STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455510	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	8020 Blanco Rd San Antonio, TX 78216

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 5 residents (Resident #1 and #2) reviewed for care plans:1. The facility failed to ensure Resident #1's care plan reflected the resident's family members had been instructed/educated regarding the requirement that resident care be provided by facility staff rather than by family members.2. The facility failed to ensure Resident #2's care plan reflected he had been assessed to safely self-administer medications.These deficient practices could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services.The findings included:1. Record review of Resident #1's face sheet dated 5/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included respiratory failure, morbid/severe obesity, urinary tract infection, and tracheostomy status (surgical procedure in which an opening is made in the front of the neck into the trachea [windpipe] to help a person breathe).Record review of Resident #1's Order Summary Report dated 5/14/26 reflected the following:- has indwelling (urinary) catheter indicated for neurogenic bladder (condition in which the bladder does not function normally because of problems with the nerves that control urination) order date 5/13/26 and no end date- monitor and record catheter output every shift with order date 5/8/26 and no end date- position catheter privacy bag and tubing below level of bladder every shift with order date 5/8/26 and no end dateRecord review of Resident #1's care plan with initiation date 5/11/26 reflected there was no focus, goal, or intervention that included family members had been instructed/educated regarding the requirement that resident care be provided by facility staff rather than by family members. During an interview on 5/14/26 at 12:37 p.m., Resident #1 was observed in the room and two family members at the bedside. Resident #1 stated he was admitted to the facility a week ago. Resident #1 was observed with an indwelling urinary catheter and sitting up in a wheelchair. Resident #1's family member stated she had been having to help the resident to the bathroom because nobody will come. During an interview on 5/14/26 at 1:07 p.m., RN B stated he had several discussions and provided education to Resident #1 and his family members about providing care to the resident. RN B stated, Resident #1's family member had requested disposable wipes and when asked why, the family member told RN B the wipes were needed to clean him. RN B stated he had educated the family not to provide care to Resident #1 and to call us for help.During an observation and interview on 5/15/26 at 8:52 a.m., Resident #1's family member was observed walking out of the resident's room and obtained a pair of gloves from the box mounted on the wall outside of the resident's room. Resident #1's family member stated he needed a pair of gloves because he had assisted Resident #1 to the bathroom and needed to put on gloves to clean him. RN B approached the State Surveyor and Resident #1's family member at the same time and stated he had educated Resident #1 and the resident's family members on numerous occasions regarding this (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior. During an interview on 5/15/26 at 11:40 a.m., the DON stated, she did not know Resident #1 well but was aware the resident's family members were at the resident's bedside all the time. The DON stated she was made aware of the resident's family members providing care to the resident a day earlier because RN B reported the behavior to her. The DON stated, it was a concern because there were safety concerns since the family members were providing care to Resident #1. The DON stated, as soon as a problem was identified, and if the family members were provided with education or any kind of feedback, the staff should be documenting it as soon as it happened. The DON stated RN B would be capable of revising or adding that problem to Resident #1's care plan and document that education was provided to the resident and the family members. During a follow up interview on 5/15/26 at 12:04 p.m., RN B stated he had worked with Resident #1 from the time of his admission on [DATE] and stated the family is almost always here and the resident's room is always packed with family. RN B stated the family members are not supposed to assist Resident #1 to get up because they did not know the strength of the resident, and the family members should be calling staff because the resident could have a fall or hit his head. RN B stated Resident #1's family member asked for disposable wipes that same morning and had educated the family about asking for help and they had acknowledged that they understood. RN B stated, the family members assisting the resident without asking for help has been since day one. RN B stated he had never put information in a care plan and believed management and the DON developed the care plan. RN B stated, if a behavior was exhibited consistently then it should be reported to the DON and the behavior would then need to be care planned. RN B stated he had not documented or kept a record of having had the discussion or education with Resident #1 and family members on what they are doing, but I will make it a point to document it today. 