident #31's wall to the right side of the bathroom door had approximately 6 inches of the baseboard peeling away from the wall. In an interview on 6/6/24 at 8:24 AM, the Maintenance Supervisor verbalized being the only staff member who worked in the Maintenance Department. He received problems that needed addressed through the company's software application. At the time of the interview, he explained he didn't have any repairs needed as everything is up to date. In addition, he made rounds around the facility rooms on a daily basis to see if any rooms needed repairs. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/6/24 at 12:09 PM, the Administrator explained the facility didn't have a policy related to informing Maintenance of room repair needs. He added, the facility used a software system to identify work tasks. The staff could enter the tasks requested through their electronic resident charting software. From there, the requested tasks go to the maintenance software system. At morning standup meetings, they give repair requests to the Maintenance Director. Sometimes, repair requests go through the use of text messages to the Maintenance Director. The Maintenance Director uses company software to complete weekly tasks and monthly maintenance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, and staff interview, the facility failed to identify resident problems and implement appropriate interventions on the Care Plans for four of four residents reviewed (Residents #13, #21, #31, and #34). The facility reported a census of 52 residents. Findings include: 1. Resident #13's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #13 required substantial/maximal staff assistance with dressing and required total assistance from staff with toilet use, showers, putting on and taking off footwear. In addition, the MDS also identified Resident #13 had an indwelling catheter and colostomy. The MDS included diagnoses of diabetes mellitus, paraplegia (paralysis of one half of the body) and arthritis. The Order Summary Report dated 6/4/24 included an order dated 12/28/22 for Ozempic (0.25 or 0.5 milligrams MG/dose) Solution Pen injector 2 MG/1.5 ml. Inject 0.25 MG subcutaneously in the evening every 7 day(s) for diabetes mellitus. The Care Plan lacked information related to Resident #13's diagnosis of diabetes mellitus and interventions. On 6/3/24 at 1:27 PM observed Resident #13 sit in his wheelchair in his room. He reported he lived at the facility for 6 years. He explained he had problems with diabetes and pressure ulcers. Resident #13 appeared well groomed, wearing clean clothing, wore gripper socks, appeared comfortable and looked properly positioned. On 6/4/24 at 2:40 PM, the Assistant Director of Nursing (ADON) reported Resident #13 had orders for Ozempic since 2022, however used Metformin (a medication also used to treat diabetes mellitus) long before 2022. 2. Resident #31's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive deficit. Resident #31 required substantial/maximal staff assistance with showers, lower body dressing and help with walking. The MDS also identified Resident #31 as totally dependent on staff to assist with toilet use, putting on footwear, taking off footwear, personal hygiene, and transfers. The MDS included diagnoses of coronary artery disease, diabetes mellitus and hip fracture. Resident #31's June 2024 Physician Orders and Medication Administration Record (MAR) included the following orders: a. 2/6/24: Eliquis Oral Tablet 5 MG. Give 5 MG by mouth two times a day for anticoagulant (blood thinner). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. 6/1/24: Metformin HCl ER Oral Tablet Extended Release 24-hour 500 MG. Give 1 tablet by mouth in the evening related to type 2 diabetes mellitus. Resident #31's Diagnoses Report reviewed 6/7/24 identified diagnoses of diabetes mellitus and atrial fibrillation (an abnormal heart rhythm which requires treatment with anticoagulants) with an onset date of 9/9/22. The Care Plan initiated 2/13/24 lacked the diagnosis of diabetes mellitus, the use of an anticoagulant, and interventions related to both. In an interview on 6/6/24 at 10:32 AM, Staff G, Licensed Practical Nurse (LPN), reported any nurse could update the Care Plans, however, the MDS Coordinator usually takes care of it. If a resident is Diabetic, she expected the Care Plan to address it and common interventions she expected to see on the Care Plan included: the use of parameters, the use of protein drinks, interventions to address low or high blood sugars, and the use of sliding scale. If a resident has orders for an anticoagulant, she expected the Care