STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335647	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLIAMSVILLE SUBURBAN, L L C	**163 SOUTH UNION ROAD WILLIAMSVILLE, NY 14221**

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 0836 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** Based on interview and record review during the COVID-19 Focused Infection Control Survey (Complaint #NY 802) completed 6/1/20 it was determined the facility did not ensure compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility did not comply with New York State Executive Order (EO) 202.18, and ensure that resident's family and/or their next of kin were notified of either a single confirmed infection of COVID-19 or COVID-19 death within 24 hours from the date of occurrence for three (Residents #5, 6 &7) of three resident's family and/or their next of kin reviewed for notification. The finding is: The Executive Order #202.18 dated April 16, 2020 documented the following: Any skilled nursing facility, nursing home, or adult care facility licensed and regulated by the Commissioner of Health shall notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death. The facility policy and procedure titled Notifying Residents, Representatives, and Families of COVID-19 Cases dated 5/7/20 documented the facility will notify residents, their representatives and families of confirmed or suspected COVID-19 infections among residents. The facility will notify family members and next of kin within 24 hours of a resident testing positive or suffering a COVID-19 related death. All residents/family members/legal representative notifications will be documented in the resident's medical record. Review of the facility's Long-Term Care (LTC) Respiratory Surveillance Line List dated 5/13/20 through 5/25/20 revealed there were 50 residents that tested (were cultured) positive for COVID -19 and an additional two residents that were listed as positive but did not include a date (total 52). The line list documented there were five resident deaths related COVID-19 (four at the facility and one in the hospital). During a telephone interview on 6/1/20 at 1:50 PM, Resident #6's son, who was the designated family contact for Resident #6, stated he found out his mother had tested positive for COVID-19 when his wife called the facility for an update to see how her mother-in law was. He was not made aware of any positive COVID-19 related deaths in the facility and had not received any additional notifications of COVID-19 positive cases. During a telephone interview on 6/1/20 at 2:00 PM, Resident #5's niece, who was the designated family contact for Resident #5, stated she received a call from the facility two weeks ago and was notified of two positive cases of COVID-19 in the facility. Additionally, she had not been notified of any positive COVID-19 related deaths that had occurred in the facility. During a telephone interview on 6/1/20 at 2:40 PM, Resident #7's sister stated three weeks ago she received a call from the facility stating there were positive COVID-19 cases in the building, but the facility never informed her of any COVID-19 related deaths in the facility. During an interview on 6/1/20 at 2:10 PM, Registered Nurse (RN) #3 Nurse Manager stated if a resident test is positive for COVID-19 the immediate family was to be notified within 24 hours by the Social Worker and the Nurse Manager notifies the immediate family when a death occurs. RN #3 was unaware that all resident's family or next of kin were to be notified of positive COVID-19 cases and COVID-19 related deaths. She further stated, not all families for all residents were notified. During an interview on 6/1/20 at 2:42 PM, the Director of Nurses (DON) stated all resident's family or next of kin have not been notified of positive COVID-19 cases or deaths within 24 hours. The immediate family only had been notified when a family member passed or tested positive. During an interview on 6/1/20 at 2:45 PM, the Administrator stated a letter was sent to the family members on 5/15/20 to inform them of recent positive cases identified in the facility. The Nursing department notifies the immediate family members when a death occurs. The facility has not notified all resident's family or next of kin of all positive COVID-19 cases or COVID-19 related deaths. In addition, the Administrator stated there was no system in place to contact all residents/family members within 24 hours. (10 NYCRR 400.2)

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.