STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135094	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRING HEALTH & REHABILITATION OF CASCADIA	**2105 12TH AVENUE ROAD NAMPA, ID 83686**

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 -** Immediate jeopardy **Residents Affected -** Some	**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 implement and maintain standard infection control measures and practices to contain or prevent facility transmission of COVID-19 infection. The facility reported an active COVID-19 outbreak with 33 of 50 current residents and 24 staff positive for COVID-19. The facility designated an area of the facility as a COVID unit but failed to ensure physical separation and dedicated staff for the COVID unit in accordance with Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services. (CMS) guidelines. The COVID unit shared a nursing station and common areas with the non-COVID unit with ongoing co-mingling of COVID and non-COVID unit staff and co-mingling of COVID staff and non-COVID staff's PPE (personal protective equipment) for re-use. Staff failed to perform hand hygiene when indicated and staff traveled between the COVID and non-COVID units without changing PPE. The facility failed to ensure staff donned, doffed, and used PPE in accordance with accepted standards of practice to prevent contamination of PPE intended for reuse and to prevent transmission of COVID-19 or other infectious organisms from one person, object, or surface to another. These failures placed all COVID negative residents and staff in the facility in immediate jeopardy and at risk for facility-transmission of serious and potentially life threatening COVID-19 infection. Findings include: Upon arrival at the facility on 8/10/20 at 10:15 AM, the facility main entrance opened to the foyer. The foyer had two wire shelf units filled with lunch-size brown paper bags. The bags were dated and labeled with staff names. A large plastic tub in the lobby held washable/reusable gowns. Facility administrative staff performed screening and directed surveyor to don a gown and keep the facemask and eye protection on while in the facility. The administrator explained all staff except for staff assigned to the ventilator unit entered and exited through the main entrance for screening and to don a gown, facemask and eye protection. The administrator stated the brown paper bags held facemasks for staff reuse for up to 5 days. During an interview on 8/10/20 at 10:30 AM the facility Administrator and the Director of Nursing (DON) reported the facility experienced an outbreak of COVID-19 with a total of 34 residents and 24 staff tested positive. The administrator reported the facility implemented physical barriers and dedicated staff to ensure separation of a COVID-19 positive unit (200 and 300 halls), a quarantine unit for new admissions (400 hall), a COVID negative unit (100 hall), and specialized Ventilator unit (500 hall). The DON provided a copy of the LTC Respiratory Surveillance Line List for the period 7/15/20 to 8/8/20 which showed positive COVID-19 test results for residents residing on the 200 and 300 halls. Most recently, positive results were reported for R2 and R5 on 8/3/20. In the prior two weeks, 7/26/20 -8/8/20, positive COVID-19 test results were reported for fourteen staff who worked on the listed departments or units; 100 hall, 200 hall. 100/200, ventilator unit, wound care, dietary, and maintenance. The DON said COVID positive residents were moved to the 200/300 COVID unit. The DON confirmed a census of 50 with 33 of 50 (66%) current residents COVID positive. On 8/17/20/20, review of the Centers for Disease Control and Prevention (CDC) cases and deaths by county report at htttps://www.cdc.gov/coronavirus/2019-ncov/cases-updates/county-map.html, updated 8/17/20, showed Canyon County, the location of the facility, had 2,768 cases per 100,000 indicating a high level of community COVID-19 activity. The door from the foyer led to a large open corridor with an open sitting area and a nurse station. The nurse station was directly ahead and was open to the corridor. A corridor to the right had a temporary plastic barrier that hung from ceiling to floor and wall to wall across the entrance to the 100 hall. The plastic barrier had an opening in the center to allow staff to pass through. The corridor to the left housed a conference room, dining room, kitchen and other services. The corridor straight ahead was the 200/300 halls (COVID unit). The COVID unit was open to the corridor and nurse station. Resident rooms [ROOM NUMBERS] were directly across from the open nurse station. On 8/10/20 at 11:50 AM the 201 and 203 doors were open. Resident (R1) sat in the doorway to room [ROOM NUMBER] and called out for assistance. Licensed nurse LN1 wore two gowns, LN1 entered the room and repositioned R1's wheeled chair to next to the bed. LN1 removed disposable eating utensils and disposable food containers from the room. LN1 changed gloves and performed hand hygiene then still wearing the two gowns, LN1 went directly to room [ROOM NUMBER] and removed eating utensils and food containers. Still wearing two gowns with mask and face shield, LN1 went from room [ROOM NUMBER] to the nurse station. LN1's top gown was tied loosely at the neck. LN1 pulled the gown up over her head