2. Record review of Resident #2's face sheet dated 5/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included factitious disorder imposed on self with combined psychological and physical signs and symptoms, need for assistance with personal care, muscle weakness, and obsessive-compulsive disorder.Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and only required set-up or clean-up assistance with ADL's and mobility.Record review of Resident #2's comprehensive care plan with revision date 2/25/26 did not reflect the resident was able to self-administer medications.Record review of Resident #2's Self Administration of Medication Evaluation with effective date 7/3/25 and authored by LVN D reflected the resident was capable of independent self-administration of medications and the physician's orders stated the resident may self-administer. Record review of Resident #2's Order Details document dated 4/24/26 and time stamped 1:41 p.m. prescribed by the NP reflected the following:- Permethrin cream 5%, apply to body topically one time only; apply on body, neck down and leave on for 8 hours for 1 day and repeat in 7 daysRecord review of Resident #2's Order Summary Report dated 5/14/26 reflected there was no order that indicated the resident could self-administer medications.During an observation and interview on 5/14/26 at 9:07 a.m., Resident #2 stated he overheard of an outbreak of scabies in the facility and several residents were treated. Resident #2 walked over to the vanity in his room, opened the drawer and took out a tube of Permethrin 5% cream with the pharmacy label attached to it with the resident's name on it. Resident #2 stated an unidentified nursing staff provided him with the cream 3 weeks ago and applied the cream to his hands. Resident #2 stated he only applied the cream to his hands once and kept the tube. Resident #2 stated he was the most cognitive and most alert resident and was waiting for the doctor to approve being allowed to self-administer medications. During an interview on 5/14/26 at 10:12 a.m., the DON stated she had been employed at the facility since February 2026, and since that time there were no residents in the facility who had been assessed to self-administer medications, and she did not have any residents who requested to self-administer medications. The DON stated, per her expectation, that for a resident who wanted to self-administer medications, there would have to be an assessment, and if appropriate to self-administer, a physician's order, and it would have to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be care planned. The DON stated she was not aware Resident #2 had been assessed to self-administer medications and the resident had never asked to be allowed to self-administer medications. During an interview on 5/15/26 at 8:52 a.m., RN C stated she was not aware of any of the residents in the facility who had been assessed and allowed to self-administer medications. RN C stated, if a resident had been assessed and determined to be able to safely self-administer medication, then an order would have to be obtained, and it absolutely, it should be care planned. During an interview on 5/15/26 at 10:00 a.m., the ADON stated she was aware there was an assessment involved that determined if a resident was able to self-administer medications. The ADON stated in addition to an assessment, the nurse would have to obtain orders for the residents to self-administer medications and it would have to be included in the care plan. The ADON stated, the care plan was important because it helped the staff know that the resident had the ability to safely self-administer medications. The ADON stated, care plans were revised by herself and the DON.During an interview on 5/15/26 at 10:21 a.m., LVN D stated she completed the Self Administration of Medication Evaluation with effective date 7/3/25 for Resident #2. LVN D stated the assessment was done during July 2025, because Resident #2 had requested to go out on pass and the resident wanted to take his medications with him. LVN D stated, Resident #2 was hospitalized shortly after that, so LVN D did not obtain a physician's order or update the care plan to reflect the resident could self-administer medications. LVN D stated, since Resident #2 often complained of symptoms and had been diagnosed with fictitious disorder, which made the resident focus on an illness he really didn't have, the resident would probably not be capable of self-administering medications. During an interview on 5/15/26 at 10:48 a.m., the Treatment Nurse stated, to determine if a resident was able to safely self-administer medications it would require an assessment, a physician's order and it would have to be care planned. The Treatment Nurse stated, everything needs to be care planned because it showed the resident was able to self-administer medications and she believed the care plan would be revised by the DON, but not sure.Record review of the facility document titled Comprehensive Care Plans with implementation date 2/2025 reflected in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.The comprehensive care plan will describe, at a minimum, the following.The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 1 of 5 Residents (Resident #2) reviewed for medication storage:The facility failed to ensure Resident #2 did not have a tube of Permethrin 5% cream (a topical medication used to treat scabies; a contagious skin condition caused by tiny mites that burrow into the skin) inside a drawer in the resident's vanity.This deficient practice could affect residents who received medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion.The findings included:Record review of Resident #2's face sheet dated 5/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included factitious disorder imposed on self with combined psychological and physical signs and symptoms (mental health diagnosis in which a person intentionally exaggerates, falsifies, or causes both physical and psychological symptoms in themselves, even though there is no obvious external reward such as money, avoiding work, or legal benefit), need for assistance with personal care, muscle weakness, and obsessive-compulsive disorder.Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and only required set-up or clean-up assistance with ADL's and mobility.Record review of Resident #2's comprehensive care plan with revision date 2/25/26 did not reflect the resident was able to self-administer medications.Record review of Resident #2's Self Administration of Medication Evaluation with effective date 7/3/25 and authored by LVN D reflected the resident was capable of independent self-administration of medications and the physician's orders stated the resident may self-administer. Record review of Resident #2's Order Details document dated 4/24/26 and time stamped 1:41 p.m. prescribed by the NP reflected the following:- Permethrin cream 5%, apply to body topically one time only; apply on body, neck down and leave on for 8 hours for 1 day and repeat in 7 daysRecord review of Resident #2's Order Summary Report dated 5/14/26 reflected there was no order that indicated the resident could self-administer medications.During an observation and interview on 5/14/26 at 9:07 a.m., Resident #2 stated he overheard of an outbreak of scabies in the facility and several residents were treated. Resident #2 walked over to the vanity in his room, opened the drawer and took out a tube of Permethrin 5% cream with the pharmacy label attached to it with the resident's name on it. Resident #2 stated an unidentified nursing staff provided him with the cream 3 weeks ago and applied the cream to his hands. Resident #2 stated he only applied the cream to his hands once and kept the tube. Resident #2 stated he was the most cognitive and most alert resident and was waiting for the doctor to approve being allowed to self-administer medications. During an interview on 5/14/26 at 10:12 a.m., the DON stated she had been employed at the facility since February 2026, and since that time there were no residents in the facility who had been assessed to self-administer medications, and she did not have any residents who requested to self-administer medications. The DON stated, per her expectation, that for a resident who wanted to self-administer medications, there would have to be an assessment, and if appropriate to self-administer, a physician's order, and it would have to be care planned. The DON stated, medications could not be left with the resident because there could be a risk of somebody else having access to the medication and it could be used inappropriately, or it could be a risk for injury or adverse effects. The DON stated, Resident #2 was treated for scabies prophylactically at the resident's request because of his factitious disorder diagnosis which caused him to hyperfocus on a symptom or condition and would insist on treatment even when he didn't have an illness. The DON stated she was not aware Resident #2 had been assessed to self-administer (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and had never asked to be allowed to self-administer medications. During a telephone interview on 5/15/26 at 8:52 a.m., RN C stated she had been employed by the facility for 2 months and since that time did not have any residents in the facility who had physician's orders to self-administer medications. RN C stated she was aware Resident #2 had been prescribed Permethrin 5% cream used to treat scabies because the resident kept telling her about it. RN C stated she had seen the box of the Permethrin 5% cream in the medication cart, but tube was not in the box. RN C stated she recalled when the Permethrin 5% cream was delivered by the pharmacy and recalled the cream was applied to Resident #2 by another nurse but could not recall which nurse. RN C stated she believed the DON and the Administrator, as well as the nurse would have to know if a resident was cognitive and able to self-administer medications. RN C stated, for a resident to self-administer medications there would need to be an assessment, a physician's order, and it should be care planned. During an interview on 5/15/26 at 10:00 a.m., the ADON stated she had been employed by the facility as the ADON for the past 3 months. The ADON stated she had not done an assessment on residents in the facility to self-administer medications and was not aware of any residents in the facility who were allowed to self-administer medications. The ADON stated she was aware of an assessment to self-administer medications and if a resident was able to self-administer medications, then there should also be a physician's order. The ADON stated if a resident was determined to be able to self-medicate then she and the DON would have to revise the care plan. During an interview on 5/15/26 at 10:21 a.m., LVN D stated she completed the Self Administration of Medication Evaluation with effective date 7/3/25 for Resident #2. LVN D stated the assessment was done during July 2025, because Resident #2 had requested to go out on