Plan to include that and interventions of an International Normalized Ratio (INR measures how long it takes the blood to clot), check for bruising, and bleeding. On 6/6/24 at 11:01 AM, the Director of Nursing reported any nurse can update the Care Plan, however, the MDS Coordinator is responsible for developing and updating the Care Plans. If a resident is Diabetic, she expected the Care Plan address their diagnosis and interventions related to the diagnosis such as accuchecks (blood glucose checks) according to orders, proper diet, skin assessments, and actions to take if signs of hypoglycemia or hyperglycemia. If a resident has orders for an anticoagulant, she expected the Care Plan to address it and common interventions such as monitor for bleeding, INR, and Prothrombin Time Test (PT measures how fast a blood sample can form a clot). 37072 3. Resident #34 Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #34 required partial/moderate staff assistance with showers, lower body dressing, and walking. The MDS included diagnoses of coronary artery disease, peripheral vascular disease and diabetes mellitus. A review of the June 2024 Physician Orders and Medication Administration Records revealed the following: a. 2/7/24 Eliquis Oral Tablet 5 MG Give 1/2 tab by mouth two times a day for Anticoagulant. b. 4/23/24 Glipizide (diabetic medication) 5 MG by mouth two times a day related to Type 2 diabetes mellitus. Resident #34 also has a physician order from 2/17/24 for Lispro Insulin to inject subcutaneous three times a day dependent on results of blood sugar. A review of the Facility Diagnoses Report identified Resident #34 with diagnoses of diabetes mellitus and Atrial Fibrillation (an abnormal heart rhythm which requires treatment with anticoagulants) on 2/7/24. The Care Plan initiated 12/26/23 failed to identify Resident #34 with the diagnosis of diabetes mellitus and the order for the anticoagulant and the appropriate interventions for both. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49976 4. Resident #21 Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 had a BIMS score of 13, indicating no cognitive impairment. The MDS included diagnoses of end stage renal disease, anemia, and diabetes mellitus. The MDS indicated Resident #21 received dialysis as a resident at the facility. The Dialysis Agreement form dated 6/5/22 reflected Resident #21 received dialysis 3 days per week. Resident #21's Care Plan dated 11/2/23 lacked information related to his dialysis.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 F 698 Dialysis SS=D Based on record review, resident and staff interview, and policy review the facility failed to conduct assessments of the dialysis access site and conduct post dialysis vitals for 1 of 1 resident reviewed (Res #21). The facility reported a census of 52 residents. Findings include: Resident #21 Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 had a BIMS score of 13, indicating no cognitive impairment. The MDS included diagnoses of end stage renal disease, anemia, and diabetes mellitus. The MDS indicated Resident #21 received dialysis as a resident at the facility. Resident #21's Care Plan dated 11/2/23 lacked information related to his dialysis. The Dialysis Agreement form dated 6/5/22 with the local health center documented the resident receives dialysis three days per week. Resident #21's electronic medical record lacked documentation of assessments of the access site pre and post dialysis or post dialysis vitals. The Dialysis Communication notes from 3/4/24 to 6/3/24 revealed no completion of Post Dialysis Vital Signs line on the facility section of the document. Resident #21's June 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked dialysis interventions for post dialysis vitals, access site assessment, pre-dialysis and post dialysis assessments. On 6/4/24 at 8:51 AM Resident #21 stated he received dialysis on Mondays, Wednesdays, and Fridays. He explained the dialysis center checked his vitals when he's there. The dialysis staff assess his access site, but not staff at the facility. On 6/4/24 at 3:15 PM Staff A, Licensed Practical Nurse (LPN), reported the two dialysis residents leave at 6 AM and come back around lunchtime. A communication book goes with the residents that have their name, morning vitals, and medications given. After they return, nursing checks Resident #21's blood sugars. The dialysis staff do the post vitals after dialysis and assess the access site; the facility staff didn't. On 6/4/24 at 3:29 PM the Director of Nursing (DON) explained the nurses at the facility didn't do the post dialysis vitals unless the dialysis center directs it on the form or via phone upon the resident's return. