STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285135	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne Countryview Care and Rehabilitation	811 East 14th Street Wayne, NE 68787

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)Based on observations, record review, and interviews; the facility failed to reassess and to put interventions in place to prevent potential elopement for 1 (Resident 33) and failed to prevent the potential for burns related to hot water temperatures in resident handwashing sinks. Six out of 35 facility resident rooms had water temperatures that exceeded 120 degrees. The sample size was 20 and the facility census was 41. Findings are: A. Review of the undated facility policy Water Temp revealed the facility tested water temperatures by letting the water run for 3-5 minutes and inserting a thermometer probe into the stream of running water all while holding the testers hand under the water to assess how the water felt on skin. Temperature checks were performed at various locations throughout the facility. There was no evidence at what temperature the water was considered acceptable or how often the temperature checks were performed. On 1/25/26 between 8:00 AM and 8:12 AM water temperature checks conducted by the survey team identified the following water temperature in the hand-washing sinks in the following resident rooms.Rm 200 - 139 degrees Fahrenheit (F)Rm 207 - 133 degrees FRm 318 - 139 degrees FRm 315 - 138.5 degrees FRm 431 - 140 degrees FRm 426 - 140.9 degrees F Review of Water Temperature Safety education provided by the facility on 1/25/26 after identifying unsafe water temperatures in the facility revealed the following: -Water temperature standards indicated water temperature must not exceed 120 degrees Fahrenheit. -Water temperatures hotter than 120 degrees Fahrenheit could cause scald burns. -Maintaining safe water temperatures was required for resident safety and regulatory compliance. -Staff were to be aware of water temperatures during all resident care activities and if the water temperatures felt unusually hot, caused discomfort upon contact, appeared to fluctuate, or felt out of range staff were to take immediate action including stopping water usage, verifying the water temperature using a thermometer located at the nurses station, and report immediately to the facility Administrator, Operations Manager, and Maintenance Director. During an interview with the Maintenance Director on 1/25/26 at 10:39 PM revealed the following: upon being made aware, staff had called this morning due to the identified hot water temperatures and when maintenance staff arrived and checked temperatures, they were around 130 degrees. The water temperature mixing valves were checked, and the hot water temperature turned down, and the subsequent temperatures had rapidly decreased and had returned to a range of 120-122 degrees. The maintenance was then checking water temperatures every 30 minutes. The Maintenance Director confirmed that water temperatures were to be at or below 120 degrees. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/25/26 at 12:45 PM the facility Administrator confirmed once the hot water temperatures were identified the facility implemented all staff education, monitoring of water temperatures every 30 minutes morning and afternoon, and would continue checking the temperatures 3 times daily through the week and then 5 days a week until the cold weather temperatures improved, and most likely through the winter months. The facility had placed do not use signs on the bathroom sinks and stopped bathing residents. In addition, the facility had contacted a professional plumber to determine an exact cause of the sudden rise in the water temperatures. Review of the undated facility floor plan revealed 35 total resident rooms. Review of the facility Resident list dated 1/28/26 and included the resident room numbers, revealed 26 of the resident rooms were occupied. Two of the rooms (rooms [ROOM NUMBERS]) identified as having water temperatures exceeding 120 degrees had 4 residents who were identified as capable of entering their bathroom and washing their hands without assistance. During an interview on 1/28/26 at 8:30 AM the facility Operations Manager confirmed the facility was aware water temperatures in the resident's bathroom were not to exceed 120 degrees to prevent potential resident burn injuries and the temperature ranging from 133 to 140.9 degrees on 1/25/26 were too hot to ensure the resident's safety. B. Review of the facility Elopement Policy and Assessment with a revised date of 6/2019 revealed it was the policy of the facility to provide a safe environment for all residents. The facility was to accurately assess all residents and to plan their care to prevent accidents related to wandering behavior or elopement. The following procedures were identified for assessment and identification of wandering behaviors: -history of behaviors, including wandering, was to be obtained prior to admission. -each resident's level of supervision or plan of care was to be developed based on their elopement risk assessment score and other risk factors which included but was not limited to observed wandering/exit seeking behaviors. -each resident was to be assessed quarterly and after a significant change in condition. The following steps were to be taken for residents who were identified at risk for elopement: -wander guard bracelet may be placed on the resident. -the residents care plan was to address behaviors with resident specific goals and interventions. -a current picture of the resident was to be maintained by the facility. -staff were to ensure that all exit alarms were responded to immediately. C. Review of Resident 