and then hung the gown on a hook in the nurse station. LN1 performed hand hygiene with ABHR (alcohol-based hand rub) after doffing the gown. Five gowns hung on hooks at various locations throughout the nurse station and one hung in the corridor. Three of the gowns were hung with the outside of the gown out and two were hung with the inside out. When asked about the gowns, LN1 pointed out a plastic tub on the floor that held clean gowns. LN1 said you need to put on a gown to go in the 200 and 300 halls. LN1 said you put it on over the gown you put on at screening. LN1 said, Then you just find an empty hook somewhere in the nurse station so you can use it again during the shift. LN1 said the facility issued a new facemask and face shield or goggles every five days and added This is my Monday so I have new PPE. On 8/10/20 at 12:40 PM central supply staff (CS1) exited from the Ventilator unit and went to 100 hall. CS1 pushed a cart with supplies and went from room to room on the 100 hall. CS1 wore a gown, facemask, and eye protection. CS1 did not wash hands or perform hand hygiene after exiting each resident room. CS1 said she did not touch anything, just dropped off supplies When interviewed, CS1 explained that her duties in central supply included stocking resident rooms, nurse stations, and other areas of the building such as supply closets. CS1 said she was in the process of delivering supplies. CS1 described her typical day and duties. CS1 said she was screened at the front entrance then put on her facemask, eye protection and gown then went outside to central supply. CS1 said she always started her day in the clean area, the ventilator unit. Then went to the other units and lastly the COVID unit. CS1 said she wore the same gown all day and mask for five days for all units. CS1 said after she went on the COVID unit she did not go anywhere else in the building until the next morning. CS1 stated at the end of the day she returned her mask to her brown bag in the front lobby area for reuse the following day. On 8/10/20 at 1:18 PM nursing assistant (NAC1) was observed in room [ROOM NUMBER]. The door was wide open. NAC1 made the bed nearest the door. NAC1 wore a facemask, eye shield, and two gowns. NAC1 did not wear gloves. NAC1 leaned against the bed and [MEDICATION NAME] the bed linens with her forearms and hands. When asked if she should wear gloves to make the bed, NAC1 responded Yes, I need gloves. NAC1 stated PPE supplies were available but she must have forgot the gloves. Observation on 8/10/20 at 1:18 PM; NAC1 and NAC2 were observed in the nurse station wearing two gowns. Two randomly observed staff each wearing one gown exited the nurse station and entered the COVID-negative 100 hall. RCM1 exited through the plastic barrier and entered the nurse station. RCM1 wore one gown and sat at a computer in the nurse station. 100 hall staff and COVID unit staff comingled at the nurse station and both COVID unit staff and 100 hall staff went down the hall toward the dining room. In an interview on 8/10/20 at 3:00 PM the DNS stated the breakroom and time clock were located at the end of the corridor (dining room). On 8/10/20 at 1:22 PM NAC1 and NAC2 prepared to perform incontinent care for R3. NAC1 and NAC2 wore facemasks, eye protection, gloves, and two gowns. NAC2 unfastened the incontinence brief and cleansed R3's perineum (area between legs) and noted bowel movement on the wipe. R3 moved onto her side and NAC1 cleansed the BM and changed gloves. NAC1 did not wash her hands or perform hand hygiene with ABHR before donning clean gloves. NAC1 and NAC2 placed a clean brief on R3. NAC1 again changed gloves with no hand hygiene. When asked

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135094	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRING HEALTH & REHABILITATION OF CASCADIA	**2105 12TH AVENUE ROAD NAMPA, ID 83686**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) about the second glove change, NAC1 said she changed them because she touched the new brief. NAC1 confirmed she did not perform hand hygiene with glove change. NAC1 and NAC2 were interviewed immediately following incontinent care.at 1:40 PM. When asked what the facility instructed staff about hand hygiene and glove changes. NAC1 said she used ABHR at other places but Not so much here because there was no alcohol in the rooms. NAC2 said she agreed it made it difficult to perform hand hygiene when indicated because the facility did not make ABHR available in the resident rooms. NAC2 said she did not like to leave the resident uncovered or near the edge of the bed and added So I don't leave the resident's side to go way over there (pointed to the bathroom in the far corner of the room) to wash my hands. NAC2 said the facility taught/instructed staff to perform hand hygiene each time gloves were changed. On 8/10/20 observation of the nurse station between 2:02 PM and 2:30 PM revealed LN2 entered the nurse station wearing two gowns, facemask and eye protection (goggles), but no gloves at 2:06 PM. With bare hands, LN2 removed her goggles and laid them face down on the chart rack, then removed her isolation gown and hung it on a hook. LN2 then re-donned the goggles touching the front of the goggles with bare hands. LN2 sat at the desk in the nurse station without disinfecting/sanitizing the chart rack