

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Hickory Creek of Athens		STREET ADDRESS, CITY, STATE, ZIP CODE 51 East 4th Street The Plains, OH 45780	
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of on-call physician contact procedures, and staff interview, the facility failed to ensure a resident, who had a significant change in condition, received appropriate and timely consultation with the on-call advanced level provider for a transfer to the hospital for an evaluation. This affected one (Resident #36) of two residents reviewed for hospitalization. Actual Harm occurred when Resident #36 displayed a significant change in condition consistent with a cerebrovascular accident (CVA) and did not receive a timely transfer to the hospital for evaluation and treatment. Resident #36 suffered an ischemic stroke but could not be given tissue plasminogen activator (a medication used to break down blood clots) due to being outside the treatment window for optimal results. Resident #36 was hospitalized for several days before returning to the facility with residual effects from his stroke. The facility census was 78. Findings Include: Review of Resident #36's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included paranoid schizophrenia, chronic obstructive pulmonary disease, adult onset diabetes mellitus, congestive heart failure, and hypertension. Review of a quarterly Minimum Data Set (MDS) assessment, dated 03/03/25, revealed the resident had clear speech and minimal difficulty hearing. He was able to make himself understood and was able to understand others. His cognition was severely impaired. He was not known to have any functional limitations in his range of motion. Supervision or touching assistance was needed with bed mobility and transfers. Review of a physical therapy treatment encounter note dated 05/23/25 revealed Resident #36's physical therapy was focused on lifting a 10-pound kettlebell with a deadlift/ squat pattern to help increase his functional task performance. He had reports of increased fatigue in his bilateral lower extremities with deadlift/ squat activities requiring longer rest periods. They were also working on transfer training to improve reciprocal movement patterns. His functional status because of the skilled interventions indicated he was supervision or touching assistance for transfers. He was able to ambulate up to 10 feet with supervision or touching assistance and was able to wheel himself 50 feet with two turns only requiring supervision or touching assistance. He had reports of increased fatigue in his bilateral lower extremities with deadlift/ squat activities requiring longer rest periods but no mention of any weakness or limited mobility of his upper extremities. The therapy encounters notes did not indicate he had any problems with weakness or limited mobility of his upper extremities. Review of Resident #36's nursing progress notes revealed a nursing note dated 05/26/25 at 1:06 A.M. by Licensed Practical Nurse (LPN) #161 that documented the resident was up in his wheelchair and was assisted to the bathroom with the assistance of one staff. He had weakness in his right upper and lower extremities. The resident was unable to lift his right arm fully by himself. He was encouraged to elevate his right arm and not let it dangle while in his wheelchair. The resident was able to lift his right arm some without assistance but not more than halfway up the length of his body. He was able to stand on his right lower leg but when the staff were wheeling him in his wheelchair, he was dragging his right leg. The resident was offered snacks and was continued to be confused off and on, trying to suck ice cream out of a spoon like it was a straw. The on-call physician was paged at that time to update him on the resident's change in condition. Review of a neurological assessment flow (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365589
		If continuation sheet Page 1 of 7

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F 0684 Level of Harm - Actual harm Residents Affected - Few	sheet revealed the facility's nurses were obtaining neurological assessments on Resident #36 beginning on 05/25/25 at 6:45 P.M. At this time Resident #36 was alert and oriented times three (person, place, time) and had no abnormal findings noted. The neurological assessment that was completed on 05/26/25 at 1:30 A.M. revealed the resident remained alert and oriented times three but had some confusion and weakness to the right arm and leg. Review of a nursing note dated 05/26/25 at 1:34 A.M. documented LPN #161 paged the on-call physician again to update him on Resident #36's change in condition. Review of a nursing note dated 05/26/25 at 2:18 A.M. revealed LPN #161 left a message for Resident #36's legal guardian with instructions to call back into the facility to give an update on the resident's status. The nurse also attempted to contact the on-call physician again to update him of the resident's change in condition. Resident #36 continued to have weakness in his right upper arm. Review of a nursing note dated 05/26/25 at 2:32 A.M. documented LPN #161 received a return call from Resident #36's legal guardian and was able to update her on the resident's change in condition. The guardian requested the resident to be sent to the local emergency room (ER) for evaluation of his right sided weakness. The nurse discussed in detail the resident's history and code status (full code). Resident #36 was made aware of the guardian wanting him sent to the emergency room for an evaluation. 