33's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 11/24/25 revealed the resident was admitted [DATE] with diagnoses of coronary artery disease, high blood pressure, Alzheimer's disease, and malnutrition. The assessment revealed the following related to Resident 33: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-cognition was severely impaired. -behaviors which included rejection of cares. -required substantial to maximal assistance with dressing, bathing, personal hygiene, bed mobility, and transfers. -frequent urinary incontinence. -history of falls. Review of an Elopement/Wandering Evaluation for Resident 33 dated 12/8/25 at 10:19 PM revealed the resident had a predisposing disease of Alzheimer's, was mobile in the wheelchair, was alert and orientated and had no history of elopement or of wandering. The resident's total evaluation score was five, indicating the resident was at low risk for elopement. Review of a Nursing Progress Notes dated 1/10/2026 at 1:00 PM, revealed the staff were informed by another resident that Resident 33 was attempting to open a door down on the 300 halls. The resident was found in the building, but with the door open. The resident was redirected back to the commons area. Review of Resident 33's medical record revealed no evidence the facility reassessed the resident's elopement risk and/or developed interventions to prevent a potential elopement. During an interview with the Director of Nursing (DON) on 1/27/26 at 3:00 PM, the DON confirmed the following regarding Resident 33: -the resident was admitted [DATE] and was to be a short term admission with the long term plan for the resident to go back home and to live with the daughter. -the facility staff were to complete an Elopement/Wandering Evaluation to determine the resident's risk for elopement within 72 hours of admission. -an Elopement/Wandering Evaluation was not completed until 12/8/25 (18 days after the resident was admitted) for the resident. -the assessment indicated the resident was at low risk for wandering. -the resident was having increased confusion and behaviors with continued stay at the facility. -1/10/26 at 1:00 PM the resident was found after opening a door to exit out the 300 hallways. The resident had not left the building but was at the opened door. -the DON was unaware this had occurred. -the resident's elopement risk was not reassessed and no interventions were put into place to prevent a potential elopement.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(G)(ii)(iii)Based on record review and interviews, the facility failed to complete a comprehensive discharge summary including a recapitulation of care and reconciliation of medications for 1(Resident 43) and failed to notify the State Ombudsman of discharges for 2 (Resident's 43 and 45) of 4 sampled residents. The facility census was 41.0 Findings are: A. Review of the facility policy Criteria for Transfer and Discharge with a revision date of April 2025 revealed the following: -The facility would not transfer or discharge a resident unless appropriate criteria existed. -The transfer and/or discharge were documented in the resident record and appropriate information was communicated to the receiving provider. -The physician signed a discharge summary when a resident was discharged or transferred and the summary included a post discharge plan of care, indication of where the resident would reside, any arrangements for follow up care, and any post-discharge medical and non-medical services. B. Review of Resident 43's Electronic Medical Record revealed the resident was admitted to the facility on [DATE] and discharged from the facility to an acute care hospital on [DATE]. Review of Resident 43's Electronic Medical Record revealed no evidence the facility completed a comprehensive recapitulation of the resident's stay including a reconciliation of the residents' medication/discharge summary. In addition, there was no evidence the facility notified the State Ombudsman's of the resident's discharge. During an interview on 1/28/25 at 12:00 PM the Director of Nursing confirmed the facility did not complete a recapitulation of the Resident 43's stay following the discharge including a reconciliation of the resident's medications. C. Review of Resident 45's Electronic Medical Record revealed the resident was admitted to the facility on [DATE] and discharged from the facility to home on 1/2/26. There was no evidence the facility notified the State Ombudsman of the discharge. D. During an interview on 1/28/26 at 11:00 AM the Social Services Director confirmed the facility did not notify the State Ombudsman of facility transfers and discharges as required for Resident's 43 and 45.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(i)(3) Based on observations, record review, and interview; the facility failed to provide timely eating assistance for Residents 33 and 19. The sample size was 2 and the census was 41. Findings are: A. Review of Resident 33's Minimum Data Set (MDS-a federally mandated assessment tool used for care planning) dated 11/24/25 revealed the resident was admitted on [DATE] with diagnoses of Alzheimer's dementia, malnutrition, coronary artery disease, and high blood pressure. The assessment identified the following:-cognition was severely impaired;-partial/moderate assistance was provided by staff with dietary intakes; and-weight of 100 pounds (lbs.). During the breakfast meal service on 1/25/26 the following was observed related to Resident 33:-8:34 AM was seated at a table in the dining room for residents who required assistance with eating. The resident was served a glass of milk and juice, a bowl with hot cereal, and a plate with a biscuit and scrambled eggs. Nursing Assistant (NA)-D was seated at the other end of the table and was providing assistance to others. Staff failed to offer and/or provide the resident assistance with setup of the meal. The resident made no attempt to eat/drink the breakfast meal. -8:42 AM a tablemate asked Resident 33 if the resident was going to eat. The resident closed their eyes, folded arms, and backed the wheelchair away from the table. NA-D who remained at the other end of the table failed to cue the resident or to provide any assistance with eating. -9:06 AM the resident had consumed none of the breakfast meal. The resident indicated a need for toileting and attempted to stand independently from the wheelchair.