where she laid the contaminated goggles and without performing hand hygiene after doffing her contaminated gown and handling contaminated goggles. RCM1 traveled back and forth between the 100 hall and the COVID unit. RCM1 brought ice and handed it off to COVID staff. RCM1 entered rooms at the back of the nurse station, handled the staffing clipboard and sat briefly at the nurse station desk conversing with COVID unit staff LN1 and LN2. RCM1 wore one gown, facemask, and eye protection and returned to the 100 hall in the same gown, facemask, and eye protection. In an interview at 2:23 PM when asked where the nurse station was for the 100 hall, LN2 said It is right here. LN2 confirmed the nurse station also served the COVID unit but added; RCM1 is the nurse for the 100 hall but RCM1 does not come out here much (referring to the nurse station). When informed of observations of co-mingling of staff from the COVID unit and the 100 hall, LN1 and LN2 agreed staff comingled, including close contact such as tying gowns for each other and sharing of the nurse station space and equipment including computer keyboards, documents and supplies. CDC website: Responding to Coronavirus (COVID-19) in Nursing Homes; Considerations for the Public Health Response to COVID-19 in Nursing Homes Updated Apr. 30, 2020 Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19 Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19 o Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. Assign dedicated HCP (health care professionals) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. o To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. o Assign environmental services (EVS) staff to work only on the unit. If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. Observation: 8/10/20 at 2:28 PM LN2 got up from the desk in the nurse station and went to a small table with the assignment book, LN2 pulled her mask down and her goggles up then lifted her gown and wiped sweat from her face with the front of the gown. LN2 replaced her goggles and facemask and sat back at the computer with no hand hygiene after handling her facemask and eye protection and no gown change after wiping her face including her mouth and nose with the gown In an interview on 8/10/20 at 3:00 PM DON said the facility had adequate PPE supplies and utilized a PPE conservation plan. DON explained the current facility expectation regarding PPE. DON said it was company policy for staff to don either facility provided scrubs or a cover gown when entering the facility and wear facemask and eye protection for continual use for all care in the facility. DON said washable gowns for extended use on the COVID unit (200 and 300 hall) should be donned when entering the unit and doffed when exiting the unit. DON said the COVID unit should use one gown per one staff per shift. DON said the COVID-negative unit (100 hall) was on a two-gown system in which the staff donned an isolation gown over the top of the cover gown to enter a resident room that required transmission-based precautions. Gowns hung on the outside of the 100 hall rooms and staff donned the gown and gloves at the threshold. When asked why gowns hung on the outside of the door instead of inside the room, DON said it was originally due to wall space in long term resident rooms that had many decorations and no space to hang gowns. When informed of observations of COVID unit staff donning and doffing PPE in the nurse station, DON said the practice was unacceptable. DON stated all staff were trained on PPE use including proper sequence and technique for donning and doffing. The facility policy titled Personal Protective Equipment (PPE) Conservation Plan read in part: *Extended use refers to the practice of wearing the same PPE for repeated encounters with several residents, without removing PPE between the encounters. Extended use may be implemented when multiple residents are infected and placed together in dedicated area, room, or unit(s). *Reuse refers to the practice of using the same piece of PPE for multiple encounters with residents under precautions but removing it ('doffing') between encounters with other residents. The PPE is stored between encounters and reused. *Continual use refers to the practice of wearing the same PPE for all resident care as the PPE is dedicated for use by individual healthcare personnel for a single shift. Decontamination is required between continual use shifts. Procedure: IA. Gloves are single patient use. Hand hygiene occurs prior to putting on (donning) and with taking off (doffing). New gloves are utilized for each new patient. D. Extended use is preferred over re-use on the premise that it is safer for the health care professional (HCP) to leave their mask and eye protection in place, to reduce the risk of self-contamination through frequent donning and doffing of the same equipment. G. Donning and doffing PPE is an essential process to prevent contamination of the item and protect the employee. When conservation of PPE is implemented it is even more important to maintain the integrity of the PPE as the exterior/front (outside) of the gown of reused PPE is now soiled during the next donning process. Education is provided to HCP, posters are placed as reminders for good practice, and surveillance is in progress to validate technique. II. Hand