STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335777	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Father Baker Manor	6400 Powers Road Orchard Park, NY 14127

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. Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00383408) the facility did not ensure that all alleged violations involving abuse are reported immediately but not later than 2-hours after the allegation is made if the events that cause the allegation involve abuse, to the Administrator of the facility and to other officials (including to the State Survey Agency) for one (1) (Residents #1) of three (3) residents reviewed for abuse. Specifically, an allegation that a Certified Nurse Aide slapped a resident was not reported to the Administrator in the required timeframe and resulted in delayed reporting to the New York State Department of Health. The finding is: The policy titled Identification, Prevention, Investigation and Reporting of Victims of Potential Abuse, Neglect, or Exploitation dated 9/26/24 documented it was the facilities policy to report any suspected or actual victim of abuse when identified. All alleged violations involving abuse or mistreatment are reported immediately, but not later than 2 hours after the allegation is made if the events that caused the allegation involved abuse, to the administrator of the facility and to other officials including the New York State Department of Health through established procedures. Resident #1 had diagnoses including dementia, anxiety, and type 2 diabetes. The Minimum Data Set (a resident assessment tool) dated 3/19/25 documented Resident #1 had severe cognitive impairment, had rejection of care behaviors, and required substantial/maximal assistance with bathing/showering. The comprehensive care plan dated 10/15/24 documented the resident had dementia with sundowning (a state of increased confusion and restlessness, usually in late afternoon or evening, experienced by people with dementia) interventions included to cue, reorient, and supervise as needed; the resident was a maximal assist for showers. Review of the New York State Department of Health Complaint Tracking System Complaint/Incident Investigation Report revealed the date/time of the alleged incident was 6/7/25 at 7:00 AM. The date/time the Administrator was first made aware of the incident was 6/11/25 at 9:45 AM. It was submitted by the facility on 6/11/25 at 11:47 AM. Review of the Resident/Patient Occurrence Report dated 6/11/25 revealed a potential altercation between a staff member and resident occurred on 6/7/25 between 6:45 AM-7:00 AM in the shower room. The staff member alleged they witnessed another staff member slap the resident across the face. (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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(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	During an observation on 6/17/25 at 9:23 AM, Resident #1 was seated in their chair. They were alert and oriented to self only. There were no bruises or injuries were noted to their face, neck, or hands. During an interview on 6/17/25 at 11:52 AM, the Registered Nurse #1 stated on 6/7/25 around 7:00 AM, Certified Nurse Aide #2 reported to them that they witnessed Certified Nurse Aide #1 slap Resident #1 across the face in the shower room. Registered Nurse #1 stated they thought there was a supervisor working that day, but they did not report this allegation to the supervisor and stated they knew they should have. They stated they got busy and had no other excuse as to why they didn't inform the supervisor. They stated an alleged slap was considered physical abuse. During an interview on 6/17/25 at 2:05 PM, Registered Nurse Supervisor #1 stated they worked on 6/7/25 from 7:00 AM to 10:00 PM. They stated nobody had reported any allegations of abuse to them. They also worked the next day, and no allegations of abuse were reported to them. They stated the floor nurse should have called them and reported the allegation, then they would have called the Director of Nursing or Administrator to inform them because they were required to report it. During an interview on 6/17/25 at 2:27 PM, the Director of Nursing stated Certified Nurse Aide #2 told the nurse on the floor (Registered Nurse #1) that they witnessed another Certified Nurse Aide #1 slap Resident #1. Registered Nurse #1 should have called the supervisor to report this, and the supervisor would have then called them or the Administrator at home. This was their policy for any allegation of abuse. The Director of Nursing stated they never got a call that weekend. The Director of Nursing stated the process broke down when Registered Nurse #1 did not report it to the Registered Nurse Supervisor #1. This incident should have been reported to Administration on Saturday (6/7/25) morning and was not reported to them until Wednesday (6/11/25), when Certified Nurse Aide #2 reported the incident to the Registered Nurse Unit Manager, who then reported it to the Administrator. During an interview on 6/17/25 at 3:03 PM, the Administrator stated a slap across the face would be considered abuse. They expected staff to report any allegation of abuse to them. They stated in this situation there was a 4-day delay in staff reporting the allegation to themselves, the Director of Nursing, or a supervisor. The Administrator stated if they knew about this allegation sooner, they would have reported it as required. 