-9:07 AM the resident was assisted out of the dining room by NA-D.-9:12 AM the resident returned to the dining room and was positioned at the dining table. NA-D cued the resident to try and eat the breakfast meal but provided no assistance to the resident. In addition, NA-D did not offer to warm up the resident's food which had been left uncovered since service at 8:34 AM (35 minutes prior). Resident 33 took one bite of the meal, put down the fork, closed eyes, and remained seated at the table but made no effort to eat or to drink. -9:20 AM the resident was assisted out of the dining room after consuming only one bite of the meal. B. Review of Resident 19's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of debility, heart failure, Non-Alzheimer's dementia, anxiety, and depression. The following was assessed for Resident 19:-cognition was severely impaired.-required substantial staff assistance with eating and drinking.-weight of 174 lbs. Observations of Resident 19 on 1/25/26 for the breakfast meal revealed the following: -8:20 AM was seated in a wheelchair at the assisted table in the dining room. The resident was served the breakfast meal which consisted of scrambled eggs, a biscuit, hot cereal, and glasses of orange juice and of water. The resident was holding a baby doll and made no attempt to put the doll down or to eat/drink the breakfast meal.-8:55 AM NA-D approached the resident who had remained at the table without eating and/or drinking. NA-D assisted the resident with taking a drink of orange juice while standing next to the resident. The resident accepted the drink and then staff placed down the juice and walked away. The resident made no further attempt to eat/drink.-9:06 AM NA-D buttered the resident's biscuit and then placed it on the resident's plate. NA-D exited the dining room to assist another resident with toileting. No other staff were available to cue or to assist the resident with eating. -9:22 AM (1 hour and 2 minutes after the resident's breakfast was served) NA-D sat next to the resident and provided total assistance with eating. C. During an interview on 1/27/26 at 3:00 PM, the Director of Nursing (DON) confirmed Resident 19 and 33 required extensive/total assistance with meal intakes. The DON indicated the staff should not be requesting or providing the residents' food from the kitchen until staff were able to provide them with cues/assist to eat.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(J)(i) Based on observations, record review, and interview; the facility failed to implement weight loss interventions for Resident 33. The sample size was 4 and the facility census was 41. Findings are: A. Review of the facility policy Nutrition Status Management with a revision date of 4/2025 revealed it was the policy of the facility to assess each resident's status and needs, including medications and medical conditions to ensure that all residents maintained an acceptable parameter of nutritional status unless the resident's clinical condition demonstrated this was not possible. The following procedure was identified:-each resident's nutritional status was assessed at admission and at least quarterly afterwards.-dietary evaluations were to include determination of ideal body weight range, usual body weight, current diet, percentage of food eaten, possible dental problems, current illness, likes and dislikes, and any other change in medical condition that may impact weight loss.-if there was a significant change in the residents' condition related to weight or nutrition, the Registered Dietician (RD) would make recommendations to offer additional nutrition to those residents.-the Interdisciplinary Team (IDT) and/or the RD would monitor and evaluate the resident's response to the interventions.-any resident weight which varied from the previous reporting period by more than 5 percent (%) in 30 days, 7.5 % in 90 days and 10 % in 180 days would be evaluated by the IDT to determine the cause of weight loss and interventions required.-the nurse would notify the physician, family, and the resident of weight loss.-any resident meeting criteria for weight loss would be weighed weekly and reviewed by the RD.-the IDT would update and revise care plan as appropriate. B. Review of Resident 33's Minimum Data Set (MDS-a federally mandated assessment tool used for care planning) dated 11/24/25 revealed the resident was admitted with diagnoses of Alzheimer's dementia, malnutrition, coronary artery disease, and high blood pressure. The assessment identified the following:-cognition was severely impaired;-partial/moderate assistance was provided by staff with dietary intakes. Review of Resident 33's Nursing Progress Note dated 11/20/25 at 9:44 PM revealed the resident's Primary Care Practitioner (PCP) was sent a facsimile (fax) requesting an order for Med Pass Nutritional supplement 60 cubic centimeters (cc) twice a day due to the resident's diagnosis of protein calorie malnutrition. Review of Resident 33's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed on 11/20/25 the resident's weight was 105 lbs. Further review revealed on 11/29/25 the resident's weight was 100 lbs. (down 5 lbs. or a 5 percent (%) loss in 9 days). Review of Nursing Progress Notes revealed the following:-12/2/25 at 3:56 PM the resident was seen by the PCP and a new order was received for Lasix (medication used to treat fluid retention) to be administered 4 days for fluid in the resident's lower legs.