STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an alleged violation of neglect was immediately, no later than two hours, reported to the State agency (SA) for 1 of 1 resident (R1) reviewed who sustained serious bodily injury after a fall from a mechanical lift. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had severely impaired cognition with [DIAGNOSES REDACTED]. The MDS identified R1 required extensive assistance of two staff with bed mobility, and total assistance for transfers with assistance of two staff. Review of R1's Progress Notes from 6/14/20 to 6/15/20 revealed the following: -6/14/20, at 6:15 p.m. nurse practitioner was informed of R1's fall and current status, x-rays were ordered of right shoulder and left knee at that time. -6/14/20 at 6:45 p.m. x-rays were completed, and informed staff not to move R1 until the results of the x-ray returned to rule out any fracture. -6/15/20, at 12:46 a.m. indicated X-ray results received through fax, and on-call medical provider was updated. Review of R1's Professional Portable X-Ray dated 6/14/2020, identified R1 had an acute mildly displaced supracondylar fracture of distal femur. Review of untitled investigation report, dated 6/14/20 indicated the submission to the SA was completed on 6/15/20, at 12:16 p.m. of a controlled landing during a transfer on 6/14/20 resulting in a fracture. On 6/19/20, at 2:00 p.m. DON confirmed she was the on-call supervisor over the weekend and was called with the report of the fall of R1 on 6/14/20 from the supervisor, RN-A and the order given from the nurse practitioner to complete the X-ray. DON further stated she was clear with RN-A that she needed to be informed if there was a confirmed fracture. DON confirmed she did not receive a call that R1 sustained a fracture and was informed of the fracture on 6/15/20 at approximately 11:00 a.m. DON indicated the night was a perfect storm and the staff did not circle back around to check on the results of the x-rays. DON explained her expectations of the floor nurse was to report all falls with injury to the supervisor on duty and the supervisor would work with the on-call supervisor to determine if the event was reportable to the SA. Review of policy titled Vulnerable Adult Abuse Prevention Plan and Suspicion of a Crime Reporting dated last revision on 11/1/19, defined neglect as 'failure of the employees to to provide services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress'. The policy further indicates that reporting of neglect that results in serious bodily injury were to be reported immediately, but not later than two hours to the administrator of the facility and to other officials in accordance with state law.
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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** Based on observation, interview and document review, the facility failed to implement the care plan for 2 of 2 residents (R1, R2) related to the use of mechanical lifts, which resulted in a fractured femur when R1 fell out of the mechanical lift. This resulted in an immediate jeopardy (IJ) situation for R1. This deficient practice had the potential to affect all 62 residents in the facility who required the use of a mechanical lift for transfers. The immediate jeopardy began on 6/23/20, at 2:11 p.m. when it was identified that staff continued to work with residents in the facility without training on implementation of care plans, use of appropriate transfer equipment according to the residents care plans. The administrator, and the director of nursing (DON) were notified of the IJ on 6/23/20, at 2:11 p.m. The IJ was removed on 6/24/20, at 5:12 p.m. but noncompliance remained at the lower scope and severity level G-isolated, scope and severity, which indicate actual harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 has severe cognitive impairment and had [DIAGNOSES REDACTED]. The MDS identified R1 required extensive assistance of two staff for bed mobility and toileting, total assistance with two staff for transfers, and extensive assistance with one staff for locomotion, personal hygiene and dressing. MDS further indicated R1 had a fall prior to admission and one fall since admission. R1's care plan, revised 6/20/20, identified R1 was high risk for falls related to history of falls, cognitive impairment with poor short term memory, impaired safety awareness, wheel chair bound, dependence on others for transfers, had dementia, weakness, impaired balance, and chronic pain. R1's care plan listed various interventions including: one command/idea at a time, yes/no questions, use a mechanical lift with assistance of two staff for transfers using a large or a med sling, and re-educate staff on reading care plans prior to caring for residents. Review of R1's lift mobility assessments dated 2/11/20, and 6/21/20, indicated R1 required a mechanical lift with large sling, R1 could tolerated a semi-reclined position and was under 600 pounds. Review of R1's physical therapy notes dated 4/2/20, indicated R1 required significant time between each task due to redirection and reassurance with each transfer attempt, and recommendation was to continue with