hygiene continues to be extremely important. If a staff member touches the front of the mask or face shield, hand hygiene is essential at that time. G. Isolation Gowns Extended Use - Washable/Disposable: 3. Storage - Gowns are only removed during breaks. Remove your gloves, complete hand hygiene and don a clean pair of gloves. Untie gown belt tie, then neck pulling the front of the gown off the shoulders. Ensure that sleeves do not touch your personal clothing. Lean slightly forward. Place one hand down the neck and inside one sleeve without touching the outside of the gown, slide the sleeve cuff over the hand in a straight forward motion keeping hands inside the sleeve, using care that the outside of the gown or sleeve does not contact your clothing. With your hand inside the sleeve, use the sleeve as a barrier to pull the cuff over the other hand. Hands are now both inside the sleeves. Be sure that you are only touching the inside of the gown as the outside contains potential contaminates. While still holding the inside of the gown hang on the hook. The arm openings and the inside of the gown face out for easy donning. Use caution so the outside of the gown does not make contact with the clean side of the gown. Validate that your gown is not touching other gowns. 4. Disinfecting-At the end of the shift. HCP will be asked to doff their gown as they exit the building. Receptacles are placed so that gowns may be collected for laundering, decontamination, and redistribution. On 8/10/20 at 4:00 PM NAC3 and NAC4 provided incontinent care to R3. NAC4 removed the incontinent brief and cleansed the perineum and surrounding skin. NAC4 prepared to open a clean brief when NAC3 reminded NAC4 to wash her hands and change her gloves. The edges of a dressing on the coccyx (tailbone) appeared wet, had a brown tinge and was separating from the skin. When asked if the dressing was OK, NAC3 directed NAC4 to call the nurse. NAC3 said R3 had a large sore. LN1 entered the room, opened a new duoderm (brand of wound dressing) and laid the new dressing on the bed. LN1 removed the soiled dressing, which consisted of duoderm with a foam dressing over the top, and placed it in the trash. LN1 did not change the soiled gloves. While wearing the gloves soiled by the old wound dressing, LN1 opened the door and called out to staff to bring her wound cleanser. LN1 pulled back the privacy curtain and answered a knock on the door. LN1 took the wound cleanser, a spray bottle, and moistened gauze pads. LN1 touched the spray bottle to the bed linens. LN1 cleansed the wound then removed her gloves but did not perform hand hygiene. LN1 donned new gloves and proceeded to dry the area around the wound. LN1 applied a skin preparation and the dressing. LN1 placed the bottle of wound cleanser on the table near the door, removed her gloves, and used ABHR for hand hygiene in the corridor. LN1 removed the top gown in the nurse station using bare hands. The Centers for Disease prevention and Control website provided guidelines for glove use: When and How to use gloves. Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. *Gloves are not a substitute for hand hygiene. *If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. *Perform hand hygiene immediately after removing gloves. *Change gloves and perform hand hygiene during patient care if; gloves become damaged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135094	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRING HEALTH & REHABILITATION OF CASCADIA	2105 12TH AVENUE ROAD NAMPA, ID 83686

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) *gloves become visibly soiled with blood or body fluids following a task *when moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. *Never wear the same pair of gloves in the care of more than one patient. *Carefully remove gloves to prevent hand contamination. On 8/10/20 at 4:30 PM facility administrator and DON were informed deficient infection control practice was identified regarding no physical separation of COVID-positive unit with comingling of COVID-positive unit and COVID-negative unit staff in a shared nurse station and common areas. COVID positive unit staff donned and doffed contaminated PPE in the shared nurse station. PPE was not donned and doffed correctly for safe reuse and staff failed to perform hand hygiene when indicated/required. Staff CS1 worked on all units during the course of the day including ventilator unit, COVID positive unit, and COVID negative unit while wearing the same PPE. At 4:40 PM, the administration was informed that these findings represented systemic failure in infection control and prevention and constituted immediate jeopardy. On 8/11/20 at 11:30 AM the facility administrator presented an immediate jeopardy removal plan that included re-education of staff regarding separation of COVID unit and dedicated COVID unit staff, PPE use, and handwashing. The facility relocated barriers to define and segregate the COVID unit, and revised central supply procedures. On 8/11/20 observation at 10:00 AM revealed the barrier was relocated to include nurse station in the COVID unit and separate the COVID unit from the remainder of the building. The COVID-negative unit was now open to the common area and foyer entrance. Observation on the COVID-negative unit (100 hall) revealed signage