-12/9/25 at 11:46 AM a follow-up fax was sent to the PCP regarding a request for Med Pass 60 cc twice a day as no response was received from the first fax which was sent on 11/20/25 (19 days earlier). Review of Resident 33's Weights and Vitals Summary Sheet revealed the resident's weight on 12/18/25 was 108 lbs. Review of Nursing Progress Notes revealed the following:-12/15/25 at 5:13 PM the staff sent a third fax to the residents' PCP requesting an order for the Med Pass 60 cc twice a day as the PCP had still not responded to the facilities request on 11/20/25 and on 12/9/25. -12/17/25 at 10:59 AM (27 days after the facility initially requested the order) a new order was received for Med Pass 60 cc twice a day. Review of a Nutrition Progress Note dated 12/19/25 at 2:05 PM revealed the Registered Dietician (RD) identified the resident had a weight gain of 8 % in 30 days and confirmed the resident was seen by the PCP and started on medication for the fluid gain. The note further revealed on average the resident was consuming only 50 % of food at meals. No new recommendations were identified. Review of a Weights and Vitals Summary Sheet revealed the following weights:-12/20/25 weight was 105 lbs.-12/31/25 weight was 101 lbs. Review of a Progress Note on 1/15/26 at 4:33 PM revealed the resident was seen by the PCP and a new order was received to restart the Lasix 20 milligrams (mg) daily due to fluid to lower extremities. Review of Weights and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vitals Summary Sheet revealed the resident maintained weight at 101 lbs. Review of a Nutrition Progress Note dated 1/26/25 at 12:22 PM revealed the resident's current body weight was 101 lbs. which was a significant loss of 6 % in 34 days. The residents' lower extremity fluid retention was improved. Meal intakes on average remained at 50 %. No new recommendations were identified. During the breakfast meal service on 1/25/26 the following was observed related to Resident 33:-8:34 AM was seated at a table in the dining room for residents who required assistance with eating. The resident was served a glass of milk and juice, a bowl with hot cereal, and a plate with a biscuit and scrambled eggs. Nursing Assistant (NA)-D was seated at the other end of the table and was providing assistance to others. Staff failed to offer and/or provide the resident assistance with setup of the meal. The resident made no attempt to eat/drink the breakfast meal. -8:42 AM a tablemate asked Resident 33 if the resident was going to eat. The resident closed their eyes, folded arms, and backed the wheelchair away from the table. NA-D who remained at the other end of the table failed to cue the resident or to provide any assistance with eating. -9:06 AM the resident had consumed none of the breakfast meal. The resident indicated a need for toileting and attempted to stand independently from the wheelchair.-9:07 AM the resident was assisted out of the dining room by NA-D.-9:12 AM the resident returned to the dining room and was positioned at the dining table. NA-D cued the resident to try and eat the breakfast meal but provided no assistance to the resident. In addition, NA-D did not offer to warm up the resident's food which had been left uncovered since service at 8:34 AM (35 minutes prior). Resident 33 took one bite of the meal, put down the fork, closed eyes, and remained seated at the table but made no effort to eat or to drink. -9:20 AM the resident was assisted out of the dining room after consuming only one bite of the meal. Observations of Resident 33 on 1/26/26 revealed the following:-7:29 AM the resident was lying in bed with eyes closed and call light in reach.-9:08 AM the resident remained in bed with eyes closed. NA-H entered the room and asked if the resident was ready to get up, but the resident refused and told the staff to leave the room. -10:01 AM the resident remained in bed.-10:16 AM NA-F assisted the resident with morning cares and positioned the resident in a wheelchair. The resident was taken to the commons area with other residents who were watching the television. Resident 33 was not offered anything to eat/drink despite the resident having missed the breakfast meal. Review of Resident 33's meal intakes for the breakfast meal from 1/1/26 to 1/26/26 revealed no documentation of intakes on 1/1, 1/2, 1/5, 1/6, 1/10, 1/27, 1/29, 1/20, 1/21, 1/22, 1/23, 1/25 and 1/26/2026 (13 out of 26 days). An interview with the Director of Nursing (DON) on 1/27/26 at 3:00 PM confirmed the following regarding Resident 33:-required extensive/total assistance with meal intakes. Intakes were frequently poor and the resident reported no appetite.-the staff should not be requesting or providing the residents' food from the kitchen until staff are available to provide with cues/assistance to eat.-the resident had weight fluctuations related to fluid retention and was started on a new medication to address.-11/20/25 a fax was sent to the resident's PCP requesting a nutritional supplement as the resident had a diagnosis of malnutrition. The staff had to send additional faxes on 12/9/25 and on 12/17/25 as the PCP failed to respond. 12/17/25 the PCP ordered the Med Pass nutritional supplement. The DON indicated that the facility has difficulty with some of their PCP answering/responding to faxes. Confirmed the supplement was not initiated until 12/19/25.