mechanical lift for safety. Review of an untitled document dated 6/14/20, listing activities of daily living (ADL's), indicated on page 2 of the document, under the title of transferring, R1 required assist of two staff using the mechanical lift with a large sling Review of R1's Pain Interview form dated 5/19/20, indicated R1 denied any pain in the last five days before the interview. Review of R1's Incident Report Summary dated 6/15/20, indicated nursing assistant (NA)-A reported a controlled landing during a transfer on 6/14/20, with R1. R1 had complaints of pain to left knee, x-rays were ordered and showed a fracture to left femur. Review of R1's Witnessed Fall Report, 6/14/20, indicated R1 was transferred with one assist using an EZ stand when R1 let go of the bars and was lowered onto the floor. Range of motion (ROM) of upper arms was done with complaints of discomfort in right shoulder. ROM was done to both lower extremities with complaints of pain in left knee. R1 was unable to report the degree of pain. R1 had been lifted off the floor using a mechanical lift and assistance of 4 staff. Review of R1's Investigation/Analysis dated 6/15/20, indicated R1 was being transferred with the stand lift on 6/14/20, by NA-A when R1's knees gave out and she began to slide to the floor. NA-A discovered after the fall that she had misread the residents Kardex for transfers and should have used the mechanical lift with assistance of two staff. NA-A was removed from the floor and educated on reading the Kardex and transfers before returning to the floor. R1 experienced left hip pain and was found to have a left femur fracture and was sent to the hospital on [DATE]. The report indicated R1 and other residents who utilized a lift were reviewed and housewide education of staff unsafe transfers initiated. Review of R1's Progress Notes from 6/14/20, to 6/15/20, revealed the following: -6/14/20, at 5:35 p.m. indicated R1 was sitting on the floor in her room with head on the edge of the bed. ROM completed with R1 complaining of discomfort in right shoulder and left knee. - 6/14/20, at 6:27 p.m. RN-C indicated X-rays were completed and staff were not to move R1 until the results of the X-rays were known. R1 was having some facial grimacing with repositioning and elevation of left extremity. - 6/15/20, at 1:23 p.m. staff spoke with orthopedics and they recommended R1 have surgical repair of the fracture to the left femur. A later note at 2:15 p.m.

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
	245055	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WALKER METHODIST HEALTH CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) indicated R1 was transferred to hospital. Review of R1's X-ray dated 6/14/20, identified an acute mildly displaced supracondylar fracture of distal femur, no joint effusion, and moderate osteopenia/[MEDICAL CONDITION] and moderate [MEDICAL CONDITION]. Review of R1's hospital discharge summary dated 6/18/20, indicated R1 had sustained mechanical lift fall at the facility on 6/14/20, complained of right shoulder pain and x-ray negative for fracture. R1 complained of left thigh and ankle pain. A computed tomography (CT) scan of left lower extremity identified an acute comminuted moderately displaced [MEDICAL CONDITION] femoral shaft with intra-condo articular extension (a traumatic break from a direct blow or impact in the large thigh bone in more than two pieces, near the knee, involving the knee joint). R1 required open reduction and internal fixation of femoral fracture surgery. On 6/18/20, at 5:10 p.m. R1 was awake, lying in bed in her room. R1 indicated she had discomfort in her foot but was unable to remember recent events of surgery, hospitalization or fall. On 6/19/20, at 8:40 a.m. NA-C stated he was working on the morning of R1's fall, but had not received any training on care plans. NA-C stated the last training he received was on hand washing weeks prior. On 6/19/20, at 8:53 a.m. NA-A indicated she was working with R1 on the day shift on 6/14/20. During a transfer with the stand lift R1 moved her arms inside the sling, and her knees buckled. NA-A loosened the strap across the chest of R1 allowing R1 to be lowered to the floor. R1's head was on the bed and buttocks were on the floor. NA-A indicated R1 had been transferred back to bed with a full mechanical lift. NA-A stated when she arrived at work she reviewed R1's care card and most of her cares were assist of one staff, so NA-A wrote assist of one on her sheet and thought that was also for the transfers. On 6/19/20, at 10:14 a.m. NA-D indicated she had not received any recent training on reading care plans, usually training would be on the computer. On 6/19/20, at 10:18 NA-E confirmed she had not received any recent training on care plans. On 6/19/20, at 10:55 a.m. RN-A confirmed he was the supervisor on duty on 6/14/20, and responded to the fall for R1. RN-A indicated he completed the training on reading care plans and transfers with NA-A and reported to the DON the fall and the order from the NP to obtain x-rays all relating to the transfer with incorrect lift. RN-A confirmed NA-A reported she used the incorrect lift, getting the information