STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Health and Rehabilitation Center	688 Kingsborough Square Chesapeake, VA 23320

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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 - Few	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** Based on staff interview and clinical record review, the facility staff failed to maintain dignity by not providing appropriate grooming or clothing before a scheduled outside appointment for 1 of 70 residents (Resident #88), in the survey sample.The findings included: Resident #88 was originally admitted to the facility on [DATE]. The current diagnoses included; Type 2 Diabetes Mellitus with diabetic chronic kidney disease, anemia, heart failure, and peripheral vascular disease.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/16/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were moderately impaired.A synopsis of an event dated 4/22/26 revealed that Resident #88 had a scheduled morning outside appointment and was transported via stretcher by a transport provider. Resident #88 was not appropriately groomed or dressed for this appointment and was transported to the appointment in an undignified manner.A review of section GG (Functional Abilities and Goals) dated 4/16/26 of Resident #88's Minimum Data Set (MDS) coded the resident as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands(excludes baths, showers, and oral hygiene). A review of Resident #88's nurses note dated 4/22/26 at 2:26 PM read: LOA to MD appt per order. Left facility approximately 7:10am and returned approximately 1:30pm via stretcher transport. No acute distress/discomfort noted upon returning. No additional areas of skin impairments noted.An interview was conducted on 5/20/26 at 10:20 AM with Licensed Practical Nurse (LPN) #6. LPN #6 stated that on the morning of 4/22/26, the 11 PM - 7AM shift did not get Resident #88 ready for her scheduled outside appointment. LPN #6 also stated that she had a conversation with Resident #88's daughter and it was discussed that Resident #88 went to the appointment in a gown and was not groomed. LPN #6 further stated that the 11 PM - 7AM staff should have had Resident #88 ready for the appointment and confirmed that Resident #88 was not dressed or groomed appropriately for the scheduled outside appointment. An interview was conducted on 5/20/26 at 10:55 AM with the Unit 2 Nursing Manager. The Unit 2 Nursing Manager stated that Resident should have been appropriately groomed and dressed for the scheduled outside appointment on 4/22/26. The Unit 2 Nursing Manger also stated that it was the responsibility of the 11 PM - 7 AM shift to have Resident #88 ready for the outside appointment on 4/22/26.On 5/20/26 at approximately 6:05 p.m., a final interview was conducted with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident/staff and RP (responsible party) interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for seven of 70 residents, Residents #17, #195, #66, #145, #190, #88 and #134.The findings include: 1. The facility staff failed to provide ADL (activities of daily living) specifically bathing, incontinence care, dressing, oral hygiene and personal hygiene for a dependent resident, Resident #17 (R17). R17 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DM (diabetes mellitus), CKD (chronic kidney disease) and bipolar disorder. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 3/30/26, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for locomotion/transfer/dressing/toileting, hygiene and meals. A review of the comprehensive care plan dated 4/24/23 revealed, FOCUS: Resident requires assistance with ADLs related to advanced age, chronic health conditions, fatigue, malaise, DM and CKD. The resident is incontinent of bladder and frequently incontinent of bowels. She has a diagnosis of overactive bladder. INTERVENTIONS: Provide toileting hygiene as needed for incontinent episodes. Lift sheet for turning and repositioning while in bed. A review of the March, April and May 2026 ADL documentation revealed missing evidence of bathing, incontinence care, dressing, oral hygiene and personal hygiene on 3/5, 3/17, 3/21, 3/31, 4/3, 4/12, 4/18, 4/23, 4/24, 4/25, 4/27, 4/30, 5/15 and 5/18. An interview was conducted on 5/17/26 at approximately 11:50 AM with RP for R17. Asked about the care R17 receives, RP stated, overall it is okay, but they do not change her briefs often enough and it is because they are short staffed. An interview was conducted on 5/17/26 at 4:45 PM with CNA (certified nursing assistant) #2. Asked where their