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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** Licensure Reference Number 175 NAC 12-006.17Based on observations, record review, and interview; the facility failed to perform hand hygiene at appropriate intervals and to utilize the required Personal Protective Equipment (PPE) when providing management/care of Resident 39's catheter. The sample size was 2 and the facility census was 41.Findings are:A. Review of the Hand Hygiene policy with a revision date of 12/2025 revealed it was the policy of the facility to provide the necessary supplies, education, and oversight to ensure healthcare workers performed hand hygiene based on accepted standards. Hand hygiene was identified as one of the most effective measures to prevent the spread of infection. Staff were to perform hand hygiene when:-hands were visibly soiled.-before and after coming on duty.-before and after direct contact with residents.-before preparing or handling medications.-before and after handling an invasive device (urinary catheter).-before handling clean or soiled dressings, gauze pads.-before moving from a contaminated body site to a clean body site during resident care.-after contact with blood or bodily fluids.-after removing gloves.-after removing and disposing of personal protective equipment. B. Review of the facility policy Standards and Transmission-Based Precautions with a revision date of December 2025 revealed it was the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. The policy further indicated Enhanced Barrier Precautions (EBP) referred to the use of gowns and gloves during high-contact resident care activities for residents with:-Multi-Drug Resistant Organism (MDRO-a germ that is resistant to many of the antibiotics) infection or colonization (presence of a microorganism in or on a host without causing any symptoms).-wounds and/or indwelling medical devices regardless of MDRO colonization.Examples of high-contact resident care activities that required gown and gloves use for EBP included the following:-dressing.-bathing/showering.-transferring.-providing hygiene.-changing linens.-changing briefs or assisting with toileting.-device care or use: indwelling urinary catheter, feeding tubes.-wound care: any skin opening that required a dressing.The resident would be in EBP for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at risk. C. Review of Resident 39's Minimum Data Set (MDS-federally mandated comprehensive assessment tool used to develop resident Care Plans) dated 12/16/25 revealed the resident was admitted [DATE] with diagnoses of anemia, neurogenic bladder, Non-Alzheimer's dementia, depression, previous stroke, and high blood pressure. The resident was identified as requiring substantial to total assistance with toileting hygiene, dressing, personal hygiene, bed mobility, and transfers; and as having an indwelling urinary catheter. During a care observation on 1/26/26 at 9:41 AM the following was observed:-the resident was seated in a recliner in the commons area and was watching television.-Nurse Aide (NA)-F approached the resident without use of a gown or gloves and transferred the resident from the recliner to a wheelchair then assisted the resident to their room. -without completing hand hygiene NA-F, placed on a disposable gown and gloves and emptied the resident's urinary catheter drainage bag.-NA-F disposed of the urine in the resident's bathroom and removed both the gown and gloves NA-F was wearing.-without washing hands or completing hand hygiene, NA-F returned to the resident and used an alcohol wipe to cleanse the drainage tube of the catheter bag, adjusted the residents clothing and placed foot pedals back on the wheelchair.-NA-F assisted the resident back to the commons area and transferred the resident into the recliner before performing hand hygiene. During an interview on 1/26/26 at 10:20 AM, NA-F confirmed Resident 39 was on EBP and staff should have been wearing PPE when working with the resident for transfers, repositioning and adjusting the resident's clothing. In addition, staff should not have removed PPE when working with the resident's indwelling urinary catheter.On 1/27/25 at 3:20 PM, an interview with the Director of Nursing confirmed the staff had been trained to wear gloves and gowns for direct cares and any catheter cares for Resident 39 who remained is on EBP due to an indwelling urinary catheter.