from only looking at the first page of the care plan, seeing assist of one, and not reading the second page of the care plan where it reads the transfer is assist of two staff with the full mechanical lift. On 6/19/20, at 11:16 a.m. LPN-A stated she was the day shift nurse on 6/14/20, and was called to R1's room by NA-A at 2:15 p.m. R1 was sitting on the floor and NA-A stated R1 let go of the stand lift. LPN-A stated she had seen the stand lift in the hallway outside the room when she responded to the fall and told NA-A that R1 was a mechanical lift that requires assistance of two staff. NA-A indicated to LPN-A she wrote down assist of one from the care plan. LPN-A stated R1 had complained of pain with ROM at right shoulder and left knee. LPN-A confirmed she called the NP asking for x-rays due to the pain with movement. On 6/19/20, at 2:00 p.m. DON confirmed she was the on-call supervisor for 6/14/20, and was notified by RN-A about the fall from the stand lift for R1 and the orders to complete the X-rays. DON indicated she ensured teaching was completed with NA-A and instructed to be called if the x-rays showed a fracture. DON stated her expectations would be for the nursing assistants to read the care plans before caring for the residents to ensure they are following the care plan. DON stated after the fall the facility had started training the staff on care plans and transfers and had been able to reach about 45% of the staff up at that time with a goal to reach 100% of the staff. R2 R2's quarterly MDS dated [DATE], indicated R2 was severely cognitively impaired with [DIAGNOSES REDACTED]. The MDS further indicated R2 required extensive assistance of one staff for bed mobility, locomotion, dressing and personal hygiene and extensive assistance of two staff with transfers and toileting. Review of R2's care plan revised on 6/15/20, indicated R2 had a self care deficit related to weakness, [MEDICAL CONDITIONS], and had limited mobility. The care plan further indicated R2 had impaired thought processes due to [DIAGNOSES REDACTED]. Review of R2's untitled document provided by the facility and identified as the Kardex dated 6/23/20, indicated R2 required assistance of one staff using the EZ stand with the medium/beige sling. Review of R2's Lift Mobility assessment dated [DATE], indicated R2 required the mechanical EZ stand lift with the medium beige sling for transfers. On 6/18/20, at 4:45 p.m. NA-B grabbed the stand lift in the hall and brought it into R2's room. NA-B indicated she needed a different sling size and left the room briefly to obtain a different sling. NA-B returned with a green colored sling and transferred R2 with the stand lift to the bathroom, then to the wheel chair. After R1 was transferred to the wheelchair, observation of the label on the green sling listed large size. On 6/22/20, at 2:15 p.m. RN-F stated she received training on 6/19/20, on transfers and how to respond, residents who need assistance of two staff during transfers, and what slings to use. On 6/22/20, at 2:55 p.m. NA-B confirmed R2's care plan directed to use a medium sling and confirmed she had used a large size sling for the transfer. She indicated she did not know what was wrong with her that day. NA-B stated she had received training on reading the care plan the previous day, over the weekend. On 6/22/20, at 3:28 p.m. DON provided the following training materials and indicated the various training tools addressed different areas of resident care and had been initiated since R1's fall: -Audit/competency check list for how to use the smart EZ stand and the full lift. 11 out of 215 staff completed the stand lift and 12 out of 215 had completed the full lift competency. -Face to face competency on vulnerable adult (VA) reporting covered how to report an incident for the nurses and the nursing assistants, when to call the supervisor, falls/incident reports, injuries, infection control, use of goggles, cleaning equipment, wearing of face masks and gloves, and hand hygiene. Completed by 125 staff out of 215. -Kardex competency, asking the staff to go to the care plan or the Kardex and show the trainer what kind of transfer a particular resident requires and the equipment needed. Completed by 59 staff out of 215. - Blast email sent on 6/19/20, about 3:45 p.m. and included the VA, infection control, when to report to the supervisor, falls/incidents and transfer training's. A follow up call was made to ensure the email was received and allow for any questions. 