care is documented, CNA #2 stated, the care is documented in PCC (point click care). Asked what is indicated if there are blanks in the documentation, CNA #2 stated, if there are blanks, then it was not documented and was not done. An interview was conducted on 5/18/26 at 11:00 AM with CNA #1, when asked where their care is documented, CNA #1 stated, there is documentation in the computer in PCC. Asked what blanks in the documentation indicates, CNA #1 stated that the care was not provided. On 5/20/26 at 3:00 PM, the administrator and the director of nursing were made aware of the findings. A review of the facility's Nursing Care & Services policy revealed, Nursing staff will provide nursing care and services following current standards of practice recognized by state boards of nursing as informed by national nursing organizations and by hiring individuals who graduate from an approved nursing school and/or nurse aide curriculum and have or will have successfully passed a licensing (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or certification examination. The center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skill & Techniques by [NAME], [NAME], and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals. No further information was provided prior to exit. 2. The facility staff failed to provide ADL (activities of daily living) specifically bathing, incontinence care, dressing, oral hygiene and personal hygiene for a dependent resident, Resident #195 (R195). R195 was admitted to the facility on [DATE] with diagnosis that included but were not limited to DM (diabetes mellitus), CVA (cerebrovascular accident) and dementia. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 11/25/25, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for locomotion/transfer/dressing/toileting, hygiene and meals. A review of the comprehensive care plan dated 11/22/25 revealed, FOCUS: Resident requires assistance with ADLs relate to weakness, impaired mobility and cognition related to recent hip fracture and dementia. The resident is incontinent of bladder and frequently incontinent of bowels. INTERVENTIONS: Provide toileting hygiene as needed for incontinent episodes. Check and change briefs frequently as needed. Provides assistance in feeding for meals. A review of the November and December 2025 ADL documentation revealed missing evidence of bathing, incontinence care, dressing, oral hygiene and personal hygiene on 11/25, 11/28, 11/30, 12/7, 12/8, 12/9, 12/10, 12/13, 12/16, 12/20 and 12/22. An interview was conducted on 5/17/26 at 4:45 PM with CNA (certified nursing assistant) #2. Asked where their care is documented, CNA #2 stated, the care is documented in PCC (point click care). Asked what is indicated if there are blanks in the documentation, CNA #2 stated, if there are blanks, then it was not documented and was not done. An interview was conducted on 5/18/26 at 11:00 AM with CNA #1, when asked where their care is documented, CNA #1 stated, there is documentation in the computer in PCC. Asked what blanks in the documentation indicates, CNA #1 stated that the care was not provided. On 5/20/26 at 3:00 PM, the administrator and the director of nursing were made aware of the findings. No further information was provided prior to exit. 3. For Resident #66 (R66), the facility staff failed to provide showers and incontinence care/toileting assistance on dates in February, March, April and May 2026. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 4/15/2026, the resident was assessed as being severely impaired for making daily decisions, being dependent for toileting and showering/bathing and always incontinent of bowel and (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder. On 5/18/2026 at 9:26 AM, an interview was conducted with R66's responsible party who stated that they had voiced concerns to facility staff regarding R66 being left soiled for extended periods and not receiving showers in the past. She stated that she felt it was due to short-staffing and felt that the certified nursing assistants (CNA) could not get to every resident timely when they had more than 20 residents to take care of. She stated that she used to come in and shower R66 herself but could not do this anymore and had to rely on the staff to do it. Review of the ADL (activities of daily living) documentation for R66 from 2/1-2/28/2026 failed to evidence incontinence care provided on day shift on 2/10/26, 2/11/26, 2/19/26, 2/23/26, and 2/28/26, on evening shift on 2/10/26 and 2/27/26 and on night shift on 2/15/26 and 2/28/26. It failed to evidence a shower provided on 