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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. Based on interview and record review conducted during a survey, the facility failed to ensure that residents were free of significant medication errors for one (1) (Resident #1) of three (3) residents reviewed for medication errors. Specifically, on 02/23/2026 Licensed Practical Nurse #1 pre-poured 20 residents' medications and administered medications to Resident #1 that were intended for Resident #2. Resident #1 later became difficult to arouse, developed hypotension (low blood pressure), bradycardia (heart beat fewer than 60 times per minute), and a lower respiratory rate which required the administration of Narcan (naloxone, medication used to reverse opioid overdoses). This resulted in, or had the likelihood of serious injury, serious harm, or death for Resident #1 that was Immediate Jeopardy and Substandard Quality of Care.The findings are: The policy titled Medication Administration dated 02/26/2026 documented the purpose was to ensure that all medications were administered accurately, appropriately, safely, and in a timely manner. All medication orders must include date, time, medication name, dose, frequency, and indication for the medication. The administration of medications procedure included to identify resident, compare medication label to the medication administration record, prepare/administer ordered medications to resident, and document administration of medications in the medication administration record. The policy titled Notification of a Significant Change in Condition dated 06/26/2015 documented the resident's medical provider will be notified promptly when the patient/resident experiences a significant change in condition. The licensed nurse should notify the medical provider of a change in the resident's condition that warrants notification. Resident #1 had diagnoses including Parkinson's disease (progressive movement disorder of the nervous system), dementia (progressive memory disorder), and anxiety. The Minimum Data Set (a resident assessment tool) dated 02/06/2026 documented that Resident #1 was cognitively intact and received medications including but not limited to antipsychotic (medication used to treat psychosis), antianxiety, antidepressant, and anticoagulant (medication used to prevent blood clots). The Comprehensive Care Plan revised 02/11/2026 documented Resident #1 had impaired cognitive function/impaired thought process related to dementia. Interventions documented for staff to administer medications per the provider's order, monitor for adverse reactions, effectiveness, and report as needed. The iQIES (internet Quality Improvement and Evaluation System) Complaint/Incident Investigation Report 2790253, received 02/26/2026 documented on 02/23/2026 Resident #1 was administered Resident #2 medications. Resident #1 was administered medications including but not limited to Ativan (medication used to treat anxiety) 0.5 milligrams, pregabalin (Lyrica, medication used to treat seizures and nerve pain) 300 milligrams,methadone (long-acting opioid medication used to treat pain) 7.5 milligrams, and oxycodone (opioid medication used to treat moderate to severe pain) 10 milligrams. The Progress Note completed by Licensed Practical Nurse #1 dated 02/23/2026 at 9:09 PM documented Resident #1 was given another resident's medication. The nursing supervisor, medical doctor and family were notified. Resident #1's vital signs remained stable. The Weights and Vitals Summary dated 02/24/2026 at 12:05 AM documented Resident #1's blood pressure was 90/52 (normal range 90-120/60-80) and they had a heart rate of 52 (normal 60-100 beats per minute). There was no documented evidence of corresponding nurse's notes, other vital signs documented or noted changes (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	in the resident's mental status. There was no documented evidence that Medical Doctor #1 was notified. The Progress Note completed by Registered Nurse Supervisor #1 dated 02/27/2026 at 3:14 PM (late entry), documented on 02/23/2026, they were notified at 7:00 PM that a medication variance (discrepancy between a prescribed medication order and what is actually administered) had occurred with Resident #1. The resident remained at baseline with stable vital signs, and Medical Doctor #1 was updated at 7:20 PM with new orders to monitor the resident and vital signs every four (4) hours for 24 hours. The Progress Note completed by Licensed Practical Nurse #2 dated 02/24/2026 at 4:35 AM, documented Resident #1 was difficult to arouse, sternal rub (painful stimulus to test level of consciousness) with minimal effect, blood pressure 85/50, and extended period of time between respirations. A follow-up note dated 02/24/26 at 5:39 AM by Licensed Practical Nurse #2 documented a level 3 (non-urgent notification no return call necessary) voicemail was left for Medical Doctor #1. The Progress Note completed by Registered Nurse Supervisor #2 dated 02/24/2026 at 5:41 AM, documented resident lethargic, responsive to verbal and tactile stimuli, blood pressure 85/50, pulse (heart rate) 50, respirations 10 (normal 12-20 breaths per minute) with resident pausing for periods of time between each breath then taking heavy breaths. The Acute Visit Provider Note completed by the Medical Doctor #1 dated 02/24/2026 documented they met with Resident #1 at approximately 10:00 AM on 02/24/2024 for an acute visit secondary to a medication error. The note documented Resident #1's vital signs; respiration rate 10, heart rate 64, blood pressure 156/55. The note further documented Resident #1 was sleeping and not following