

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey conducted on February 3, 2025, and completed on February 4, 2025, at Fair Acres Geriatric Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

FAIR ACRES GERIATRIC CENTER

STATE LICENSE NUMBER: 061002

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 061002 Component 02 Building 05</p> <p>Based on a Medicare/Medicaid Recertification Survey conducted on February 3, 2025, and completed on February 4, 2025, it was determined that Fair Acres Geriatric Center - Building 05 was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one-story, Type III (200) unprotected ordinary building, with a basement, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025					
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE				
K 0321 SS=E	<p>NFPA 101 Hazardous Areas - Enclosure</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <table border="0"> <tr> <td>Area</td> <td>Automatic Sprinkler</td> </tr> <tr> <td>Separation</td> <td>N/A</td> </tr> </table> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	Area	Automatic Sprinkler	Separation	N/A	K 0321	<p>Preparation and submission of this POC is required by State and Federal Law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any court proceedings.</p> <p>New strike plate was installed and will be monitored monthly for one quarter by a maintenance department designee to ensure condition is not replicated.</p>	<p>Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025</p>
Area	Automatic Sprinkler							
Separation	N/A							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0321 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain doors to hazardous areas, affecting one of two levels. Findings include: Observations on February 3, 2025, at 10:35 a.m., revealed on the first floor, Clean Utility Room entry door had a missing strike plate. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the missing strike plate.	K 0321		
K 0374 SS=E		K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 3 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Plan of Correction: Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0374 A & B A. New door coordinator for double doors next to room 129 will be installed. Door will be monitored monthly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. B. New door coordinator for double doors next to room 118 will be installed. Door will be monitored monthly for 1 Quarter by a maintenance department designee to ensure this	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain smoke doors affecting one of two levels. Findings include: Observation on February 3, 2025, from 10:25 a.m. until 10:40 a.m., revealed the following smoke doors failed to close smoke tight when tested: a. 10:25 a.m., on the first floor, double doors to Day Room, next to room 129; b. 10:40 a.m., on the first floor, double doors to Day Room, next to room 118. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the doors the failed to close smoke tight.	K 0374	condition is not replicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0920	<p>Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings.</p> <p>K 0920 a & b</p> <p>a. Fan power source was relocated to wall outlet.</p> <p>Smoking room will be monitored weekly for one quarter by maintenance designee to ensure this condition is not replicated.</p> <p>b. Extension cord was removed.</p> <p>Room 118 will be monitored weekly for one quarter by maintenance designee to ensure this condition is not replicated.</p> <p>2/19/2025</p>	<p>Completion Date: 02/19/2025</p> <p>Status: APPROVED</p> <p>Date: 02/21/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of electrical devices, affecting one of four levels. Findings include: Observation on February 3, 2025, between 9:00 a.m. and 12:30 p.m., revealed the following unauthorized electrical devices were in use: a) Designated smoking room had a fan powered into surge protector. b) Resident Room 118 utilized a brown light duty extension cord for powering resident electronics. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the unauthorized use of electrical devices.	K 0920		
K 0923 SS=E		K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 7 NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Plan of Correction: Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 8 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain oxygen storage requirements, affecting one of two levels. Findings include: 1. Observations on February 3, 2025, at 10:30 a.m., revealed first level, Clean Utility Room did not have precautionary signage required for oxygen storage: Precautionary signs shall include the wording: "CAUTION: OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING". Exit interview with the Maintenance Director on February 4, 2025, at 1:00 pm, confirmed the missing signage.	K 0923		