2/13/26, 2/20/26 and 2/27/26. Review of the ADL documentation for R66 from 3/1-3/31/2026 failed to evidence incontinence care provided on day shift on 3/8/26 and 3/30/26, on evening shift on 3/23/26, and on night shift on 3/6/26, 3/14/26, 3/16/26, 3/27/26 and 3/31/26. It further failed to evidence a shower provided on 3/3/26, 3/13/26, 3/17/26, 3/27/26 and 3/31/26. Review of the ADL documentation for R66 from 4/1-4/30/2026 failed to evidence incontinence care provided on day shift on 4/3/26, 4/6/26, 4/10/26, 4/11/26, 4/17/26, 4/18/26, 4/23/26, 4/26/26 and 4/27/26, on evening shift on 4/9/26, 4/10/26, and 4/18/26, and on night shift on 4/11/26, 4/25/26, 4/26/26 and 4/30/26. It further failed to evidence a shower provided on 4/3/26, 4/7/26, 4/14/26, 4/17/26, 4/21/26 and 4/28/26. Review of the ADL documentation for R66 from 5/1-5/31/2026 failed to evidence incontinence care provided on day shift on 5/5/26, 5/9/26, 5/10/26 and 5/16/26, and on night shift on 5/8/26 and 5/10/26. It further failed to provide evidence of a shower provided on 5/1/26 and 5/5/26. The comprehensive care plan for R66 documented in part, Long Term Care: [Name of R66] requires assistance with ADLS relate to advanced age, cognitive impairment, inability to perform ADLs, weakness . Created on: 07/21/2024. Revision on: 12/17/2025. It further documented, [Name of R66] is incontinent of bladder and bowels and is dependent on staff for toileting hygiene. Created on: 03/02/2024. Revision on: 12/17/2025. Under Interventions it documented in part, provide toileting hygiene with brief changes. Date Initiated: 03/02/2024 . On 5/18/2026 at 5:40 AM, an interview was conducted with CNA #1 who stated, Staffing is bad, there were only two of us last night and with each of us having 25 residents, we are unable to complete all the incontinence care that is needed. The CNAs try hard to get it done; it just is not possible. On 5/18/26 at 6:25 AM an interview was conducted with CNA #4, who stated that they were working overtime due to short staffing and with only two CNAs on the unit they were unable to complete the work. On 5/20/2026 at 10:36 AM, an interview was conducted with licensed practical nurse (LPN) #2, unit manager who stated that she had spoken with R66's family in the past regarding concerns of the resident being left soiled and showers. She stated that as far as she knew R66 received their (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers and the family had come in to give R66 showers in the past but had not been able to lately. LPN #2 stated that R66 did not refuse care but required two staff for all care due to stiffness. On 5/20/2026 at 12:12 PM, an interview was conducted with CNA #6 who stated that they evidenced the care they provided by their documentation in the medical record. She stated that showers were twice a week and given according to a schedule. CNA #6 stated that they evidenced incontinence care and showers by the documentation in the medical record. On 5/20/2026 at 3:59 PM, an interview was conducted with CNA #9 who stated that incontinence care was provided every two hours and as needed to residents. She stated that showers were given twice a week according to a schedule. She stated that R66 was scheduled for showers on Mondays on her shift and she never refused care. CNA #9 stated that the evidence of the showers provided was in the medical record documentation. On 5/21/2026 at 11:05 AM, the Administrator and Director of Nursing were made aware of the concern. No further information was provided prior to exit. 4. For Resident #145 (R145), the facility staff failed to provide fingernail care. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date of 5/6/2026, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions. The assessment documented R145 having impairment in the upper and lower extremity on one side and being dependent for personal hygiene, bathing and showering. On 5/17/2026 at 3:33 PM, an observation was made of R145 in their room. R145 was observed to not have use of the right arm due to paralysis and limited range of motion to the fingers of the left hand. The fingernails were observed to be approximately 1/4 inch long and uneven with visible debris underneath. An interview was attempted with R145 at that time, due to their diagnoses R145 communicated by gestures, nodding and closed ended questions. R145 shook their head No when asked if staff trimmed their fingernails for them. Additional observations on 5/17/2026 at 1:52 PM, 3:02 PM, 5/18/2026 at 10:25 AM and 5/19/2026 at 9:42 AM revealed the same as described above. The comprehensive care plan