10NYCRR 415.4(b)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interview conducted during an Abbreviated survey (Complaint #NY00383408), the facility did not have evidence that all alleged violations were thoroughly investigated and did not prevent further potential abuse or mistreatment while the investigation was in progress in response to all allegations of abuse for one (1) (Resident #1) of three (3) residents reviewed. Specifically, there was a delay in initiating an investigation when a staff member reported they witnessed physical abuse of Resident #1, and the accused staff continued working after the allegation was made. Additionally, the facility investigation did not include interviews or assessments of other residents who the accused cared for and statements from all staff involved. The finding is: The policy titled Identification, Prevention, Investigation and Reporting of Victims of Potential Abuse, Neglect, or Exploitation dated 9/26/24 documented all cases of suspected or actual abuse will be reported to the immediate supervisor/manager and an investigation will begin immediately. They would coordinate and facilitate interventions to prevent further abuse. The Occurrence Investigation Summary would be initiated and utilized as a resource; all documentation would be maintained in a confidential manner. The Director of Nursing or designee will coordinate the investigation and is responsible for maintaining and ensuring completion of all investigative documentation, including occurrence reports, assessments, statements, and other supporting documentation. Providers must be able to provide evidence that once an allegation of abuse was made, the investigation was commenced immediately regardless of the time of day or day of week the incident occurred. Resident #1 had diagnoses including dementia, anxiety, and type 2 diabetes. The Minimum Data Set (a resident assessment tool) dated 3/19/25 documented Resident #1 had severe cognitive impairment, had rejection of care behaviors, and required substantial/maximal assistance with bathing/showering. The comprehensive care plan dated 10/15/24 documented the resident had dementia with sundowning (a state of increased confusion and restlessness, usually in late afternoon or evening, experienced by people with dementia) interventions included to cue, reorient, and supervise as needed; the resident was a maximal assist for showers. Review of the Resident/Patient Occurrence Report dated 6/11/25, revealed a potential altercation between a staff member and resident occurred on 6/7/25 between 6:45 AM-7:00 AM in the shower room. The staff member alleged they witnessed another staff member slap Resident #1 across the face. The investigation file included written statements from staff dated 6/11/25 or later. There was no evidence the investigation was started immediately once the accusation was made. There was no statement provided by the accused Certified Nurse Aide #1 or that they were contacted for a statement. There was no evidence that other residents the accused cared for were assessed or interviewed to determine the potential for other victims. Review of Progress Notes dated 6/7/25-6/10/25 revealed there was no documentation that Resident #1 was assessed for any injuries. A Nurse Practitioner Progress Note dated 6/11/25, documented the resident was assessed for injuries due to a potential altercation with staff, and no injuries were noted. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/17/25 at 9:23 AM, Resident #1 was seated in their chair. They were alert and oriented to self only. There were no bruises or injuries noted to their face, neck, or hands. During a telephone interview on 6/17/25 at 10:13 AM, Certified Nurse Aide #1 stated a coworker had told them about the slap allegation and that they would never hit Resident #1. They worked with Resident #1 daily, and they were used to the resident and knew how to work with them and their behaviors. They stated Certified Nurse Aide #3 was in the shower room at the same time showering another resident. They remembered Certified Nurse Aide #2 walked into the shower room and left quickly. Nobody had asked them what happened or to provide a statement, they found out about the allegation after they were fired. They stated they finished their shift that day and worked the next day (Sunday) too. During an interview on 6/17/25 at 10:24 AM, Certified Nurse Aide #2 stated they were getting residents up for breakfast and was looking for another staff member to help them, so they went into the shower room because to ask if Certified Nurse Aide #3 knew where other staff were. When they walked into the shower room, they heard Resident #1 yelling which was their usual behavior. Both shower bay doors were open and Certified Nurse Aides #1 and #3 were giving showers. They stated as they walked to Certified Nurse Aide #3's shower bay and while walking by the other shower bay, they saw the smack. Certified Nurse Aide #2 stated they saw Certified Nurse Aide #1 hit Resident #1 on their face and neck with their open left hand. The resident moved back in the chair a little bit and said, ow was that necessary. They went over to Certified Nurse Aide #3 and asked where the other aide was to help them and left the shower room. They stated they did not intervene and did not tell Certified Nurse Aide #3 what they witnessed. When they left the shower room, they reported what they saw immediately to Registered Nurse #1. They stated nobody asked them to write a statement or anything. They stated when they returned to work after they worked the weekend, on either Tuesday or Wednesday, they told the Registered Nurse #2 Unit Manager about it. Certified Nurse Aide #2 stated they considered a slap physical abuse. During an interview on 6/17/25 at 11:30 AM, Certified Nurse Aide #3 stated they were in the shower room and Certified Nurse Aide #1 was in the other shower bay, giving Resident #1 a shower. They had the doors open for safety because Resident #1 could get worked up sometimes and they could help each other out if needed. They stated Certified Nurse Aide #2 came into the shower room briefly, asked them if they knew where another aide was and then left. Certified Nurse Aide #3 stated they heard Resident #1 say is that necessary and Certified Nurse Aide #1 stated what I'm washing your bottom. Certified Nurse Aide #3 stated they popped their head into Resident #1's shower bay and saw Certified Nurse Aide #1 kneeling down washing the resident's buttocks. A couple minutes after that, Registered Nurse #1 entered the shower room and asked them if they heard or saw anything out of the ordinary in the shower room. Certified Nurse Aide #3 told them no, then Registered Nurse #1 asked if Certified Nurse Aide #1 hit Resident #1. Certified Nurse Aide #3 stated absolutely not. Certified Nurse Aide #3 stated they could hear everything in that shower room, due to the acoustics, and they didn't hear any slapping noise, or a scuffle of any sort. The resident would have yelled out or fought back if they were hit. They stated during the shower, they heard Certified Nurse Aide #1 saying typical shower conversation like almost done, sit back, relax. Certified Nurse Aide #3 stated Certified Nurse Aide #2 didn't report anything to them when they were in the shower room, and nobody asked them to write a statement that day. They stated if they thought the resident was in an unsafe situation they were supposed to step in and make them safe and if you see something, say something. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 11:52 AM, the Registered Nurse #1 stated on 6/7/25 around 7:00 AM, Certified Nurse Aide #2 reported to them that they witnessed Certified Nurse Aide #1 slap Resident #1 across the face in the shower room. Registered Nurse #1 stated they went into the shower room and observed Resident #1 and Certified Nurse Aide #1 and didn't see anything out of the ordinary. The aide was still washing the resident in the shower and the resident had no red marks on their face and was calm. The Registered Nurse #1 stated they went over to Certified Nurse Aide #3, who was in the next shower bay showering another resident, and quietly asked if they heard or saw anything happen between Resident #1 and Certified Nurse Aide #1. The Certified Nurse Aide #3 responded they heard the resident say something like was that necessary and that they went over to check on Resident #1 and Certified Nurse Aide #1. Registered Nurse #1 stated they told Certified Nurse Aide #3 what was reported to them and the aide stated no, nothing like that happened. The Registered Nurse #1 stated if they thought the slap happened, they would have told Certified Nurse Aide #1 to leave and they would have taken over the resident's care. The Registered Nurse #1 stated they did not document their assessment of the resident and did not start and accident/incident report. They stated they should have documented their assessment and got staff statements because that was usually part of an incident for any falls, bruises, or skin tears. They had never been in this situation before and did what they were supposed to do, but did not write it down anywhere. The Registered Nurse #1 stated they did not ask Certified Nurse Aide #1 their side of the story and they should have asked, but they had it in their head they were going to notify the supervisor to handle it, but they never did that because they got busy. They stated an alleged slap was considered physical abuse. During an interview on 6/17/25 at 2:05 PM, Registered Nurse Supervisor #1 stated they worked on 6/7/25 from 7:00 AM to 