65 staff out of the 215 were reached and had no questions. Review of training material titled Resident Transfer dated 6/16/20, provided by the facility, listed a detailed step by step process for completion of resident transfers. The various steps included to check the individual resident care plan for transfer status and if staff question the transfer status, check with the nurse so the nurse can assess the resident and make changes applicable. Also, ensure correct sling size according to the residents weight. Review of face to face attendance record included 75 staff completed the training between 6/16/20 and 6/19/20 out of the total of 215. On 6/23/20, at 9:25 a.m. DON further indicated she felt the improper transfer with R1 should have never happened. She indicated her goal was to have 100% of the staff trained by the end of that week on Kardex and transfers as she felt this was the area that failed in the fall of R1. DON confirmed the Kardex and transfer training was a competency training where the staff demonstrate to the trainer how to go to the residents care plan or Kardex and look at how the individual resident transferred and the equipment needed. DON reviewed the various training components since R1's fall and confirmed the audits on transfers and Kardex's, emails with infection control, VA, fall, transfer and when to report to the supervisor training, phone calls to follow up on the Emails blast that went out late on 6/19/20, had all started at various times over the past week. she confirmed various staff had completed individual components but not all staff had completed all of the training. DON re-confirmed her goal was to ensure the competency training with the transfers and the Kardex had been completed with nursing staff. DON indicated her expectation were for staff to follow the policies, ensure residents were safe and their care plans were followed. On 6/23/20, at 11:05 a.m. DON confirmed there were currently 6 of the 84 staff scheduled to work had not received the re-education on proper implementation of care plans and transfers. DON also confirmed on 6/22/20, 36 out of 107 staff who provided direct care to residents in the facility had not received the re-education of implementation of care plans and transfers. On 6/24/20, at 10:15 a.m., medical director (MD) stated R1 had been admitted to the facility following a fall and had a [DIAGNOSES REDACTED]. The MD confirmed R1 had experienced pain after the fall on 6/14/20. The IJ that began on 2/23/20, was removed on 6/24/20, when the facility removed all staff from the schedule who had not received appropriate training on care plans, made a plan to ensure all staff were trained prior to providing direct care and assessments were completed for R1 and R2 for current plan of care accuracy, but the noncompliance remained at the lower scope and severity level of G-actual harm.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) use of eye protection for employees per Centers for Medicare and Medicaid Services (CMS), Coronavirus Disease 2019 (COVID-19) guidance. In addition, the facility failed to ensure social distancing of six feet was implemented for residents dining in two of the seven common area dining rooms per CMS COVID-19 guidance. This deficient practice had the potential to affect all 215 residents who resided in the facility. Findings include: Employee PPE use On 6/18/20, at 2:04 p.m. nursing assistant (NA)-F wore a face mask, with no eye protection on, was present in the memory care unit. She walked down the hallway, walked up to R14, who was seated in her wheelchair near the nurses station. NA-F leaned down next to R14 and briefly spoke with R14. NA-F proceeded to walk down the hall. At that time, NA-F confirmed she did not have eye protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WALKER METHODIST HEALTH CENTER	**3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409**

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** - Many	(continued... from page 2) in place, and indicated she had started her shift at 6:30 a.m. and had not worn goggles at all that shift. NA-F confirmed it was expected direct care staff wear eye protection while on duty and stated her goggles were stored on another unit in which she normally worked. NA-F stated no one had offered her a pair of goggles for her to wear on the memory care unit. -at 2:17 p.m. R14 remained seated in her wheelchair next to the nurses station of the memory care unit. Licensed practical nurse (LPN)-B wore a face mask, without eye protection, walked out of a resident room and approached R14, and assisted R14 to make a telephone call. LPN-B stood next to R14, briefly rested her right hand on her right shoulder, spoke to R14 and then returned to the medication cart located in the hallway by the nurses station. LPN-B's goggles were observed on top of the medication cart. LPN-B confirmed she did not have her goggles in place and stated she had removed them earlier prior to taking a break and forgot to place them back on after she returned. LPN-B stated direct care staff were expected to wear the goggles at all times during their shift. -at 2:29 p.m. NA-G was seated in a chair between two residents who were both seated in their wheelchairs in the living area on third floor. NA-G wore her goggles on top of her head, not on her eyes, and was approximately three feet apart from both residents. At that time, NA-G confirmed her goggles were on top of her head and stated she wore them when providing direct care to residents. NA-G confirmed she was about three feet apart from each resident and stated she felt she was currently not providing direct care to each resident. NA-G stated staff were expected to wear the goggles when providing direct care to residents. - at 3:45 p.m. registered nurse (RN)-G was present by the fourth floor dining room, with his goggles placed