for R145 documented in part, Long Term Care: [Name of R145] requires assistance with ADLS relate to right hemiparesis. Resident executes his right to refuses to wear splints. Created on: 07/27/2023. Revision on: 11/06/2025. On 5/19/2026 at 9:20 AM, an interview was conducted with licensed practical nurse (LPN) #7, unit manager, who stated that fingernail care was done daily by the CNAs (certified nursing assistants) during bathing. She stated that staff trimmed the nails as needed but every residents nails were looked at on Sundays to catch up. LPN #7 observed R145's fingernails and stated that they were long and untrimmed and needed trimming. R145 nodded Yes when LPN #7 asked if they could trim their nails and gestured that he also wanted to be shaved. On 5/20/2026 at 12:12 PM, an interview was conducted with CNA #6 who stated that they cleaned (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents nails daily during ADL care and trim them as needed. She stated that the fingernails should be assessed every day. On 5/20/2026 at 3:03 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 5. For Resident #190 (R190), the facility staff failed to provide showers on dates in September and October 2025. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 9/18/2025, the resident was assessed as having impairment in the upper extremity on both sides and being dependent for showering/bathing. Review of the ADL (activities of daily living) documentation for R190 from 9/1-9/30/2025 failed to evidence a shower provided on 9/16/2025 and 9/25/26. Review of the ADL documentation for R190 from 10/1-10/31/2025 failed to evidence a shower provided on 10/2/26. The comprehensive care plan for R190 documented in part, The resident has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Stroke. Created on: 05/25/2018. Revision on: 10/16/2025. Under Interventions it documented in part, AM Routine: assist/provide ADL care as needed. Date Initiated: 05/10/2019. Created on: 05/29/2018. Revision on: 10/16/2025 . On 5/20/2026 at 10:36 AM, an interview was conducted with licensed practical nurse (LPN) #2, unit manager who stated that showers were given twice a week according to a schedule they kept on each unit split up between each shift. On 5/20/2026 at 12:12 PM, an interview was conducted with CNA #6 who stated that they evidenced the care they provided by their documentation in the medical record. She stated that showers were twice a week and given according to a schedule. On 5/20/2026 at 3:59 PM, an interview was conducted with CNA #9 who stated that showers were given twice a week according to a schedule. She stated that the evidence of the showers provided was in the medical record documentation. On 5/20/2026 at 3:03 PM, the Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the concern. No further information was provided prior to exit. 6. The facility staff failed to provide grooming and hygiene care for a dependent resident before a scheduled outside appointment for (Resident #88), in the survey sample. Resident #88 was originally admitted to the facility on [DATE]. The current diagnoses included; Type (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 Diabetes Mellitus with diabetic chronic kidney disease, anemia, heart failure, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/16/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were moderately impaired. A synopsis of an event dated 4/22/26 revealed that Resident #88 had a scheduled morning outside appointment and was transported via stretcher by a transport provider. Resident #88 was not appropriately groomed or dressed for this appointment and was transported to the appointment in an undignified manner. A review of section GG (Functional Abilities and Goals) dated 4/16/26 of Resident #88's Minimum Data Set (MDS) coded the resident as dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands(excludes baths, showers, and oral hygiene). A review of Resident #88's nurses note dated 4/22/26 at 2:26 PM read: LOA to MD appt per order. Left facility approximately 7:10am and returned approximately 1:30pm via stretcher transport. No acute distress/discomfort noted upon returning. No additional areas of skin impairments noted. An interview was conducted on 5/20/26 at 10:20 AM with Licensed Practical Nurse (LPN) #6. LPN #6 stated that on the morning of 4/22/26, the 11 PM – 7AM shift did not get Resident #88 ready for her scheduled outside appointment. LPN #6 also stated that she had a conversation with Resident #88's daughter and it was discussed that Resident #88 went to the appointment in a gown and was