Certified End Page

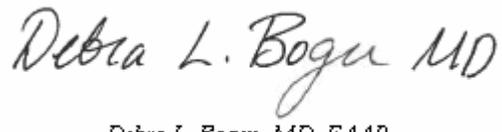
FAIR ACRES GERIATRIC CENTER

STATE LICENSE NUMBER: 061002

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 061002 Component 03 Building 06</p> <p>Based on a Medicare/Medicaid Survey conducted on February 3, 2025, and completed on February 4, 2025, it was determined that Fair Acres Geriatric Center - Building 06 was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three-story, Type II (222) fire resistive building, with a basement, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0355 Laundry cart was moved. Staff was in-serviced on the importance of not blocking fire extinguishers with laundry cart. Area will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure portable fire extinguishers were maintained, on two of fifteen floors. Findings Include: Observation on February 3, 2025, at 10:25 a.m., revealed in corridor a fire extinguisher was blocked by a soiled laundry cart that was left unattended by staff members. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the portable fire extinguisher deficiency.	K 0355		
K 0374 SS=E		K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 3 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0374 Missing Hardware on push bar was installed on door. Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. 2/19/2025	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain smoke doors affecting one of four levels. Findings include: Observation on February 3, 2025, at 11:30 a.m., revealed on the first floor, the double smoke barrier doors next to elevator had missing hardware on the push bar. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the missing hardware.	K 0374		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 5 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0918 Documentation will be provided by outside contractor for 3-year, 4-hour load test of emergency generator. Submission of Load test paper documentation will be checked quarterly to ensure all proper documentation is maintained.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 6 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire component. Findings include: Document review on February 3, 2025, at 8:00 a.m., revealed the facility could not provide documentation of a 3 year, 4 hour load test of the emergency generator. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of documentation.	K 0918		
K 0923 SS=E		K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 7 NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0923 a & b A. New signage will be installed on second floor inside oxygen storage to ensure there is no mixing of full versus empty cylinders. Area will be monitored weekly for 1 quarter by a maintenance department designee to ensure this condition is not replicated. B. New signage on ground floor will be installed to label/designate full versus empty cylinders. Area will be monitored weekly for 1 quarter by a maintenance department designee to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 8 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0923 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to properly store and identify medical gas cylinders, affecting one of three floors within the facility. Findings include: Observation on February 3, 2025, revealed: a) 10:35 a.m., on the second floor, inside oxygen storage, the full versus empty cylinders were mixed into both racks. b) 10:50 a.m., on the ground floor, inside oxygen storage, the full versus empty cylinders were not labeled. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of cylinder labeling and mixing cylinders.	K 0923		



Certified End Page

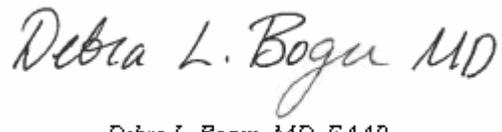
FAIR ACRES GERIATRIC CENTER

STATE LICENSE NUMBER: 061002

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002	STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	Continued from page 1 Facility ID# 061002 Component 04 Building 7 Based on a Medicare/Medicaid Recertification Survey conducted on February 3, 2025, and completed on February 4, 2025, it was determined that Fair Acres Geriatric Center -Building 07 was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type III (200) unprotected ordinary building, with a basement, that is fully sprinklered.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0345 SS=F	<p>NFPA 101 Fire Alarm System - Testing and Maintenance</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0345	<p>Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings.</p> <p>K 0345</p> <p>Johnson Controls Fire Protection was contacted and will provide information on the functionality of the duct detector.</p> <p>Annual fire alarm report will be reviewed by Maintenance designee to ensure this issue does not reoccur.</p>	<p>Completion Date: 02/19/2025</p> <p>Status: APPROVED</p> <p>Date: 02/21/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0345 SS=F	Continued from page 3 Based on document review and interview, it was determined the facility failed to maintain and inspect the fire alarm system, affecting the entire component. Findings include: Document review on February 3, 2025, at 8:00 a.m., revealed the annual fire alarm inspection report, dated 5/2/2024, noted the duct detector for the kitchen could not be found and was not tested. The facility could not provide documentation of the remediation of this deficiency. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of documentation.	K 0345		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 4 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0918 Documentation will be provided by outside contractor for 3-year, 4-hour load test of emergency generator. Submission of Load test paper documentation will be checked quarterly to ensure all proper documentation is maintained.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 5 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire component. Findings include: Document review on February 3, 2025, at 8:00 a.m., revealed the facility could not provide documentation of a 3 year, 4 hour load test of the emergency generator. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of documentation.	K 0918		



Certified End Page

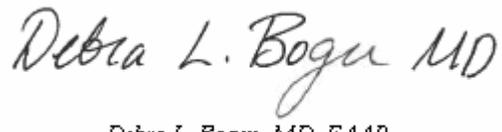
FAIR ACRES GERIATRIC CENTER

STATE LICENSE NUMBER: 061002

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002	STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
--------------------	--	---------------	--	--------------------