911 was called and report was called to the local emergency room (ER) regarding the resident's condition. Review of a nursing note dated 05/26/25 at 3:10 A.M. by LPN #161 revealed Emergency Medical Services (EMS) personnel were onsite to transport Resident #36 to the ER. The resident was transferred to the gurney with the assist of three and all paperwork was sent with resident at that time. Review of a nursing note dated 05/26/25 at 7:13 A.M. revealed LPN #161 called the ER at that time for an update. Resident #36 was being transported to the ER's main hospital for symptoms of a stroke. The resident was on a Heparin drip (medication given intravenously that acts like a blood thinner and was used to prevent or treat blood clots) at this time. The resident's legal guardian was updated at that time. Review of Resident #36's hospital records revealed an ER note dated 05/26/25 at 3:53 A.M. that documented the resident with multiple comorbidities presented to the ER via EMS from a skilled nursing facility for an evaluation of a fall and possible stroke. The resident was reported to have had an unwitnessed fall on 05/25/25 at around 6:00 P.M. The nursing report indicated the resident did strike his head and the nurses were continuing to do neurological exams. Around 1:00 A.M. they noticed the resident began having deficits. He complained of a headache and stated he had weakness in his right arm and leg. His physical exam in the ER showed he did have marked weakness in the right arm and leg. The nursing staff at the ER did reach out to the facility's nurse to further elaborate on the resident's last known well check. It was very unclear when the symptoms began. The initial report was 1:00 A.M. when they noticed the neurological deficit, however, a separate report indicated that he potentially was having issues at 11:00 P.M. with grasp of the right hand. The ER physician consulted with a stroke neurologist, who agreed with the current workup. It was recommended to transfer the resident, if a computed tomography angiography (CTA) was abnormal or admission to the hospital for further stroke workup. The CTA impression was that there was no acute intracranial abnormalities, no hemorrhage or mass effects, and no pathological enhancement. The intracranial and extracranial vessels demonstrated no flow-limiting stenosis, thromboses, dissection, or large vessel occlusion. If there was concern for an acute infarction (stroke), then Magnetic Resonance Imaging (MRI) imaging would be more sensitive. His disposition, after the ER visit, was to be admitted as an in-patient stay in the hospital. Review of Resident #36's hospital history and physical dated 05/26/25 at 1:13 P.M. revealed the resident had a past medical history of seizure disorder, hypertension, hyponatremia (low sodium level), schizophrenia, depression, insomnia, constipation, and dysphagia. He presented with right arm/ leg weakness, difficulty moving and walking, and chest pain. The resident was admitted for a cerebrovascular accident (CVA)/ transient ischemic attack (TIA) and not a candidate for tissue plasminogen activator (TPA) due to being outside the treatment window. He had a sudden onset of right arm weakness and difficulty moving and walking for greater than six hours prior to arrival at ER on [DATE]. The ER consulted (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	with teleneurology and it was deemed he was not a candidate for TPA. A neuro-exam with the RUE and RLE revealed weakness (worse in the RUE). CTA of the brain showed no acute findings and a brain MRI was ordered. Review of a neurology consult completed on 05/27/25 at 9:35 A.M. revealed Resident #36 was referred to neurology for a stroke. He had an MRI of his brain completed on 05/26/25 that revealed an acute left corona radiata ischemic infarction (stroke). Ischemic stroke was listed as his acute problem. He started on Aspirin 81 milligrams (mg) daily for three weeks and Plavix 75 mg indefinitely for secondary stroke prevention. Review of Resident #36's MRI of his brain that was obtained on 05/26/25 revealed there was an abnormal hyperintense signal