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Peritoneal Dialysis (Continuous Ambulatory) policy revised October 2010 failed to address the need for the facility to complete post dialysis vitals and to assess the access site pre and post dialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, family, and staff interview, the facility failed to document an assessment of a resident prior to their transfer to the hospital for 1 of 2 residents reviewed (Resident #6). The facility reported a census of 52 residents. Findings include: Resident #6 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severely impaired cognition. Resident #6 required total assistance from staff with most activities of daily living. The MDS included diagnoses of renal insufficiency (kidney failure), diabetes mellitus and non Alzheimer's dementia. On 6/3/24 at 10:03 AM witnessed Resident #6 sit in her recliner, awake, alert, and able to converse with the staff. Resident #6 denied pain, discomfort, or problems with cares. She looked properly positioned and comfortable. On 6/3/24 at 1:05 PM, Resident #6's family member reported Resident #6 got hospitalized in January 2024 due to influenza A. The Nurses Note dated 1/3/24 at 7:52 PM indicated the nurse spoke with Resident 6's son and informed him of Resident #6's decline that day with her poor fluid and meal intakes. The nurse could arouse Resident #6 with verbal and physical stimuli, but appeared sleepy that shift. Informed Resident #6's son of her urinary catheter placement related to urinary retention. In addition, the nurse collected a urine specimen, sent it to the lab, and received a new order for Levaquin 500 milligrams (MG) by mouth (PO) daily for 10 days. The Progress Note dated 1/4/24 at 5:08 AM reflected the emergency room (ER) nurse called to inform facility about Resident #6's admission to the hospital due to influenza A, pneumonia, and dehydration. The Daily Skilled Charting Note dated 1/7/24 at 9:38 PM indicated Resident #6 returned to the facility by ambulance following her hospitalization for influenza A, pneumonia, and minor urinary tract infection (UTI). The orders directed to continue the oral antibiotics at the facility for 4 days. The progress notes failed to document the assessment of Resident #6, when and why she went to the ER, mode of transportation, and physician orders to transfer to the emergency room . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 10:32 AM, Staff G, Licensed Practical Nurse (LPN), reported when a resident goes to the hospital, the nurse charts an assessment of when the resident began to show signs of any distress, actions I have taken, call to the doctor, mode of transportation to the hospital, notification of family. The nurse should chart the assessment within 24 hours. In addition, Staff G verified Resident #6's chart didn't have documentation to show an assessment, notification of physician, and family. The nurse should complete a transfer form in the computer on the face sheet page. Staff G verified Resident #6's clinical record had documentation of Resident #6's transfer to theER on [DATE], however, the clinical record didn't have documentation of an assessment. In an interview on 6/6/24 at 11:01 AM, the Director of Nursing reported when a resident goes to the hospital, she expected the nurse to chart in the progress notes the status change, notification of doctor, family, report, mode of transportation to the hospital, and a complete assessment. The nurse should document the assessment in the progress notes immediately. A form that documents Situation, Background, Assessment and Recommendation(SBAR) should also be completed and verified Resident #6's record did not have an SBAR prior to her hospitalization in January 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, record review, staff interview, and policy review the facility failed to specify and maintain appropriate water temperatures in order to prevent legionella growth or use appropriate personal protective equipment (PPE) when laundering contaminated items. In addition, the facility failed to use a barrier when emptying the catheter bag for 2 of 2 residents reviewed (Residents #13 and Res #32). The facility failed to utilize enhanced barrier precautions when completing wound care on 1 out 3 wound cares observed (Resident #44). The facility reported a census of 52 residents. Findings include: 1. On 6/5/24 at 9:03 AM watched Staff B, Laundry/Housekeeping, wear gloves, failed to wear a gown when transferring soiled linens from a red bin (contaminated items) to the washing machine. On 6/5/24 at 9:07 AM Staff B confirmed she only wore gloves for handling linens, she didn't wear a gown or mask with contaminated linens. They used to do that during the Covid 19 pandemic but not anymore. On 6/5/24 at 9:18 AM Staff C, Housekeeping Supervisor explained laundry staff only wear gloves to process contaminated linens or those from residents on isolation precautions. They do not wear a gown or mask. The facility policy titled Laundry Manual, undated, instructed staff to store, handle, and transport linens in a way that precludes cross contamination. 