K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 061002 Component 05 Building 8</p> <p>Based on a Medicare/Medicaid Recertification Survey conducted on February 3, 2025, and complete on February 4, 2025, it was determined that Fair Acres Geriatric Center - Building 8 was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a fifteen-story, Type II (000), unprotected noncombustible building, with a basement, that is fully sprinklered.</p>	K 0000		
--------	---	--------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0311 SS=E	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by:	K 0311	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. Spring will be reset on ceiling door to ensure latching and ability to close. Ceiling door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0311 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain the fire resistance rating of vertical openings, affecting one of fifteen floors. Findings Include: Observation on February 4, 2025, at 10:40 a.m., revealed on the tenth floor, Electrical Closet next to room 1020, a rated access ceiling door that failed to self-close and latch when tested. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the door failed to self-close and latch.	K 0311		
K 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=F	Continued from page 3 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0353 – 1 Sprinkler Company will be contracted to perform inspection. Area will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. K 0353 – 2 Escutcheon was replaced Area will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0353 SS=F	Continued from page 4 Based on observation, document review, and interview, it was determined the facility failed to maintain and inspect the sprinkler system, affecting the entire component. Findings include: 1. Document review on February 3, 2025, at 8:00 a.m., revealed the facility could not provide documentation a dry sprinkler full flow test was conducted within the past three year. 2. Observation on February 4, 2025, at 12:20 p.m., revealed a missing sprinkler escutcheon, above ice machine on fifth floor. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of documentation and missing escutcheon.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0355 a New extinguisher and bracket was installed Area will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. b Extinguishers will be remounted above handrail. Area will be monitored weekly for one quarter and by Fire & Safety Supervisor or designee for 1 quarter to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0355 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to ensure portable fire extinguishers were maintained, on two of fifteen floors. Findings Include: Observation on February 4, 2025, from 9:40 a.m. to 10:30 a.m., revealed the following deficiencies: a. 9:40 a.m., on the thirteenth floor, next to stair tower #2, the fire extinguisher mounting bracket was missing from the fire extinguisher and was being hung to wall hook by the extinguisher's hose. b. 10:30 a.m. on the tenth floor, the portable fire extinguishers at each corner of this floor were mounted directly below a handrail that negatively affected direct access to the extinguisher. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the portable fire extinguisher deficiencies.	K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002			STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
K 0355 SS=E	Continued from page 7	K 0355			
K 0363 SS=E		K 0363			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 8 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	Exit Date: 02/04/25 0363 Scope/ Severity: E NFPA 101 STANDARD Corridor - Doors: Name - BLDG. 8 Component - 05 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 9 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363	inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Observations: Based on observation and interview, it was determined the facility failed to ensure that corridor doors were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 10	K 0363	maintained to resist the passage of smoke and positively latch on one of over three hundred corridor doors within the facility. Findings include: Observation on February 4, 2025, at 10:50 a.m., revealed, on the second floor, resident room 211, failed to positively latch in the frame. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the door did not latch. Plan of Correction:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 11	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 12	K 0363	<p>Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings.</p> <p>K 0363 Door was repaired to latch in the frame Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to ensure that corridor doors were maintained to resist the passage of smoke and positively latch on one of over three hundred corridor doors within the facility. Findings include: Observation on February 4, 2025, at 10:50 a.m., revealed, on the second floor, resident room 211, failed to positively latch in the frame. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the door did not latch.	K 0363		
K 0372 SS=E		K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0372 SS=E	Continued from page 14 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0372 Penetration will be sealed with UL Rated Fire Stop. Fire safety supervisor or designee will monitored area weekly for 1 Quarter to ensure this condition is not replicated.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0372 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting one of fifteen floors. Findings include: Observation on February 4, 2025, at 10:00 a.m., revealed, on the eleventh floor, above the smoke doors by room 1108, an unsealed penetration around electrical conduits. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the penetration.	K 0372		
K 0374 SS=E		K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 16 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. Chair was removed from area blocking fire doors. Door was checked to enusre smoke tight closure. Fire and Safety or designee will monitor area weekly for 1 quarter to ensure this issue does not reoccur.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier walls were maintained to resist the passage of smoke, affecting one of fifteen floors. Findings include: Observation on Feburary 4, 2025, at 10:40 a.m., revealed on second floor, next to room 208, one of the double smoke doors was blocked by a bariatric chair and when tested the doors did not close smoke tight. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the smoke barrier door condition described.	K 0374		