and diffusion restriction along the left corona radiata consistent with acute to subacute lacunar infarction measuring 9 millimeters (mm) in diameter. The impression of the MRI was that the resident had an acute to subacute lacunar infarction along the left corona radiata measuring 9 mm. Review of Resident #36's hospital Discharge summary dated [DATE] at 4:34 P.M. revealed he was being discharged back to the skilled nursing facility in stable condition following a hospital admission that began on 05/26/25 at 10:15 A.M. He was diagnosed with an ischemic stroke and his acute problems also included dysphagia (difficulty swallowing), dysarthria (slurred speech), and right hemiparesis (weakness of the right upper and lower extremities). He was to take Aspirin 81 mg daily for three weeks and was also started on Plavix (an anti-platelet) 75 mg by mouth daily. Review of a nursing note dated 05/28/25 at 6:55 P.M. revealed Resident #36 returned to the facility. He arrived via stretcher with two EMS personnel and was transferred into the bed in his room. During an interview on 08/07/25 at 9:47 A.M., Corporate Nurse #122 stated Resident #36's physician took his own off-hour calls. She denied they used an on-call service for any emergent needs from an advanced level provider off-hours. The physician had a physician's assistant that was also available to be on call. If the physician was going to be out of town or on vacation, he would inform the facility of the name of the physician covering for him in his absence. During an interview on 08/07/25 at 9:55 A.M., LPN #161 stated she was the nurse that worked the evening of 05/26/25, when Resident #36 had a change in condition, requiring a transfer to the hospital. She recalled she had sent him out to the hospital but was not clear on the exact date of that transfer. She confirmed Resident #36 did have a change in condition that night, and she attempted to notify the physician and the resident's legal guardian. She had a hard time getting the physician and guardian to answer. The resident's vital signs were stable, but with his change in condition she wanted to notify them. She stated Resident #36 had weakness in his right arm and was having difficulty being able to fully move his right arm. She felt, with the symptoms he was displaying, the resident may have had a stroke. She stated it could also have been a sign of him having had a heart attack, a urinary tract infection, or an unknown injury. The resident was lifting his right upper arm but not per his baseline. She stated the nurses had a number to contact Resident #36's physician during the off-hours. Prompts were given when calling that number to specify if the call was an urgent call or a non-urgent call. They then received another prompt to indicate who they were trying to contact (physician, physician assistant, or the nurse). She stated she identified the call as an urgent call and left her name and number in which to be reached. She called multiple times for the physician to call her back but never did get a response from him. The only call back that she received was the one she placed to the resident's guardian. She stated she has had a problem with reaching that physician during the evening hours in the past. There were some nights he would not bother to call back at all. She denied that she attempted to contact the physician's assistant with any follow-up calls despite not being able to reach the physician. She confirmed she could have reached out to the physician's assistant at that same number as she knew there was a prompt to indicate the urgent call was for him. She did not think of reaching out to the physician's assistant and just waited to hear back from the physician or the resident's guardian on what they wanted them to do. She further confirmed it was about 30 minutes, after she contacted 911, that the EMS arrived. They only used 911 when needing to send a resident out and the county's EMS service could be dispatched from several different locations. It was typical for it to take EMS 15 (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to 30 minutes to arrive when calling for transport. She followed up with the ER later that morning and was told that the resident had been transferred to the ER's main hospital and was being admitted . She denied the resident was complaining of chest pain when in the facility. Her assessment of the resident was negative other than the weakness he had in his RUE. He has had some weakness in the past but was not rebounding as he normally would. She denied the resident had slurred speech or facial drooping. It did cross her mind to go ahead and send the resident out when they could not reach the physician. She discussed it with the house supervisor and had the house supervisor assess the resident also. She wanted the house supervisor to assess the resident as her assessment was basically negative, with the exception of the weakness, and his weakness was not all the time. They decided since his assessment was relatively negative and his vital signs were stable, they would wait to hear back from the guardian and to follow what she wanted to do about the resident's change in condition. She reported the guardian was a little hesitant to send him out at first but then decided to go ahead and send him out just to be safe.