2. A review of the weekly water temperature logs dated 5/2/24 6/3/24 revealed the hallway boiler tested less than 140 degrees Fahrenheit (F) every week. On 6/5/24 at 9:32 AM the Administrator noted he couldn't answer what they do to prevent legionella in the facility. He explained the old maintenance man didn't leave anything behind and they could not find any documentation of testing. He reported they added filters to the ice making machine and did hot water testing weekly. They try to keep the outcoming water below 110 F to prevent burns. He verbalized he did not know why the boilers tested so high (138 F). Before the new maintenance man started he kept them at 120 F, the temperature before the water reached the mixing valve. The Legionella Water Management Plan policy, dated 2017 instructed staff to make sure hot water temperatures reach the right degree, but, failed to indicate what the right degrees are. 37072 3. Resident #32 Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #32 required substantial/maximal staff assistance with dressing and total assistance from staff with toilet use, and showers. The MDS also identified Resident #32 had an indwelling catheter. The MDS included diagnoses of hypertension (high blood pressure), diabetes mellitus and renal insufficiency (poor kidney function). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Care Plan initiated 2/25/23 identified Resident #32 had a urinary catheter due to pressure ulcer on buttock. The Care Plan intervention directed staff to provide catheter care and treatment per physician orders. On 6/5/24 at 8:24 AM observed Staff E, Certified Nurse Aide (CNA), empty Resident #32's catheter. She placed the cylinder on the floor without a barrier under it prior to draining the urinary catheter bag. 4. Resident #44 Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #44 required substantial/maximal staff assistance with dressing and total assistance from staff with toilet use and showers. The MDS included diagnoses of atrial fibrillation (a type of irregular heart rhythm), hypertension, heart failure and diabetes mellitus. The MDS indicated Resident #44 had an unhealed pressure ulcer. The Care Plan initiated 4/12/24 reflected Resident #44 had a pressure ulcer to their sacrum. The Care Plan directed staff to follow facility policies/protocols for the prevention/treatment of skin breakdown. On 6/5/24 at 10:10 AM watched Staff I, Registered Nurse (RN)/ Infection Preventionist, provide wound care to Resident # 44. Prior to entering room and during the entire wound care she failed to utilize any personal protective equipment or enhanced barrier precautions. On 6/6/24 at 9:23 AM Staff I stated they utilized enhanced barrier precautions (EBP) for open wounds, catheters, and anyone who had a history of multi resistant staph aureus (MRSA) or multi drug resistant organism (MDRO). The precautions staff should use catheters, gowns, gloves, and glasses. With open wounds, the staff need to wear a gown and gloves. Resident #44 should have when they provided their wound care. Staff I explained they removed the EBP for dressing changes because his wound healed, then he ended up in the hospital, and they reinstated his wound care. At the time he readmitted back to the facility, he should have had EBP, but they we didn't restart it. On 6/6/24 at 09:48 AM the Director of Nursing (DON) reported when a resident has a wound or catheter, that required care, expect with a chronic open wound, the staff need to gown up when providing wound care for EBP. The undated policy titled Enhanced Barrier Precautions instructed the facility to implement EBP for the prevention of transmission of multi-drug resistant organisms. The policy directed the staff to obtain an order for EBP for residents with the following: wounds, (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) even if the resident if the infection status is unknown or if they are colonized with a MDRO. 25855 5. Resident #13's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. Resident #13 required substantial/maximal