not groomed. LPN #6 further stated that the 11 PM – 7AM staff should have had Resident #88 ready for the appointment and confirmed that Resident #88 was not dressed or groomed appropriately for the scheduled outside appointment. An interview was conducted on 5/20/26 at 10:55 AM with the Unit 2 Nursing Manager. The Unit 2 Nursing Manager stated that Resident should have been appropriately groomed and dressed for the scheduled outside appointment on 4/22/26. The Unit 2 Nursing Manger also stated that it was the responsibility of the 11 PM – 7 AM shift to have Resident #88 ready for the outside appointment on 4/22/26. On 5/20/26 at approximately 6:05 p.m., a final interview was conducted with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 7. The facility's staff failed to provide activities of daily living for Resident #134. Resident #134 was admitted to the facility on [DATE]. The residents' diagnoses included dementia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 05/06/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 1 out of 15. This indicated that Resident #134's cognitive abilities for daily decision-making (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were severely impaired. In section GG0130 Self-Care, the resident was coded as dependent for eating, oral care, toileting hygiene, showers, personal hygiene, upper- and lower-body dressing, and putting on and taking off footwear. On 5/17/2026 at 11:39 AM, Resident #134 was observed in bed, and the pancake call bell was not within reach. The resident had a large amount of chin hair and long, dirty, and chipped fingernails. The longest fingernails were approximately 2.25 inches beyond the fingertips. Food was observed on the resident's clothing and in the bed. On 5/18/26 at approximately 2:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) #8. LPN #8 stated that the staff had clipped and cleaned all the residents' nails. On 5/21/2026 at 2:30 PM, a final interview was conducted with the Administrator, Director of Nursing, the Regional [NAME] President of Operations, and the Regional Director of Clinical Services. They voiced no concerns regarding the above information.

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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 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. Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide care and services for an indwelling catheter for one of 70 residents in the survey sample, Residents #136. The findings include:For Resident #136 (R136), the facility staff failed to keep the catheter collection bag (1) off the floor. R136 was admitted to the facility with diagnoses that included but were not limited to obstructive uropathy (2). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 03/27/2026, R136 scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating R136 was severely impaired of cognition for making daily decisions. Section H Bladder and Bowel code R136 as having an indwelling catheter. On 05/17/2026 at approximately 1:00 p.m. an observation of R136's catheter collection bag revealed the bottom of the bag was resting on the floor. On 05/17/2026 at approximately 3:30 p.m. an observation of R136's catheter collection bag revealed the bottom of the bag was resting on the floor. The physician's order for R136 documented in part, Foley catheter (3) 16 French (4), 10cc (cubic centimeters). Order Date 3/20/2025. On 11/12/2025 at approximately 11:08 a.m. an interview was conducted with the Uniit Manager for Unit One regarding th eplacement of a residemt's catheter collect bag. She staed that the bag should be kept off the floor for infection control purposes. After informed of the observations described above she stated that the catheter collection bag should not have been resting on the floor. The facility's policy Urunary Catheterizations documented in part, 7. Ensure drainage bags are not touching the floor. On 05/21/2026 at approximately 8:43 a.m. the Administrator and Director of Nursing were made aware of the above findings. No further information was provided prior to exit. References:(1) Urine drainage bags collect urine. Your bag will attach to a catheter (tube) that is inside your bladder. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000142.htm. (2) A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm. (3) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm. (4) Refers to the size of the catheter, with higher numbers indicating larger sizes. This information was obtained from the website: https://balumed.com/en/medical-dictionary/16-french-foley-catheter.