on top of his head, standing next to R16 who had a blood pressure cuff on her arm, obtaining her blood pressure reading. At that time, RN-G confirmed his goggles were on top of his head and stated it was expected direct care staff wore them at all times. RN-G stated his goggles frequently fogged up and he moved them to the top of his head to clear up the fog. RN-G then removed the goggles from the top of his head and placed them over his eyes. Communal dining 4th Floor On 6/18/20 at 4:57 p.m. during obseervations of the supper meal, a resident walked with a walker independently out of her room to the dining room with no facemask in place. The tables in the dining room measured four feet by four feet. At one table, R16 and R17, with no face masks on, were seated across from each other at the same table. The meal had not been served yet. -at 5:00 p.m. two NA's, RN-B and RN nurse manager (NM)-A were present in the dining room. One resident wheeled next to another resident seated at a dining room table without a facemask on and staff present in the dining room made no attempt to socially distance the residents. There were nine residents in the dining room and the meal had not been served yet. -at 5:15 p.m. R16 and R17 continued to be seated across from on another and another table now had two additional residents seated across from one another. All residents present continued to have no facemask's in place, not [MEDICATION NAME] social distancing and the meal had not been served yet. -at 5:27 p.m. R16 and R17 continued to be seated across from each other at the same table and another table had two female residents seated across from one another. The meal had not been served yet. RN-B asked R16 to move to another table and she complied. On 6/18/20, at 5:07 p.m. NA-J stated R16 and R17 enjoyed each other's company, sat across from each other at the same table every night and staff did not attempt to keep them apart. NA-J confirmed residents did not wear facemask's when leaving their rooms or when staff were providing direct care. -at 5:10 p.m. NM-A stated it was not usual practice for residents to wear masks when they left their rooms and while staff provided care to them. NM-A confirmed R16 and R17 were seated across from one another at the same table and verified the tables measured approximately four by four feet which identified a lack of social distancing. -at 5:32 p.m. NA-I stated residents should be seated at different tables and confirmed two residents at two different tables had been seated across from each other earlier. NA-I confirmed the residents were routinely allowed to sit across from each other every night and stated residents did not wear masks when they left their rooms or during cares. 2nd floor memory care unit On 6/19/20, during observation and interview at 8:15 a.m. there were eight residents seated in the dining room and three tables had two residents seated across from one another at the same table. R11 and R12 were seated at one table, R10 and R14 were seated at another table and R8 and R13 were seated at another table. The tables measured approximately four by four feet. LPN-B confirmed there were three tables with two residents seated across from each other and stated the room was small and it was what they had to work with. LPN-B confirmed the residents were not socially distanced and indicated they were seated in that same manner every day. On 6/19/20, at 12:55 p.m. during an interview infection prevention coordinator (IPC) stated the expectation was for all direct care staff to wear eye protection while on duty. IPC stated residents were strongly encouraged to wear facemask's and staff were expected to redirect the residents back to their rooms if they were not wearing them. IPC stated social distancing was expected for all residents with communal dining. IPC stated residents were expected to be seated one at a table to maintain the social distancing requirements. IPC stated all staff received training related to proper PPE use and communal dining requirements. On 6/23/19, at 9:11 a.m. during an interview director of nursing (DON) stated direct care staff were expected to wear eye protection at all times during their shift. DON stated it had become increasingly difficult for residents to wear masks when leaving their rooms and verified the facility had not enforced it. DON stated social distancing was expected during communal dining and indicated it had been challenging for staff to distance residents from one another who were used to being seated in a certain table next to a certain resident. DON stated it had proved to be stressful to some residents and confirmed there were times social distancing had not been practiced during meal times. Review of facility policy titled WM Covid-19 Comprehensive Safety Plan effective 3/30/20, identified all team members were to follow proper PPE protocol and adhere to the facility's infection control polices. Review of the action plan for Walker Methodist Health Center revised 5/12/20, identified residents eating in the dining rooms would be spaced six feet apart. The plan indicated universal masking, face shields/ eye protection was initiated on 5/12/20.