staff assistance with dressing and required total assistance from staff with toilet use, showers, putting on and taking off footwear. In addition, the MDS also identified Resident #13 had an indwelling catheter and colostomy. The MDS included diagnoses of diabetes mellitus, paraplegia (paralysis of one half of the body), and arthritis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations of Resident #13 revealed the following: a. 6/4/24 at 8:08 AM Resident #13 sat up in bed eating breakfast. The urine collection bag and tubing laid on the floor. b. 6/4/24 at 8:15 AM assessment unchanged c. 6/4/24 at 8:30 AM assessment unchanged d. 6/4/24 at 8:45 AM assessment unchanged e. 6/4/24 at 9:00 AM the urine collection bag and tubing remained on the floor. f. 6/24/24 at 9:07 AM the Assistant Director of Nursing (ADON) entered the room to complete wound care and did not pick up the bag off the floor. g. 6/4/24 at 9:07 AM the ADON, Staff H, CNA, and Staff E, CNA, applied isolation gowns, gloves, and masks then entered the room. h. 6/4/24 at 9:09 AM Staff H, CNA, picked up the urine collection bag off the floor and hung it on to the bed frame. On 6/4/24 at 1:30 PM, witnessed Staff E, CNA, put on an isolation gown, gloves, and mask. Resident #13 sat in his wheelchair. Staff E failed to place a proper barrier underneath the graduate before she placed it directly on the floor and drained the urine collection bag. Additional observations: a. 6/5/24 at 7:16 AM Resident #13 sat eating breakfast. The urinary collection bag and tubing didn't touch the floor. b. 6/5/24 at 8:00 AM the urinary collection bag and tubing now on the floor. c. 6/5/24 at 8:15 AM Assessment unchanged d. 6/5/24 at 8:30 AM Assessment unchanged e. 6/5/21 at 9:07 AM Assessment unchanged The Care Plan Focus revised 2/26/24 indicated Resident #13 had a risk for medical complications due to the use of a colostomy (surgically made area in the stomach to allow the passage of stool) and urostomy (surgically made area in the stomach to allow the passage of urine). The Care Plan failed to address the need to keep the collection bag and tubing off the floor to prevent urinary tract infections. Resident #13's last collected Urinalysis dated 3/31/24 listed the white blood cell (WBC) count as TNTC too many to count. The results reflected they had a large amount of leucocyte esterase (which tests if a urinary tract infection is present) and many bacteria. (continued on next page)

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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 - Many	The Microbiology Report on the Urine dated 3/31/24 didn't identify the organism, only identified two antibiotics Trimethoprim/Sulfa as resistant and Tobramycin as susceptible. In an interview on 6/6/24 at 8:36 AM, Staff D, CNA, reported when they empty a urinary collection bag, they should put on all the personal protective equipment (PPE), put the barrier (such as a disposable chux or plastic bag) under the cylinder, then drain the urine into the cylinder. Staff D added the bag and tubing should never be on the floor. During her 5-day orientation at the facility, they explained the staff showed them how to empty catheter bags and completed a return demonstration afterward. In an interview on 6/6/24 8:51 AM, Staff E, CNA, explained when emptying a urinary collection bag, she should apply all the PPE, drain the bag into a graduate, wipe of the spout with an alcohol wipe, and return it to the holder. The bag and tubing should never be on the floor. She couldn't recall receiving infection control training from the facility. In an interview on 6/6/24 at 9:58 AM, Staff F, CNA, reported to empty a urinary collection bag, she should put on gloves, place a barrier such as a chux or plastic bag under the graduate, and drain the urine into the graduate. She only needed to wear the other PPE only if the resident has an infection. The bag and tubing should never be on the floor. The Infection Preventionist spent 3 days teaching her how to properly wash hands. She didn't receive any instruction about the enhanced barrier precautions. In an interview on 6/6/24 at 10:32 AM, Staff G, Licensed Practical Nurse (LPN), reported when emptying a urinary drainage bag, you should place a barrier such as a plastic bag or chux underneath the graduate and drain the urine into the graduate. The bag or tubing should never be on the floor. In an interview on 6/6/24 at 11:01 AM, the DON said when emptying a urinary drainage bag, they should place a barrier such as a plastic bag underneath the graduate and drain the urine into the graduate. The bag or tubing should never touch the floor.