commands. Medical Doctor #1 documented they ordered Narcan to be administered. Additionally, the note documented Medical Doctor #1 evaluated Resident #1 again at 2:00 PM on 02/24/2026 and the resident was awake but tired, conversant, and recalled being told the previous night of receiving the wrong medication. During a telephone interview on 03/05/2026 at 9:51 AM, Licensed Practical Nurse #1 stated at the beginning of their shift (2:00 PM), they had pre-poured all medications to be administered during their shift on 02/23/2026, except for narcotic medications. They placed the medications in plastic medication cups and wrote the residents names on the sides of the cups. They stated they misidentified the pregabalin (medication that treats nerve pain) as it looked exactly like a medication that Resident #1 was to receive, administered all the medications in the cup to Resident #1, immediately realized their error, and notified Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated they should not have pre-poured medications because they could be administered to the wrong resident and could cause adverse reactions. During a telephone interview on 03/05/2026 at 10:31 AM, Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 had reported the medication error on 02/23/2026 at approximately 7:00 PM. The supervisor stated they notified Medical Doctor #1 and Resident #1 remained stable throughout the shift which ended at 10:00 PM. During a telephone interview on 03/05/2026 at 10:46 AM, the Pharmacy Consultant stated they expected nurses to follow the six (6) rights of medication administration (right patient, right medication, right dosage, right route, right time, and right documentation) and not pre-pour medications secondary to the risk of administering medications incorrectly. They further stated the medications Resident #1 received in error could cause dizziness, lethargy, and decreased respirations. During an interview on 03/05/2026 at 10:57 AM, the Director of Nursing stated the facility's investigation revealed Licensed Practical Nurse #1 had pre-poured the medications to be administered during their shift and they had erroneously administered Resident #2's medications to Resident #1. The Director of Nursing stated they expected nursing staff to follow the facility policy for medication administration and to follow the six (6) rights of medication administration. During an interview on 03/05/2026 at 11:18 AM, Medical Doctor #1 stated the medications Resident #1 received in error were heavy duty medications that could cause lethargy, decreased blood pressure, decreased respirations, and altered mental status. Additionally, they stated the nurses should not pre-pour medications. During a telephone interview on 03/05/2026 at 11:27 AM, the Medical Director stated nursing staff should follow the rights of medication administration to ensure residents receive the correct medications. During an interview on (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	03/05/2026 at 12:56 PM, the Administrator stated they expected staff to follow the facility policy and medication administration rights to prevent medication errors. Medications should be prepared and administered to one (1) resident at a time. During a follow-up telephone interview on 03/02/2026 at 2:05 PM, Medical Doctor #1 stated they did not give vital sign parameters to the nursing staff when they ordered to monitor Resident #1's vital signs on 02/23/2026, but thought facility would notify them of any abnormal vital signs. They further stated they would have ordered the Narcan sooner for Resident #1, had they been made aware of the change in Resident #1's vital signs, increased lethargy and abnormal respiratory rhythm. During a telephone interview on 03/06/2026 at 8:08 AM, Licensed Practical Nurse #2 stated on the night shift of 02/24/2026, Resident #1 was difficult to arouse, they performed a sternal rub, and Resident #1 responded minimally. Additionally, they stated they notified Medical Doctor #1 via voicemail level three (3), non-urgent notification and in retrospect, they should have notified via a level one (1) (urgent - return call within 15 minutes) or level two (2) (routine - return call within two hours). The facility Administrator was informed of the Immediate Jeopardy at F 760 on 03/05/2026 at 4:13 PM and the facility submitted an approved plan to remove the immediacy on 03/05/2026. The Survey team determined through observation, interview, and record review the immediacy was removed on 03/06/2026 at 12:00 PM prior to exit based on the following corrective actions taken by the facility: - Resident #1 was monitored and there was no ill effect after the administration of Narcan.- The facility reviewed the following policies: Opioid Overdose and the Use of Naloxone Sub-acute and Long-Term Care Facilities; Medication Administration; Medication Variance Reporting; and Notification of a Significant Change in Condition.- The facility revised the Medication Administration policy to include the six (6) rights of medication administration and added one patient/resident at a time. - Nursing staff responsible for medication administration were educated on Medication Administration, Medication Variance Reporting, Notification of a Significant Change in Condition, and the medical provider paging system which included levels of urgency to return the call (Level 1 = emergency, Level 2 = routine, Level 3 = notification). Any nursing staff on vacation, on leave of absence, or agency staff will be educated prior to medication administration.-Medication administration and medication cart audits were completed and will continue. 10 New York Code Rules Regulations 415.12(m)(2)