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to provide proper justification for the use of medication for dementia. This affected one, (Resident #3) of five residents reviewed for unnecessary medications. The census was 78. Findings Include: Resident #3 was admitted to the facility on [DATE]. His diagnoses were acute kidney failure, chronic obstructive pulmonary disease (COPD), type II diabetes, morbid obesity, muscle weakness, chronic respiratory failure, dysphagia, congestive heart failure, schizoaffective disorder, atrial fibrillation, anemia, anxiety disorder, anemia, acute embolism and thrombosis, osteoarthritis, mild cognitive impairment, hyperlipidemia, peripheral vascular disease, and hernia. Review of his minimum data set (MDS) assessment, dated 06/30/25, revealed he was cognitively intact. Review of Resident #3's current physician orders found he was prescribed the following medications for dementia: Olanzapine (antipsychotic) 5 milligrams (mg) and Namenda (used to treat dementia) 10 mg twice daily. Review of Resident #3's current diagnoses, dated 08/06/25, found he did not have a diagnosis of dementia. Review of Resident #3's psychological notes, dated 10/09/23, revealed during a dementia screening, he had dementia symptoms, but there was no diagnosis of dementia given. Review of Resident #3 psychological notes, dated 04/28/25, revealed no diagnosis of dementia. The notes listed he was prescribed Namenda for dementia, but there was no justification for the use of Namenda due to not having a diagnosis of dementia. Review of Resident #3's Pre-admission Screening and Resident Review (PASRR) documents, dated 04/10/25 and 08/06/25, revealed under section Section D: Medical Diagnoses, it indicated that Resident #3 did not have dementia. Review of Resident #3 current care plan, dated 08/05/25, revealed no care plan for dementia or dementia care. Interview with Corporate Nurse #122 on 08/07/25 at 2:00 P.M. confirmed they can not find when dementia was added to resident's diagnoses or his care. She confirmed Resident #3 has two medications for the diagnosis of dementia, but they can not provide documentation to support the justification for the use.		

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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** Based on record review, observation, staff interview, and facility policy review, the facility failed to ensure indwelling urinary catheter care was provided in accordance with acceptable infection control practices to prevent infections. The facility also failed to ensure a resident's indwelling urinary catheter's collection bag was maintained off the floor to help prevent infection. This affected one, (Resident #5) of two residents reviewed for indwelling urinary catheters. The facility census was 78. Findings include: Review of Resident #5's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included neuromuscular dysfunction of the bladder, benign prostatic hyperplasia with lower urinary tract symptoms, and urinary retention. Review of Resident #5's physician's orders revealed he had an order in place for the use of an 18 French indwelling urinary catheter with 10 milliliter (ml) balloon related to obstructive uropathy. The orders also included the need to perform catheter care every shift. His antibiotic history report under the discontinued physician's orders revealed he had been on antibiotics as recent as 06/20/25 through 06/29/25, when he received Zerbaxa (Ceftolozane Sulfate-Tazobactam Sodium) Intravenous solution reconstituted 1.5 (1-0.5) Grams (GM) with directions to use 3 grams over 60 minutes intravenously every eight hours for sepsis, urinary tract infection (UTI), and bacteremia for a total of 20 administrations. Review of Resident #5's active care plans revealed he had a care plan in place for being at risk for an alteration in elimination related to a history of UTI's, use of an indwelling urinary catheter, and urinary retention. The care plan had been initiated on 06/28/23. The goal was for the resident to be clean, dry, and odor free. The interventions included the need to provide catheter care every shift and as needed (prn) and to monitor the resident for signs and symptoms of a UTI. It did not indicate to maintain the catheter's collection bag off the floor only to ensure it was maintained below the level of the bladder to prevent backflow. On 08/05/25 at 10:35 A.M., Resident #5 was observed lying in bed in a supine position with the head of bed elevated. He had his eyes closed. His indwelling urinary catheter's collection bag was lying on the floor next to the left side of his bed. It did not have a cover bag and only had a vinyl cover bag in front of the collection bag for dignity purposes. The back of the collection bag was in direct contact with the resident's tiled floor. 