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	02/13/2026

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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, review of facility policy and the review of facility documentation, it was determined the facility failed to ensure one resident was free from financial exploitation through misappropriation of resident funds for one out of 40 residents reviewed, resulting in actual harm to Resident R186 who lost thousands of dollars. Findings include:Review of the facility policy titled Prohibition of Abuse, approved January 2024, defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including failure to communicate regarding the plan of care.The policy further defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.Review of Resident R186's clinical record revealed the diagnoses of Vascular Dementia, unspecified severity, with agitation (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain) with a start date of September 12, 2024, altered mental status, and Major Depressive Disorder (mood disorder that causes a persistent feeling of sadness and loss of interest).Review of Resident R186's Minimum Data Set (federally mandated, standardized, comprehensive clinical assessment tool) dated January 8, 2025, revealed Resident R186 possessed a Brief Interview for Mental Status (BIMS) of 8 out of 15 indicating moderated cognitive impairment.Review of documentation submitted on December 17, 2025, to the State Survey Agency revealed the facility became aware of an allegation of misappropriation of funds when it was contacted by the Department (licensing entity for skilled nursing facilities) on December 17, 2025. Further review of facility submitted information revealed the Durable Power of Attorney (DPOA) for Resident R186 opened a brokerage account at a nearby banking institution to manage Resident R186's funds. The banking institution became concerned after conducting an internal audit and identifying the following transactions:On October 23, 2025, a deposit of $131,298.56 was received from Empower.On October 28, 2025, a withdrawal of $44,160.00 was made.On October 28, 2025, an authorized purchase of $3,332.00 was made to (local company)On October 28, 2025, several ATM withdrawals of $800.00 each were made.On November 5, 2025, four Venmo transactions of $450.00 each were completed to (individual confirmed as not resident).The account balance as of December 12, 2025, was $53,687.05.Further review of facility submitted information revealed, that on 11/10/25 a new brokerage account was opened but was flagged by [NAME] Fargo with concerns related to capacity of (Resident R186) to execute POA from 1/10/25. On 11/21/25 POA documents were submitted to designate (resident friend) as POA for (Resident R186)'s newly opened brokerage IRA along with a letter of incapacitation dated 9/15/25. Per the letter (Resident R186) has been a resident at Fair Acers since 5/26/22. It is not clear if date of incapacitation is May 2022 or [DATE]. Fair Acres has no such letter on file. (Resident) is sole owner on account ending [****] and (resident's friend) is listed as POA.Review of the facility's investigation dated December 17, 2025, revealed the facility referred the matter to the local police department for investigation, but current status is unknown. Review of Resident R186's Pennsylvania Durable Power of Attorney form revealed it was signed by Resident R186 on January 10, 2025, and witnessed by facility staff, Licensed Employee E2 and Unlicensed Employee E4.During an interview conducted with Resident R186 on (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 0602 Level of Harm - Actual harm Residents Affected - Few	February 12, 2026, at approximately 10:58 a.m., Resident R186 stated he/she was unaware their Durable Power of Attorney intended to transfer funds to another banking institution. Resident R186 reported knowing his/her Durable Power of Attorney for over 50 years and described him/her as a family friend.During an interview conducted with Licensed Employee E2 on February 13, 2026, at approximately 9:30 a.m., Licensed Employee E2 confirmed Resident R186 signed the POA paperwork on January 10, 2025. Licensed Employee E2 further indicated Resident R186's Brief Interview for Mental Status (BIMS) score at the time the form was signed was 8 out of 15, indicating moderate cognitive impairment. Licensed Employee E2 confirmed Resident R186 did not possess decision-making capacity at that time and, therefore, should not have signed the Pennsylvania Durable Power of Attorney form.During an interview conducted with Unlicensed Employee E4 on February 13, 2026, at approximately 1:27 p.m., Unlicensed Employee E4 reported being asked to witness Resident R186 signing the Pennsylvania Durable Power of Attorney form. Unlicensed Employee E4 stated he/she does not participate in evaluating residents to determine decision-making capacity.During a phone interview conducted with the Social Services Director (SSD) on February 13, 2026, at approximately 1:45 p.m., the SSD confirmed Resident R186 had a BIMS score of 8 and lacked decision-making capacity to sign the Pennsylvania Durable Power of Attorney form. The SSD further reported that if Licensed Employee E2 had reviewed Resident R186's BIMS score prior to the signing, the resident would not have been permitted to designate a Durable Power of Attorney and would have retained control of their funds.Review of Resident R186's clinical medical record revealed in December 2025, the POA was removed and Resident R186 was appointed a legal guardian from a nearby law firm.Resident R186's guardian was unable to be reached by phone.During an interview conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on February 13, 2026, at approximately 2:15 p.m., the investigation was reviewed. The NHA confirmed Resident R186 should not have signed the Pennsylvania Durable Power of Attorney form.The facility failed to protect Resident R186 from financial exploitation through misappropriation of resident funds resulting in actual harm to Resident R186. Resident R186's suffered financial loss when approximately $77, 611.51 was withdrawn from the banking account after Resident R186's signed power of attorney to a friend, while diagnosed with vascular dementia and cognitively impaired as demonstrated with a BIMS of 8.28 Pa. Code 201.18(b)(1)(2)(e)(1) Management28 Pa. Code 201.29 (a)(c) Resident rights28 Pa Code 211.12 (c) Nursing services

