STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265863	A. BUILDING _____ B. WING _____	**04/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TIFFANY SPRINGS REHABILITATION & HEALTH CARE CENTE	**9191 N AMBASSADOR DRIVE KANSAS CITY, MO 64154**

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	**Provide and implement an infection prevention and control program.** Based on observation and interview the facility failed to maintain social distancing by staying 6 feet apart from each other and did not wear a facial mask in a common area in the facility to assist with preventing the spread of COVID-19. The facility census was 98. Review of the facility's COVID-19 action plan policy dated 3/31/20 showed, the following efforts have been implemented to reduce the risk of COVID-19 included all employees and visitors will be required to wear a face mask at all times while in the community. Observation on 4/23/20, at 1:55 P.M., showed clerical staff who screened visitors and staff as they entered the facility for COVID-19 did not have a mask on. The staff member opened the door to let the surveyor in the facility without a facial mask on. Five staff members sat in the seating area inside the facility close to the main entrance visiting with each other and did not have facial mask on and did not maintain 6' social distancing from each other. Observation on 4/23/20, at 2:00 P.M., showed four staff members at the counter inside the facility close to the main entrance obtaining their mask and did not maintain 6' social distancing from each other. Observation on 4/23/20, at 3:00 P.M., showed hospice staff, a resident and his/her family member sat at a table in the same room where visitors and staff were being screened for COVID-19. Staff did not wear mask until they completed their COVID-19 questionnaire and obtained their facial mask from the counter to wear for their shift. During an interview on 4/27/20, at 2:05 P.M., the Administrator said he expects the screener to wear a mask at all times while inside the facility and he expects staff to maintain 6' social distancing when they are obtaining their mask and when they are being screened and do not have a mask on. He expects staff to wear mask when they are in the same area as a resident. MO 9

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.