pass and the resident wanted to take his medications with him. LVN D stated, Resident #2 was hospitalized shortly after that, so LVN D did not obtain a physician's order or update the care plan to reflect the resident could self-administer medications. LVN D stated, since Resident #2 often complained of symptoms and had been diagnosed with fictitious disorder, which made the resident focus on an illness he really didn't have, the resident would probably not be capable of self-administering medications. During an interview on 5/15/26 at 10:48 a.m., the LVN Treatment Nurse stated, Resident #2 was convinced he had scabies and an order was obtained to treat him prophylactically. The LVN Treatment Nurse stated, Resident #2 had eczema on his hands but the resident was not allowed to have medications in his possession as there were no residents in the facility, including Resident #2 who had been cleared to self-administer medications. The LVN Treatment Nurse stated, for residents who were allowed to self-administer there should be an assessment, physician's orders, and the ability to self-administer medications would have to be care planned. If the resident was allowed to have medications in their possession, the facility would have to provide a lock box in the resident's room, and the resident would have to demonstrate he or she could lock the medications. Record review of the facility document titled Resident Self-Administration of Medication with revision date 5/2026 reflected in part, .It is the policy of this facility to support each resident's right to self-administer medications. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.Resident's preference will be documented on the appropriate form and placed in the medical record.The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is maintained in the resident's medical record.Record review of the facility document titled Medication Administration with revision date 5/7/25 reflected in part, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Record review of the facility document titled Medication Storage with revision date 6/15/25 reflected in part, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	security.All drugs and biologicals will be stored in locked compartments.Only authorized personnel will have access to the keys to locked compartments.medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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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 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** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #2) reviewed for accuracy of records:The facility failed to ensure nursing staff documented Resident #2 had been assessed to self-administer medications.This failure could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment.The findings included:Record review of Resident #2's face sheet dated 5/14/26 reflected a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included factitious disorder imposed on self with combined psychological and physical signs and symptoms (mental health diagnosis in which a person intentionally exaggerates, falsifies, or causes both physical and psychological symptoms in themselves, even though there is no obvious external reward such as money, avoiding work, or legal benefit), need for assistance with personal care, muscle weakness, and obsessive-compulsive disorder.Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and only required set-up or clean-up assistance with ADL's and mobility.Record review of Resident #2's comprehensive care plan with revision date 2/25/26 did not reflect the resident was able to self-administer medications.Record review of Resident #2's Self Administration of Medication Evaluation with effective date 7/3/25 and authored by LVN D reflected the resident was capable of independent self-administration of medications and the physician's orders stated the resident may self-administer. Record review of Resident #2's Order Details document dated 4/14/26 and time stamped 1:41 p.m. prescribed by the NP reflected the following:- Permethrin cream 5%, apply to body topically one time only; apply on body, neck down and leave on for 8 hours for 1 day and repeat in 7 daysRecord review of Resident #2's Order Summary Report dated 5/14/26 reflected there was no order that indicated the resident could self-administer medications.During an observation and interview on 5/14/26 at 9:07 a.m., Resident #2 stated he overheard of an outbreak of scabies in the facility and several residents were treated. Resident #2 walked over to the vanity in his room, opened the drawer and took out a tube of Permethrin 5% cream with the pharmacy label attached to it with the resident's name on it. Resident #2 stated an unidentified nursing staff provided him with the cream 3 weeks ago and applied the cream to his hands. Resident #2 stated he only applied the cream to his hands once and kept the tube. Resident #2 stated he was the most cognitive and most alert resident and was waiting for the doctor to approve being allowed to self-administer medications. During an interview on 5/14/26 at 10:12 a.m., the DON stated she had been employed at the facility since February 2026, and since that time there were no residents in the facility who had been assessed to self-administer medications, and she did not have any residents who requested to self-administer medications. The DON stated, per her expectation, that for a resident who wanted