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review and interview with staff, it was determined that the facility failed to inform the resident or resident's representative in advance of treatment risks and benefits, options, and alternatives for one of five residents reviewed (Resident 332).Findings include: Review of Resident 332's clinical record revealed an order on December 12, 2025, for risperidone (antipsychotic medication) 0.25 mg (milligrams) at bedtime for vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain), severe, with agitation. An order was received on December 22, 2025, for lorazepam (anti-anxiety medication) 0.5 mg one tablet at bedtime for encounter for palliative care (medical care that relieves pain, symptoms and stress caused by serious illness). An additional order was received on December 30, 2025, for lorazepam 0.5 mg every six hours prn (as needed) for vascular dementia, severe, with agitation. Further review of the clinical record revealed no evidence that the resident or resident's representative was notified in advance of the risk, benefits, options, and alternatives of the use of risperidone or lorazepam. Interview with the Director of Nursing on February 13, 2026, at 1:00 p.m. confirmed that the resident or resident's representative was not made aware of the risks, benefits, options, and alternatives prior to the use of risperidone and lorazepam. 28 Pa. Code 201.18(b)(1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that resident assessments accurately reflect the residents' status for one of 35 residents reviewed. (Resident 12).Findings include:Review of Resident 12's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) dated December 31, 2025, revealed under section P0100 - Physical Restraints, that the resident was marked as using restraints less than daily.Review of Resident 12's physician's orders revealed that the resident did not have an order for any restraints.Interview with the licensed staff, Employee E6, on February 13, 2026, at 1:40 p.m. confirmed that the resident's MDS assessment was marked incorrectly.483.20 Accuracy of Assessments28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(c) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and interviews with staff, it was determined that the facility failed to develop and implement a comprehensive care plan to address the use of psychotropic medications (any drug that affects behavior, mood, thoughts, or perception, which includes medications for anxiety and antipsychotics) for one of 35 residents reviewed (Resident 332).Findings include: Review of Resident 332's clinical record revealed an order on December 12, 2025, for risperidone (antipsychotic medication) 0.25 mg (milligrams) at bedtime for vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain), severe, with agitation. An order was received on December 22, 2025, for lorazepam (anti-anxiety medication) 0.5 mg one tablet at bedtime for encounter for palliative care (medical care that relieves pain, symptoms and stress caused by serious illness). An additional order was received on December 30, 2025, for lorazepam 0.5 mg every six hours prn (as needed) for vascular dementia, severe, with agitation.Further review of the clinical record revealed that there was no care plan to address the use of the psychotropic medications risperidone and lorazepam.Interviews with licensed staff, Employee E7, on February 13, 2026, at 11:04 a.m. and licensed staff, Employee E8, on February 13, 2026, at 11:22 a.m. confirmed that there was no care plan addressing the use of the psychotropic medications.28 Pa. Code 201.18(b)(1) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based upon clinical record review it was determined that the facility failed to follow physician orders regarding fluid restriction for one of thirty-five residents reviewed (Resident 388).Findings include:Review of Resident 388's diagnosis list revealed diagnoses including respiratory failure.Review of Resident 388s physician orders revealed an order for fluid restriction 1800 milliliters (ml) daily - Nursing 7-3 - 300 ml; 3-11 - 180 ml; 11-7 - 120 ml; Dietary - Breakfast - 480 ml; Lunch - 360 ml; Dinner - 380 ml.Further review of Resident 388's clinical record failed to reveal evidence that Resident 388's fluid restriction was being monitored on a daily basis to ensure Resident 388 did not exceed the 1800 ml per day. Interview with the Director of Nursing on February 13, 2026, at 1:00 p.m. confirmed that the facility was not monitoring Resident 388's daily fluid consumption. 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to obtain and monitor weights for one of one resident reviewed for nutrition (Resident 348).Findings include:Review of facility policy, Fundamental Nursing Care: - Obtaining Resident Height and Weight, dated March 2023, revealed that A weight gain or loss of 4% within one month requires a follow- up.Weight gain or loss of 4% requires a re-weigh of the resident . Review of Resident 348's clinical record revealed recorded weights of 91.8 pounds on August 29, 2025; 90.8 pounds on September 9, 2025; 84.5 pounds on October 31, 2025 (loss of 6.3pounds or -6.94% in one month). There was no evidence of a re-weigh conducted to address the weight loss.Further review of Resident 348's clinical record failed to reveal recommendations to address the weight loss. Interview with Employee E5 on February 13, 2025, at 10:30 a.m. confirmed that further dietary interventions should have been implemented to address Resident 348's weight loss.28 Pa. Code 211.5(f) Clinical Records28 Pa. Code 211.10(c) Resident Care Policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing Service