STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335662	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn View Health Care Facility L L C	S 4650 Southwestern Blvd Hamburg, NY 14075

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted a survey, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing for one (1) (Resident #258) of four (4) residents reviewed. Specifically, when Resident #258 was readmitted to the facility with pressure ulcers there was a delay in obtaining a full assessment of the pressure ulcers, including measurements and staging. The finding is:The policy titled Documentation of Pressure Ulcer and Chronic Wounds, last revised 06/2023, documented pressure ulcers and chronic wounds were monitored closely to monitor effectiveness of treatment and change in risk factors. Risk factors would be identified, monitored and documented on the Skin Risk Data Collection Tool, upon admission and whenever there was a change in condition. The Assistant Director of Nursing (or skin nurse as designated by the Director of Nursing) would be the official baseline and subsequent reference point for all skin/wound assessments. All skin surfaces were inspected upon admission and results documented on the Nursing admission Evaluation. The Assistant Director of Nursing, or designee was responsible for initiating the weekly skin status evaluation when a pressure ulcer, stasis wound, or chronic wound was identified. The items to address on the template included but were not limited to the type of area (pressure, stasis, arterial, or diabetic), site, stage, size (length by width by depth in centimeters), description/characteristics, and treatment.The policy titled admission Nursing Evaluation, last revised 03/2026, documented each resident's physical, functional, and nutritional information was compiled initially upon admission to determine the need for care, the type of care provided and the need for further assessment. The form included the residents' skin status. Resident #258 had diagnoses including malignant neoplasm of cervix (cervical cancer), rheumatoid arthritis (chronic autoimmune disorder where the immune system attacks the joint lining, causing painful, symmetrical swelling, stiffness, and potential deformity, often in hands and feet), and vesicovaginal fistula (abnormal opening between the bladder and vagina causing continuous, involuntary urine leakage). The Minimum Data Set (a resident assessment tool) dated 05/14/2025 documented Resident #258 was cognitively intact, had two (2) unstageable pressure ulcers (full thickness tissue loss where the depth of the wound is hidden by eschar [dead tissue] and slough [yellow/white soft, stringy, thick substance]) and required a substantial/maximal assist from staff for bed mobility. The Minimum Data Set, dated [DATE] documented Resident #258 had one (1) stage three (3) (full thickness tissue loss) pressure ulcer, one stage four (4) (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer, and three (3) unstageable pressure ulcers; all were present upon admission/readmission.The comprehensive care plan dated 07/14/2025 documented Resident #258 had impaired skin integrity with interventions to administer preventative treatments per provider order, monitor skin for changes daily during care, protect skin from external devices by padding or securing pressure reduction device for bed and chair, evaluate and measure skin/wound sites at least weekly. Document outcome and treatment progress/changes and monitor sites for signs and symptoms of infection.Review of Nursing admission Evaluation dated 07/16/2025, Registered Nurse #2 documented Resident #258 was admitted to the facility via a wheelchair van. The skin assessment included Resident #258 had an ulcer to buttock stage to be (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined, left inner thigh open area approximately one (1) centimeter by one (1) centimeter, right heel and ankle open wound, left heel sore, left outer calf open area approximately one (1) centimeter by one (1) centimeter, left calf red areas not open. There was no documented evidence of a complete pressure ulcer assessment including staging and measurements.Review of Medical Visit Note dated 07/17/2025, the Medical Director documented Resident #258 was readmitted to the facility after being hospitalized , had a chronic stage four (4) sacral ulcer. Refer to nursing notes for full skin assessments and wound measurements if any.Review of Resident #258s nursing Progress Notes, Weekly Skin Status Documentation, and Medical Visit Notes dated 07/16/2025 to 07/22/2025 revealed no documented evidence Resident #258 had a full assessment of their pressure ulcers including measurements and staging. Review