on room [ROOM NUMBER] that read simply Stop. Speak to nurse before entering. The signage did not indicate required PPE. Two gowns hung on wall hooks in the corridor outside resident room [ROOM NUMBER]. One gown hung inside out and one gown hung incorrectly with the outside out. Outside of room [ROOM NUMBER], two gowns hung, stacked on one hook both gowns were outside out. Two gowns hung on separate hooks outside rooms 114 one inside out and one outside out. The DON observed the 100 hall gowns and agreed they were hung incorrectly. The DON said the gowns must be doffed in a manner to prevent contamination and the gown should consequently be inside out when hung to prevent contamination of staff when re-donned. DON said staff were educated and re-educated on donning and doffing PPE for reuse. DON spoke to RCM1 regarding reuse of gowns and directed the gowns be discarded and new gowns hung properly. Observation on the COVID unit at 1:48 PM revealed a gown hanging outside out on a hook in an office designated as COVID unit breakroom. LN3 worked at a desk and acknowledged it was her gown. When asked if the gown was properly hung, LN3 said she did not know about the gown right or wrong because she was off 2 weeks and just came in to help. LN3 said she was a wound nurse. NAC4 spoke up and said the gown was not properly hung for reuse. On 8/11/20 at 2:15 PM NAC5 measured resident vital signs (temperature, pulse, oxygen saturation). NAC5 took the wheeled vital sign equipment caddy into room [ROOM NUMBER] and placed the blood pressure cuff on R11's arm then placed the oxygen saturation monitor device on a finger. NAC placed the blood pressure cuff and finger probe into a basket attached to the wheeled caddy. NAC5 recorded the vital signs on a clipboard then placed it in the basket. NAC5 sanitized his hands but did not sanitize the blood pressure cuff or finger probe which had direct contact with the resident's hand. NAC5 repeated the process in room [ROOM NUMBER], 214, and 217. When asked if vital sign equipment should be sanitized between residents, NAC5 said he was not sure. In an interview on 8/11/20 at 2:28 PM when asked what the facility taught and expected regarding equipment that was shared from room to room and resident to resident, NAC 4 stated things like Hoyers (mechanical lifts) did not get wiped down because they were not shared with other units. Regarding vital sign equipment, NAC4 said it should be wiped down with alcohol between residents. The facility infection control policy for transmission-based precautions was consistent with CDC guidelines. The facility policy stated: Contact surfaces: 1. Resident Care Equipment: a. dedicated use of noncritical resident care equipment for the residents in enhanced precautions. B. If this is not possible, then the equipment should be cleaned and disinfected before use on another resident using an EPA registered disinfectant. C. Items are to be cleaned in the resident's room, then brought out and left to air dry. At 2:17 PM CS1 entered the COVID unit already wearing a facemask, eye protection and a gown pushing a wheeled cart stacked high with supplies such as packages of incontinent briefs, boxes of gloves, and other supplies. CS1 went into room [ROOM NUMBER] and donned gloves, CS1 proceeded down the hall and entered each room sometimes leaving supplies in the room. When asked if anyone spoke with her about being on the COVID unit, CS1 said Yes when it all started. CS1 said she knew she had to start on the cleanest unit so she started her day on the ventilator unit and lastly the COVID unit. CS1 said she knew about the wall move because she saw them moving it yesterday but was not aware of any other changes. CS1 said she was not informed of change to central supply processes. At 2:45 PM CS1 moved the cart down the hall to a room labeled temporary storage. CS1 held packages of briefs and other supplies against her gown as she moved them from the cart into the storage room. CS1 approached surveyor and asked Should I change my gown when I come on this unit? When asked what the facility told her to do CS1 responded Well no one else changes gowns on this unit. CS1 confirmed that the supplies may be used in other units in the building and asked Why? When informed of observation of supplies held against her contaminated gown, CS1 again asked Do you want me to change my gown? CS1 added she showered when she got home. CS1 was again advised to seek direction from the facility. The above findings were shared with the DON. The DON said NAC4 correctly described the facility process that required vital sign equipment be sanitized between residents. DON said; Ideally CS1 should not go on the COVID unit. CS1 should pass supply cart through to COVID staff and then the cart must be wiped down. DON said she spoke with CS1 but perhaps was not clear enough regarding facility expectations with regard to essential dedicated staff on the COVID unit. In a meeting on 8/11/20 at 4:00 PM the facility administrator was informed of ongoing practice concerns regarding PPE use, dedicated staff for COVID unit and failure to sanitize resident care equipment between uses for different residents. The facility IJ removal plan was not fully implemented. The immediacy was not removed and the immediate jeopardy was ongoing at the conclusion of the onsite survey.