to self-administer medications, there would have to be an assessment, and if appropriate to self-administer, a physician's order, and it would have to be care planned. The DON stated she was not aware Resident #2 had been assessed to self-administer medications and the resident had never asked to be allowed to self-administer medications. During an interview on 5/15/26 at 10:21 a.m., LVN D stated she completed the Self Administration of Medication Evaluation with effective date 7/3/25 for Resident #2. LVN D stated the assessment was done during July 2025, because Resident #2 had requested to go out on pass and the resident wanted to take his medications with him. LVN D stated, Resident #2 was hospitalized shortly after that, so LVN D did not obtain a physician's order or update the care plan to reflect the resident could self-administer medications. LVN D stated, since Resident #2 often complained of symptoms and had been diagnosed with fictitious disorder, which made the resident focus on an illness he really didn't have, the resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would probably not be capable of self-administering medications. Record review of the facility document titled Resident Self-Administration of Medication with revision date 5/2026 reflected in part, .It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.Resident's preference will be documented on the appropriate form and placed in the medical record.The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment, which is maintained in the resident's medical record.Record review of the facility document titled Documentation in Medical Record with implementation date 4/2026 reflected in part, .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 4 residents (Resident #1) reviewed for infection control:The facility failed to ensure Resident #1's indwelling urinary catheter tubing was not touching the floor. This failure could place residents at risk of infection due to improper care practices.The findings included:Record review of Resident #1's face sheet dated 5/14/26 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure, diabetes, urinary tract infection, heart failure, and tracheostomy status (a surgical procedure where a doctor makes an opening in front of the neck into the trachea [windpipe] to help a person breathe).Record review of Resident #1's Order Summary Report dated 5/14/26 reflected the following:- Change catheter drainage bag monthly and as needed for leaking or malfunction with order date 5/8/26 and no end date.- urinary catheter care every shift and as needed, cleanse with soap and water or peri-wash as needed with order date 5/8/26 and no end date.-Position urinary catheter privacy bag and tubing below level of the bladder with order date 5/8/26 and no end date.-Enhanced Barrier Precautions related to indwelling medical device; urinary catheter every shift with order date 5/8/26 and no end date.Record review of Resident #1's comprehensive care plan dated 5/11/26 did not address the resident's use of a urinary indwelling catheter.Record review of Resident #1's Clinical admission document with effective date 5/8/26 reflected the resident utilized a urinary catheter. During an observation on 5/14/26 at 12:37 p.m., Resident #1 was seen sitting up in a wheelchair, and the indwelling urinary catheter was draining via gravity on the resident's left side, and the tubing was touching the floor. Resident #1's indwelling urinary catheter tubing was touching the floor in front of the resident's feet and between his bedside table. Resident #1's family member was at the bedside and stated she had been having to help the resident to the bathroom because nobody will come. Resident #1 did not or would not answer the State Surveyor's questions regarding the urinary indwelling catheter.During an observation and interview on 5/14/26 at 12:54 p.m., CNA A stated he often worked the same unit Resident #1 resided on and made rounds of the resident at least every two hours. CNA A stated he and the charge nurse for the unit were responsible for the care of the urinary indwelling catheter. CNA A observed Resident #1's indwelling urinary catheter tubing touching the floor and stated it should not be touching the floor because it was cross contamination and an infection control issue. CNA A stated that the indwelling urinary catheter tubing observed between the resident's feet and the bedside table could potentially get tangled in the bedside tables wheels or the tubing could get stepped on which could cause injury to the resident. During an observation and interview on 5/14/26 at 1:07 p.m., RN B observed Resident #1's indwelling urinary catheter touching the floor between the resident's feet and the bedside table and stated the tubing should not be touching the floor because it was an infection control issue and could result in the resident developing an infection. RN B stated Resident #1 could also fall and trip on the indwelling urinary catheter tubing or the catheter could dislodge if stepped on. During an interview on 5/15/26 at 11:40 a.m., the DON stated, ensuring the indwelling urinary catheter bags and tubing were not touching the floor because keeping those items off the floor was considered an infection control standard of care and to maintain a closed drainage system and prevent infection. Record review of the facility document titled Catheter Care dated 11/25/25 reflected in part, .It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.