08/05/25 at 11:45 A.M., Resident #5 was observed sitting up on the side of his bed eating his lunch. His indwelling urinary catheter's collection bag was still resting on the floor, but was more underneath the bed than the side of the bed that it was observed to be at earlier. On 08/05/25 at 11:46 A.M., an interview with Resident #5, at the time of the observation, revealed he had not been up out of bed, since the prior observation was made on 08/05/25 at 10:35 A.M. He stated the last time he had been up and out of bed was about two hours ago. He confirmed staff had brought his lunch in to him (between the two observations made) and failed to secure his indwelling urinary catheter's collection bag to the side of the bed to maintain it off the floor. He confirmed he has had problems with UTI's in the past. On 08/05/25 at 11:55 A.M., an interview Licensed Practical Nurse (LPN) #145 confirmed Resident #5 did have the use of an indwelling urinary catheter and was known to have UTI's in the past. He was asked to go to the resident's room to verify his indwelling urinary catheter's collection bag was resting in direct contact with the floor. He responded to the room and noted the catheter's collection bag to be on the floor under the resident's bed. He stated it had clips on it and should be secured to the side of the bed hanging from the bed frame. He noted the resident's urine in the indwelling urinary catheter's tubing to be cloudy, which could be indicative of a UTI. He asked the resident if he was having any problems related to his catheter and he indicated he was having some pressure in his bladder area. He indicated he would have to update the physician to see if they wanted to check the resident for a UTI. He acknowledged the catheter's collection bag should be maintained off the floor for infection control purposes. He secured it to the bed frame using the clips raising it off the floor. He acknowledged a staff member had been in the resident's room to deliver the resident's lunch tray to him and did not raise the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter's collection bag off the floor. On 08/05/25 at 2:35 P.M., catheter care was observed being provided to Resident #5, after consent was obtained from the resident permitting it to be observed. The catheter care was being provided by Certified Nursing Assistant (CNA) #203 and she was assisted by LPN #165. CNA #203 was the one who washed the resident's groin, penis, and catheter tubing before rinsing and drying those areas in the same fashion. She dropped the wash cloths that she was using to wash and rinse the resident's penis and catheter tubing directly onto his floor at the bedside. She did not have a plastic bag to place the used, soiled wash cloths in and simply turned away from the resident by twisting at the waist and dropping the soiled wash cloths from her gloved hands onto the tiled floor. Findings were confirmed with CNA #203. On 08/05/25 at 2:41 P.M., an interview with CNA #203 confirmed she did not set out any plastic bags to use to properly dispose of her used wash cloths and towel after use. She further confirmed she threw the used wash cloths and towel directly onto the floor, which was an infection control concern. She was asked if she was the aide that delivered Resident #5's lunch tray to him earlier that day and confirmed that she was. She reported she did observe Resident #5's indwelling urinary catheter's collection bag to be lying on his floor. She denied she attempted to secure it off the floor when she seen it lying on the floor. She was the only one passing trays at the time and did not want to stop passing the trays to the other residents to take care of Resident #5's catheter bag being on the floor. Review of the facility's policy on Use of Indwelling Urinary Catheters dated 03/07/15 revealed for a resident with an indwelling urinary catheter, the facility staff were to use appropriate infection control practices regarding hand washing, catheter care, tubing, and the collection bag. They were to identify potential evidence of symptomatic UTI's or other related changes in the urine condition, such as onset of bloody urine, cloudiness, or oliguria. Catheters must be anchored to avoid excessive tugging on the catheter during transfers and the delivery of care to prevent inadvertent catheter removal or tissue injury from a dislodged catheter.		