STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395780	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Acres Geriatric Center	340 N. Middletown Road Lima, PA 19037

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policy, clinical record, facility documentation, and staff interview, it was determined the facility failed to ensure that residents were free from abuse resulting in actual harm of continued nonconsensual sexual contact for one of five sampled residents (Resident 1). This failure resulted in an Immediate Jeopardy situation. The incident has been identified as past non-compliance. Findings include:Review of facility policy, Prohibition of Abuse, reviewed December 2024, revealed that residents, families, and staff are provided with information on how and to whom they may report concerns, and incidents. Any individual observing an incident of abuse, neglect, or misappropriation, or suspecting abuse, neglect, or misappropriation has a responsibility to intervene immediately so that safety of the resident can be ensured. Once the resident is safe, the individual who witnessed the incident of abuse or suspected abuse will immediately report the incident to a Licensed Nurse. Review of Resident 1's significant change MDS (Minimum Data Set - periodic assessment of resident needs) of June 9, 2026, included diagnoses of but not limited to schizophrenia (serious mental health condition that affects how people think, feel, and behave, often leading to hallucinations, delusions, and disorganized thinking). The assessment also revealed that the resident had a BIMS (brief interview for mental status) score of 9, indicating moderate cognitive impairment. Review of Resident 2's annual MDS of June 9, 2026, revealed the resident had a BIMS score of 15, indicating normal cognitive function. Review of Nurse Aide, Employee E4's written statement obtained on June 29, 2026, revealed on June 25, 2026, Resident 1 was heard saying Resident 2 likes to kiss his body. Employee E4 questioned Resident 1 on June 26, 2026, if Resident 2 ever asked Resident 1 to do things he does not want to do and Resident 1 replied yes, he jerks me off and indicated this act happened often. Employee E4 also stated that he/she was not sure what to do and did not feel comfortable talking to anyone but the unit manager, Employee E5. Review of unit manager, Employee E5's written statement obtained on June 29, 2026, revealed; nurse aide, Employee E4 reported the allegation of non-consensual sexual contact which Resident 1 made regarding Resident 2 four days after the initial allegation. Review of Resident 1's verbal statement obtained on June 29, 2026, revealed, [Resident 2] jerks me off, he kisses all over my body, he likes to jerk me off, he grabbed and kissed my ass, I don't like it. Resident 1 further revealed he did not give consent and was unclear of the timeline but stated that it (sexual contact) happened often. Review of Resident 2's verbal statement obtained on June 29, 2026, revealed, I have kissed Resident 1 all over his body, from top to bottom. I touched his private. Resident 2 indicated that two nights ago was the last time (June 27, 2026) sexual contact occurred. Review of hospital emergency department note of June 29, 2026, revealed Resident 1 was assessed for sexual assault. Assessment revealed no injury to genitalia. Resident was discharged on antibiotic for STD (sexual transmitted disease) prophylaxis (treatment to prevent a disease from occurring). Review of information submitted by the facility to the Department on June 29, 2026 at 1 a.m. revealed, [Resident 1], long-term resident of [facility]. He is alert to self, place at times. He has a BIMS of 9. [Resident 1] made the following statement to his aide on 6/25 He likes to kiss my body (referring to his roommate, [Resident 2]). On further questioning, resident reported manual manipulation of his genitals, kissing/licking of his body & anal penetration. Further (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	review of the documentation revealed, CNA [name removed] reported allegation to this writer today, 6/29/26, at 0840. Immediately separated residents & investigation initiated. Review of the facility submitted documentation including PB-22 (Report of Investigation of Alleged Abuse, Neglect, or Misappropriation of Property) initiated June 29, 2026, revealed the facility substantiated the sexual abuse as there was a delay in reporting by nurse aide, Employee E4 of Resident 1's allegation of sexual abuse against Resident 2 (roommate). Review of Employee E4's 2025 mandatory in-service training revealed nurse aide, Employee E4 had received abuse prevention training on August 18, 2025. Based on the above findings, Immediate Jeopardy to the safety of the residents was identified to the Director of Nursing (DON) on July 2, 2026, at 1:25 p.m. for failure to keep a resident free from abuse due to nurse aide's delay in reporting which resulted in actual harm of Resident 1 who was subjected to further nonconsensual sexual contact of Resident 2. The DON was provided with the Immediate Jeopardy template, and an immediate action plan was requested. The facility identified the jeopardy at the time the incident was reported on June 29, 2026, and implemented the following corrective action plan:The residents were immediately separated and 1:1 supervision was implemented.The alleged victim was ordered by the physician to be transferred to the emergency room for further evaluation.Park police (campus police unit) were notified.Employee E4 was placed on paid administrative leave.All residents and previous roommate of alleged perpetrator were interviewed regarding nonconsensual sexually contact or abuse by another resident.Applicable staff were interviewed regarding the allegation of sexual assault/abuse.Prohibition of Abuse policy and procedure was reviewed. All employees were immediately educated on the policy and procedure.The Director of Nursing or designee will audit resident concerns to ensure allegations of sexual assault/abuse are reported immediately to appropriate authorities. Audits will occur weekly x2 and then monthly x2. If trends are identified, corrective action, including a root cause analysis will be reported to the QA (quality assurance) committee. On July 2, 2026, a review was conducted to verify the complete implementation of the facility's corrective action plan. Ten staff were interviewed and confirmed they received the training described in the facility's action plan. All nursing staff were aware of abuse prevention and reporting. All staff training was completed by June 29, 2026. Resident 1 was observed in a room on a different nursing unit from Resident 2 with both on 1:1 supervision. The Immediate Jeopardy existed from June 25, 2026, until June 29, 2026. Verification of all elements of the action plan was completed on July 2, 2026, at 3:00 p.m., and Immediate Jeopardy was lifted. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on the review of job descriptions, review of facility documentation and interviews with staff, it was determined the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure that residents were free from abuse by ensuring staff report timely and implement interventions to prevent abuse. This failure resulted in an Immediate Jeopardy situation.Findings Include:Review of the job description for the Nursing Home Administrator (NHA) revealed that the NHA ensures that the facility operates in compliance with all local, state, and federal regulations. Review of the job description for the Director of Nursing (DON) revealed that the DON is responsible for leading the Nursing Department to provide quality care to the residents based on best practices and regulatory guidelines. The findings in this report identified the facility failed to ensure that allegations of abuse were reported timely and interventions implemented to protect residents from potential abuse. This failure placed residents at risk for serious injury from abuse and resulted in an Immediate Jeopardy situation. Based on the deficiencies identified in this report the NHA and DON failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate Jeopardy situation. Refer to F689 Pa Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(b)(3) Management