10:00 PM. They stated nobody reported any allegations of abuse to them. They stated a slap would be considered abuse, they would have had to get statements from everyone, and an accident/incident report should have been done, especially if it was reported it was witnessed. They stated they would have asked the Director of Nursing if anything should have been done with the accused Certified Nurse Aide (like sending them home). During an interview on 6/17/25 at 2:55 PM, the Registered Nurse #2 Unit Manager stated on Wednesday (6/11/25) when Certified Nurse Aide #2 arrived to work they reported they witnessed Certified Nurse Aide #1 slap Resident #1 across the face when they went into the shower room to ask another aide something. The Certified Nurse Aide #2 stated they did not hear any slap sound but heard the resident say, was that necessary and Certified Nurse Aide #2 did not think the nurse did anything about it when they reported it to them on Saturday (6/7/25). They had Certified Nurse Aide #2 write a statement immediately and then they took the statement to the Administrator and reported it. The Registered Nurse #2 Unit Manager stated they assessed the resident and asked them some questions, monitored for any bruising or complaints of pain. They noticed no difference in the resident's demeanor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 2:27 PM, the Director of Nursing stated there was an allegation that a resident was slapped on 6/7/25 around 7:00 AM and they considered a slap physical abuse. They stated the guidance they would have given to the supervisor would have been to assess the resident and to send the accused Certified Nurse Aide home during the investigation. To put someone on leave was protection for both the staff and the resident during the investigation stage. The Director of Nursing stated they took over the investigation after the Administrator reported it to the Department of Health. They stated they did not talk to any other residents the Certified Nurse Aide #1 cared for and whether that should be part of an investigation depended on the situation. In this situation they did not because by the time they found out about the allegation, the Certified Nurse Aide #1 no longer worked at the facility. If the supervisor had known about the allegation and reported it to them, they would have told them to go ask other residents. The Director of Nursing stated the Certified Nurse Aide #1 finished their shifts on Saturday, Sunday and worked Monday morning. They were terminated on Monday (6/9/25) afternoon for an unrelated issue. When they were aware of the allegation on Wednesday (6/11/25), the resident was assessed, interviewed, and their family and provider were notified. The Director of Nursing stated they did not talk to or get a statement from Certified Nurse Aide #1 because they were termed, and they do not usually talk to staff after that. The Director of Nursing stated it was hard to do a thorough investigation after the fact, and it should have been a conversation they had with the accused after the incident occurred. The Director of Nursing stated the Registered Nurse #1 did not document any kind of assessment of Resident #1 on 6/7/25 in the electronic medical record and anything the nurses did for the residents should be documented in the electronic medical record. During an interview on 6/17/25 at 3:03 PM, the Administrator stated Registered Nurse #2 Unit Manager reported to them on Wednesday (6/11/25) that Certified Nurse Aide #2 reported they witnessed Certified Nurse Aide #1 slap a resident. They immediately started an investigation, had the Unit Manager assess the resident, gather statements from any other staff involved. They had the witness demonstrate what they saw, and they reported they saw a raised hand that connected to the resident's face. Staff were educated to call Administration about any abuse allegations, and it was not their job to say if an allegation happened or did not happen. If staff would have reported it sooner, they would have completed the investigation sooner, but nothing else would have changed. The process did not change, by the time they knew about the allegation, Certified Nurse Aide #1 no longer worked at the facility and had no contact with the residents. The Administrator stated Certified Nurse Aide #1 had contact with other residents before Administration was aware of the allegation as they worked the rest of their shifts on Saturday, Sunday and Monday before they were terminated. They stated the Director of Nursing took over the investigation and they did not know if any other residents were interviewed or assessed as part of their investigation. They would have told the supervisor to get a statement from Certified Nurse Aide #1 and given the nature of the allegation, they would have been put on suspension. The Administrator stated they could have checked with other residents on Certified Nurse Aide #1's assignment, but they did not because they did not know about the allegation. 10NYCRR 415.4(b)(3)