of Wound Care Assessment/Consultation dated 07/23/2025, the Wound Care Consultant documented Resident #258 was admitted with a stage four (4) pressure ulcer to their sacrum (area above tailbone on right and left buttocks), coccyx (tailbone), and bilateral gluteal (buttock) folds. There were multiple areas clustered together that measured 26 centimeters long by 23 centimeters wide by 6.2 centimeters deep. Resident #258 had an unstageable pressure ulcer to their right lower extremity that measured 1.5 centimeters long by 2 centimeters wide with slough (layer of dead tissue) covering the surface, an unstageable pressure ulcer to their right heel that measured 2.5 centimeters long by 2.8 centimeters wide with slough covering the surface, an unstageable pressure ulcer to their right ankle that measured 1.5 centimeters long by 2 centimeters wide with slough covering the surface, and a stage three (3) pressure ulcer to their left medial thigh that measured 1 centimeters long by 2 centimeters wide 0.1 centimeters deep.During an interview on 03/13/2026 at 9:52 AM, Licensed Practical Nurse #3 stated the admitting nurse was responsible for completing a full skin assessment on a new admission/readmission, a Registered Nurse then was responsible for reviewing and signing off on the assessment. They stated a Licensed Practical Nurse could not stage pressure ulcers, a Registered Nurse was responsible for measurements and staging of pressure ulcers which needed to be completed within 24 hours after admission. Licensed Practical Nurse #3 reviewed Resident #258s Nursing admission Evaluations skin assessment dated [DATE] and stated there were no specific measurements or stages documented for Resident #258s pressure ulcers upon admission and there should have been. They reviewed Resident #258s progress notes, wound notes, and wound consultant notes and stated the first documented staging and measurements for Resident #258s pressure ulcers after admission were documented on 07/23/2025. Licensed Practical Nurse #3 stated it was important to have timely measurements and staging of pressure ulcers after admission to ensure accurate treatments were in place and to monitor for worsening of the wounds. During a telephone interview on 03/13/2026 at 10:54 AM, Registered Nurse #2 stated they completed the Nursing admission Evaluation for Resident #258 when they returned from the hospital in July. They did a full body assessment but did not document specific stages or measurements. They stated they were not trained in how to measure wounds or stage wounds. Registered Nurse #2 stated Licensed Practical Nurse #3 was responsible for completing wound assessments after the Wound Care Consultant saw the residents. They stated Resident #258 should have had measurements and staging completed sooner than 07/23/2025 because infection happened fast, wounds and pressure ulcers needed to be monitored for worsening or improvement.During an interview on 03/13/2026 at 11:19 AM, the Medical Director stated all residents should be examined within 24 hours of admission or readmission, all new and existing wounds needed to be documented. The Medical Director stated they would have expected nursing staff to have documented measurements, characteristics, and descriptions of wounds, new or existing, within 24 hours of admission for Resident #258; it was important for adequate documentation of progression, to monitor for improvement or worsening so that the wounds could be tracked accordingly.During an interview on 03/13/2026 at 11:34 AM, the Assistant Director of Nursing stated they would have expected a Registered Nurse to have completed a full assessment of Resident #258s pressure ulcers within 24 hours of admission, including staging and measurements. If Registered (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 did not feel comfortable staging or measuring a pressure ulcer, they should have reached out for guidance. During an interview on 03/13/2026 at 11:45 AM, the Director of Nursing stated they would have expected a full assessment of Resident #258s pressure ulcers, including staging and measurements, to have been completed, and documented upon admission, or within 24 hours after admission. The Director of Nursing stated if the admitting nurse, Registered Nurse #2, did not feel comfortable doing those things, they should have reached out to another unit coordinator, the Assistant Director of Nursing or the Director of Nursing so that they could guide them in the right direction. They stated it was important to have accurate timely assessments of wounds to determine whether a wound was improving or worsening, if different treatments were needed, and it could lead to further health issues.10NYCRR 415.12 (c)(2)