K 0521 SS=E		K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0521 SS=E	Continued from page 18 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0521 Temporary AC units were removed from the building. Maintenance Department or designee will monitor are weekly for one quarter to ensure this issue does not reoccur.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0521 SS=E	Continued from page 19 Based on observation and interview, it was determined the facility failed to maintain the heating, ventilating and air conditioning (HVAC) system affecting one of fifteen floors. Observation on February 4, 2025, at 9:20 a.m., revealed, on the ground floor, inside office therapy department, there was (3) portable air conditioning units vented above the drop ceiling, into the interstitial space, creating a plenum. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the portable air conditioning venting assemblies.	K 0521		
K 0541 SS=E		K 0541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0541 SS=E	Continued from page 20 NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 0541	Plan of Correction: Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0541- a Door was repaired to positive latch Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. K 0541 – b Door was repaired to positive latch Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated. K 0541 – c Linen chute door was closed and Facility staff will be educated about the hazards of propping doors open. Door will be monitored weekly for 1 Quarter by a maintenance	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0541 SS=E	Continued from page 21	K 0541	<p>department designee to ensure this condition is not replicated.</p> <p>K 0541 – d Door will be repaired to positive latch. Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.</p> <p>K 0541 – e Door will be repaired to positive latch. Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.</p> <p>K 0541 – f Door will be repaired to positive latch.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0541 SS=E	Continued from page 22	K 0541	Door will be monitored weekly for 1 Quarter by a maintenance department designee to ensure this condition is not replicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0541 SS=E	Continued from page 23 Based on observation and interview, it was determined the facility failed to maintain the fire protection rating for linen chutes, affecting six of fifteen levels. Findings include: Observations on February 4, 2025, between 9:00 a.m. and 12:45 p.m., revealed: a) On the second floor: Soiled Utility Room, Rubbish chute door failed to positively latch. b) On the third floor: Soiled Utility Room, Rubbish chute door failed to positively latch. c) On the fourth floor: Soiled Utility Room, Laundry chute door, propped open by lining cart. d) On the tenth floor, Soiled Utility Room, Laundry chute door failed to close and latch. e) On the eighth floor, Soiled Utility Room, Laundry chute door failed to close and latch. f) On the seventh floor, Soiled Utility Room, Laundry chute door failed to close and latch.	K 0541		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0541 SS=E	Continued from page 24 confirmed the chute door failed to latch. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the above chute door deficiencies.	K 0541		
K 0911 SS=E	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings. K 0911 Junction box cover was replaced. Facilities Director or designee will monitor weekly for 1 Quarter to ensure this issue does not reoccur.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0911 SS=E	Continued from page 25 Based on observation and interview, it was determined facility failed to maintain protection of electrical wiring, affecting one of fifteen floors. Findings include: Observation on February 4, 2025, at 10:15 a.m., revealed on the tenth floor, above double smoke doors at resident room 1008, a junction box was missing its cover plate, exposing the inner wiring. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the missing cover plate.	K 0911		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 26 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	K 0918 a Documentation provided by outside contractor for 3-year, 4-hour load test of emergency generator. b Documentation provided by outside contractor for Annual load bank test of c Documentation provided by outside contractor, Ferguson & McCann for fuel quality test. All paperwork needed for these items will be reviewed monthly by maintenance designee to ensure this issue does not reoccur.	Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025	
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER STATE LICENSE NUMBER: 061002		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 27 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire component. Findings include: Document review on February 3, 2025, at 8:00 a.m., revealed the facility could not provide documentation of the following tests and inspections: a. 3 year, 4 hour load test; b. Annual 90 minute load bank test; c. Annual fuel quality test. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the lack of documentation.	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0920	<p>Preparation and submission of this POC is required by State and Federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice, or any other court proceedings.</p> <p>K 0920</p> <p>Fan was plugged into wall outlet</p> <p>Fire and Safety or designee will monitor room weekly for 1 quarter.</p>	<p>Completion Date: 02/19/2025 Status: APPROVED Date: 02/21/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395780	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>05</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/04/2025
NAME OF PROVIDER OR SUPPLIER: FAIR ACRES GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 340 N MIDDLETOWN ROAD PO BOX 496 LIMA, PA 19037		
STATE LICENSE NUMBER: 061002				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0920 SS=E	Continued from page 29 Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of electrical devices, affecting one of fifteen floors. Findings include: Observation on February 4, 2025, at 10:20 a.m., on the first floor, inside resident room 118, revealed an osculating fan, plugged into a power outlet multiplier. Exit interview with the Maintenance Director on February 4, 2025, at 1:00 p.m., confirmed the fan powered by outlet multiplier.	K 0920		



Certified End Page

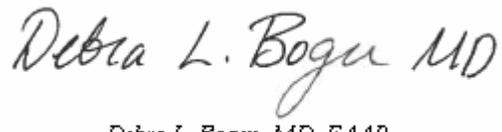
FAIR ACRES GERIATRIC CENTER

STATE LICENSE NUMBER: 061002

SURVEY EXIT DATE: 02/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY