STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395439	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Johnstown	807 Goucher Street Johnstown, PA 15905

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on a review of facility policies, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide care in a manner that maintained dignity for one of 15 residents reviewed (Resident 6). Findings include:The facility's policy regarding Resident Rights, dated August 21, 2025, indicated that a resident has the right to a dignified existence and will be treated with dignity. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated March 27, 2026, indicated that the resident was cognitively intact and required extensive assistance from staff for activities of daily living, including incontinence care.Review of a facility grievance for Resident 6, dated January 2, 2026 revealed that the resident was receiving incontinence care from Nurse Aide 1 during the night on January 1, 2026. She stated that he undressed her completely, told her that she was not allowed to poop, and then left the room to get supplies leaving her fully exposed with the curtain open and the door open. He then returned and again left the room during care while she was still naked and fully exposed with the curtain open and the door open. When he returned she asked him why he left her naked and he asked her if she slept in the nude at home. She told him that she did not think that was appropriate.Interview with Resident 6 on April 13, 2026 at 3:42 p.m. revealed that she did not like the way that Nurse Aide 1 provided care for. She stated that he left her naked and exposed while providing care for her and that he spoke inappropriately to her. She stated that he asked her if she slept in the nude when she was at home and then proceeded to tell her that he likes to look at naked women. She said that he told her that he was staring at a naked woman there and that she did not like it, but it didn't matter to him because he can get away with it. She said that Nurse Aide 1 also bragged to her about stuff that he was doing and getting away with. She said that Nurse Aide 1 told her that he was suspended because of something he did, but that the facility needed him to work so bad that they had to stagger his suspension over two weeks, instead of consecutive nights. Resident 6 stated that she was told that he would not work with her again after she informed staff of what he had done and said. She said that she felt exposed and undignified being left naked with the curtain and the door open.Interview with the acting Director of Nursing on April 13, 2026 at 4:08 p.m. confirmed that this was an undignified experience for Resident 6.28 Pa. Code 201.29(j) Resident rights.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on a review of facility policies, clinical records, grievances, and resident and staff interviews, it was determined that the facility failed to promptly take measures necessary to protect residents from sexual abuse after abuse was identified for four of 15 residents reviewed (Residents 1, 6, 7, 14). This failure placed the residents in immediate jeopardy due to the actual sexual abuse that already occurred, as well as the potential for further sexual abuse to occur. Findings include:Review of the facility's abuse policy, dated August 21, 2025, revealed that each resident has the right to be free from abuse.A comprehensive Medicare 5-day Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated December 16, 2025, revealed that the resident was cognitively intact, required minimal help from staff for her daily care needs, and was always continent of urine.Review of a grievance filed by Resident 14 on December 18, 2025 revealed that she reported that Nurse Aide 1 entered her room around 5:00 a.m. while she was sleeping and put his hand inside her pants to see if she was wet. She was upset because he did not tell her what he was doing, she was able to tell him that she was not wet, and she had no history of being incontinent. She felt that this was a violation of her dignity and rights.An interview with Resident 14 on April 14, 2026 at 1:47 p.m. revealed that she was upset that Nurse Aide 1 woke her up around 5:00 a.m. by putting his hand inside her pants to see if she was wet. She stated that he touched her genitalia inappropriately and she felt violated. She said she immediately asked to speak to the nurse, however, the nurse did not come in until around 7:30 a.m. She stated she told Licensed Practical Nurse 2 what happened and that she was upset about it. She stated that she felt like they dismissed her and treated her like this was not important.A quarterly MDS assessment for Resident 6, dated March 27, 2026 revealed that the resident was cognitively intact and required assistance from staff for daily care needs, including incontinence, and that she was usually incontinent of urine and bowel. Review of a grievance for Resident 6, dated January 2, 2026, revealed that the resident was upset because of her interaction with Nurse Aide 1 during incontinence care. She stated that when he answered her call bell he told her that daylight staff would change and reposition her, however it was midnight and daylight staff would not come in for another six hours. She told him that was too long to wait and he needed to change her. He told her that she was not allowed to poop and stated oh my gosh, you pooped everywhere. He proceeded to take her nightgown and her brief off, then left the room to gather supplies leaving her naked on her bed with the curtain and the door open. She was upset that she was exposed. Nurse Aide 1 returned and started providing care for her then left the room a second time to get supplies while she was naked and exposed on the bed with the curtain and door open. After providing care for the resident he asked her if she slept in the nude. She felt this was a violation of her right to privacy and dignity. She also grieved that he frequently made statements regarding disciplinary actions he has already received, such as being suspended and having the days split up so his paycheck wasn't affected; that a co-worker accused him of touching her inappropriately; and that other residents have complained about his care and the inappropriate things he says.Interview with Resident 6 on April 13, 2026 at 3:42 p.m. revealed that she felt exposed when Nurse Aide 1 left her naked on her bed with the door open and the curtain open two times while he gathered supplies. She stated that she told him she did not like being left exposed and he asked her if she slept in the nude at home. She stated this made her feel awkward and she asked him not to talk like that. He told her he liked looking at naked women, while he was looking at her, and that there was another resident that he liked to look at naked and she didn't like him doing it either. She said that he also told her that a nurse aide accused him of touching her and that he was supposed to be suspended because of it, but because staffing was so bad they needed him and could not suspend him the right way. Resident 6 said she told Nurse Aide 1 that if he was doing those things he needed to stop and get himself some help. She stated that she was not afraid for herself, but she feared for (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	other residents who could not speak for themselves.A comprehensive MDS assessment for Resident 7, dated April 5, 2026, revealed that the resident was cognitively intact, required help from staff to get in and out of the bathroom, and that she was always incontinent of urine and bowel.An interview with Resident 7 on April 13, 2026 at 1:19 p.m. revealed that she did not want Nurse Aide 1 to provide care for her. She stated that he startled her awake by sticking his hand inside her brief to see if she was wet. She said that he did not need to do that because he should have just asked her like all of the other staff. She stated she did not like him putting his hand in her brief and that she did not want him back in her room.A quarterly MDS assessment for Resident 1, dated January 21, 2026 revealed that the resident was cognitively intact, required observation from staff for ambulation, and that she was frequently incontinent of urine and bowel.A grievance for Resident 1, dated March 27, 2026, revealed that Family Member 1 phoned the Director of Social Services on March 25, 2026 and asked her why a staff member went into Resident 1's room around 1:00 a.m. in the morning and startled her awake by turning on the light and pulling her blanket off.An interview with Resident 1 on April 13, 2026 at 9:58 a.m. revealed that she did not want to talk about the grievance or any details of the incident.An interview with Family Member 1 on April 13, 2026, at 3:53 p.m. revealed that she called the Director of Social services because she wanted to know what went on during the night. She stated that Resident 1 called her at 1:00 a.m. crying and stated that Nurse Aide 1 had put his hand inside her brief while she was sleeping and his fingers penetrated her vagina. Family Member 1 stated that Resident 1 told her that he had done this 2 or 3 other times and that she was afraid she was going to be raped by him. She said that Resident 1 was crying and afraid. She said that she phoned the Director of Social Services and told her that Resident 1 was crying and said that Nurse Aide 1 stuck his hand in her crotch while she was sleeping. She stated that Resident 1 told her later that day that Nurse Aide 1 had been fired, but he had not been. She stated that Resident 1 felt safe because she believed he was no longer working there.An interview with Nurse Aide 3 on April 13, 2026, at 10:44 a.m. revealed that when he went to provide morning care to Resident 1 following the incident she said to him that man put his hand in my pants and touched my private area. He said that she was upset while she was telling him about the incident and that he went to Licensed Practical Nurse 4 and told her immediately. An interview with Licensed Practical Nurse 4 on April 13, 2026 at 2:50 p.m. revealed that she entered Resident 1's room and Resident 1 told her that the male nurse aide on night shift put his hand inside her brief and that his fingers penetrated her vagina. Licensed Practical Nurse 4 stated that she immediately went to Registered Nurse 5 and reported the incident to her. She said that she told Registered Nurse 5 that he digitally penetrated her and she was upset.An interview with Registered Nurse 5 on April 13, 2026 at 4:50 p.m. revealed that when Licensed Practical Nurse 4 told her that Nurse Aide 1 put his finger inside Resident 1's vagina she immediately went to the Director of Social Services and told her what Resident 1 said. She said she told the Director of Social Services that Resident 1 said that Nurse Aide 1 put his hand in her brief and his finger inside her vagina. She stated that the Director of Social Services and the Assistant Director of Nursing said that they were already aware of this so Registered Nurse 5 did not do anything further regarding this issue.An interview with Registered Nurse 6 on April 13, 2026 at 10:44 a.m. revealed that she had been asked by a nurse aide if there was a hole in the schedule on the night shift since Nurse Aide 1 would not be reporting to work after the allegations that were made by Resident 1. Registered Nurse 6 said she went to the Nursing Home Administrator and asked if Nurse Aide 1 needed to be replaced on night shift. The Nursing Home Administrator asked her why he would need to be replaced and she informed him what happened with Resident 1 and Nurse Aide 1. The Nursing Home Administrator said that he was not aware of the allegation.An interview with the Director of Social Services on April 14, 2026, at 9:55 a.m. revealed that she did not believe any abuse had occurred. She stated emphatically that she knew there was no abuse, that no abuse took place, and that the resident was not sexually abused. She also stated she wished people would stop saying that. She stated that she had a very good rapport with Resident 1 and that Resident 1 would have told her if it had happened. She denied that (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Family Member 1, Registered Nurse 5, or the Nursing Home Administrator had told her that Nurse Aide 1 touched Resident 1's crotch, digitally penetrated her, or fingered her. She again said emphatically that she would take an allegation very seriously and that she knew there was no way this happened.An undated list of residents that Nurse Aide 1 was not permitted to work with, provided by the acting Director of Nursing, revealed that he was not to work with Residents 1, 6, or 7. Nurse Aide 1 was not to work with Resident 6 after her allegation of abuse on January 2, 2026. A review of Resident 6's task record, dated January, March, and April 2026, revealed that Nurse Aide 1 worked with her on January 26, March 14, March 15, March 16, March 28, April 2, April 6, April 11, and April 12. Nurse Aide 1was not to work with Resident 7 after she made an allegation of sexual abuse in January, 2026. A review of Resident 7's task record, dated February, and April 2026, revealed that Nurse Aide 1 worked with Resident 7 on Feburary 19, April 1, and April 2.An interview with the acting Director of Nursing on April 13, 2026 at 4:55 p.m. revealed that Nurse Aide 1 should not have worked with Resident 6 or Resident 7 on the above referenced dates.An interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026 at 1:04 p.m. revealed that they did not feel the allegation regarding Resident 1 and Nurse Aide 1 was abuse, and just wrote the incident up as a grievance. The acting Director of Nursing stated that she was not aware of any sexual abuse allegations. The Nursing Home Administrator stated that when he was made aware of the allegation he had the Director of Social Services talk with Resident 1. He said the Director of Social Services stated that Resident 1's story had changed and therefore the incident did not happen. An Immediate Jeopardy situation was identified to the Nursing Home Administrator and the acting Director of Nursing on April 14, 2026, at 3:29 p.m. related to the facility's failure to ensure that immediate and adequate safeguards were taken to protect the residents from sexual abuse by Nurse Aide 1. On April 14, 2026, at 6:15 p.m. the facility submitted an immediate action plan that included:Nurse Aide 1 was terminated on April 14, 2026, and was no longer employed at the facility. An in-house audit was performed on residents on April 14, 2026, and assessments were completed along with interviews to confirm no other residents were identified. In-house re-education was provided to all staff on abuse and reporting of abuse on April 14, 2026. The facility will not allow an employee to work unless this education has been completed prior to returning to work. Daily random audits of care and interviews continue to ensure that no residents have been affected. The Immediate Jeopardy was lifted on April 14, 2026, at 6:46 p.m. when it was confirmed that the corrective action plans developed on April 14, 2026, were completed.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.29(a)(c)(d) Resident rights.

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, personnel files, clinical records, and grievances filed by residents, as well as resident, family and staff interviews, it was determined that the facility failed to implement its abuse policy by not immediately protecting residents who were at risk of sexual abuse, which led to three more residents being sexually abused by a staff member for four of 15 residents reviewed (Residents 1, 6, 7, 14). Findings include:The facility's policy regarding abuse, dated August 21, 2025, indicated that any employee whose conduct gives rise to a reasonable suspicion of resident abuse may be immediately removed from the floor, and where appropriate suspended without pay pending an investigation and that facility staff were to investigate all possible incidents of abuse.A review of Nurse Aide 1's disciplinary file revealed that on December 7, 2025, Nurse Aide 7 reported that Nurse Aide 1 asked her personal questions, told her to get on her knees while she was helping provide care for a resident, and then shortly after that, slapped her on her buttock. She said that he told her she was not the first co-worker.A mandatory Medicare 5-day Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated December 16, 2025, revealed that the resident was cognitively intact, required minimal help from staff for her daily care needs, and was always continent of urine.A review of a grievance filed on December 18, 2025 by Resident 14 revealed that she reported that Nurse Aide 1 entered her room around 5:00 a.m. while she was sleeping and put his hand inside her pants to see if she was wet. She was upset because he did not tell her what he was doing, she was able to tell him that she was not wet, and she had no history of being incontinent. She felt that this was a violation of her dignity and rights.An interview with Resident 14 on April 14, 2026 at 1:47 p.m. revealed that she was upset thatNurse Aide 1woke her up around 5:00 a.m. by putting his hand inside her pants to see if she was wet. She stated that he touched her inappropriately and she felt violated. She said she immediately asked to speak to the nurse, however, the nurse did not come in until around 7:30 a.m. She stated she told Licensed Practical Nurse 2 what happened and that she was upset about it.An interview with Licensed Practical Nurse 2 on April 13, 2026 at 2:30 p.m. revealed that Resident 14 told her that Nurse Aide 1 put his hand in her pants while she was sleeping and the he touched her inappropriately. She stated that she immediately reported this to the Director of Nursing. She stated that she was aware that Nurse Aide 1 had sexually assaulted a nurse aide and that the nurse aide quit because nothing was done about it the week prior to this happening to Resident 14. She stated she was very concerned for her other residents, especially Resident 2 who was a [AGE] year old female and in a comatose state. She said she told the Director of Nursing that she did not want him working on her hall, or at all for that matter and that she was surprised that he was permitted to return to work that evening.A quarterly MDS assessment for Resident 6, dated March 27, 2026 revealed that the resident was cognitively intact and required assistance from staff for daily care needs, including incontinence, and that she was usually incontinent of urine and bowel.A grievance form for Resident 6, dated January 2, 2026, revealed that the resident was upset because of her interaction with Nurse Aide 1 during incontinence care. She stated that when he answered her call bell he told her that daylight staff would change and reposition her, however it was midnight and daylight staff would not come in for another six hours. She told him that was too long to wait and he needed to change her. He then told her that she was not allowed to poop and oh my gosh, you pooped everywhere. He then proceeded to take her nightgown off and her brief off. He then left the room to gather supplies leaving her naked on her bed with the curtain and the door open. She was upset that she was exposed. He then returned, proceeded to start to provide care for her and again left the room to get supplies while she was naked and exposed on the bed with the curtain and door open. After providing care for the resident he asked her if she slept in the nude. She felt this was a violation of her right to privacy and dignity. She also grieved that he often made statements regarding personal things, such as that he was suspended and (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	the days were split up so that they did not affect his paycheck; that a co-worker accused him of touching her inappropriately; and that other residents have complained about his care and things he says.Interview with Resident 6 on April 13, 2026 at 3:42 p.m. revealed that she felt exposed when Nurse Aide 1 left her naked on her bed with the door open and the curtain open two times while he gathered supplies. She stated that she told him she did not like being left exposed and he asked her if she slept in the nude at home. She stated this made her feel awkward and she asked him not to talk like that. He then told her that he liked looking at naked women, while looking at her naked, and that there was another woman there that he liked to look at naked and she didn't like him doing it either. She said that he also told her that a nurse aide accused him of touching her and that he was supposed to be suspended because of that, but that staffing was so bad they needed him and could not suspend him the right way. She said she told him that if he was doing those things he needed to stop and get himself some help. She stated that she was not afraid for herself, but she feared for other residents who could not speak for themselves.A comprehensive MDS assessment for Resident 7, dated April 5, 2026, revealed that the resident was cognitively intact, required help from staff to get in and out of the bathroom, and that she was always incontinent of urine and bowel.An interview with Resident 7 on April 13, 2026 at 1:19 p.m. revealed that she did not want Nurse Aide 1 to provide care for her. She stated that he startled her awake by sticking his hand inside her brief to see if she was wet. She said that he did not need to do that because he should have just asked her like all of the other staff. She stated she did not like him putting his hand in her brief and that she did not want him back in her room.A quarterly MDS assessment for Resident 1, dated January 21, 2026 revealed that the resident was cognitively intact, required observation from staff for ambulation, and that she was frequently incontinent of urine and bowel.A grievance filed by Resident 1, dated March 27, 2026, revealed that Family Member 1, (Resident 1's daughter in law and power of attorney), phoned the Director of Social Services on March 25, 2026 and asked her why a staff member went into Resident 1's room around 1:00 a.m. in the morning and startled her awake by turning on the light and pulling her blanket off.An interview with Resident 1 on April 13, 2026 at 9:58 a.m. revealed that she did not want to talk about the grievance or any details of the incident.An interview with Family Member 1 revealed that she called the Director of Social services because she wanted to know what went on during the night. She stated that Resident 1 called her at 1:00 a.m. crying and stated that Nurse Aide 1 had put his hand inside her brief while she was sleeping and his fingers penetrated her vagina. Family Member 1 stated that Resident 1 told her that he had done this 2 or 3 other times and that she was afraid she was going to be raped by him. She said that Resident 1 was crying and afraid. She said that she phoned the Director of Social Services and told her that Resident 1 was crying and said that Nurse Aide 1 stuck his hand in her crotch while she was sleeping. An interview with Nurse Aide 3 on April 13, 2026 at 10:44 a.m. revealed that when he went to provide care for Resident 1 in the morning that she said to him did you hear what happened to me? That man put his hand in my pants and touched my private area. He said that she was upset when she was telling him about this. He stated that he went to his nurse, Licensed Practical Nurse 4 and told her immediately. An interview with Licensed Practical Nurse 4 on April 13, 2026 at 2:50 p.m. revealed that she spoke to Resident 1 and Resident 1 told her that the male nurse aide on night shift put his hand inside her brief and that his fingers penetrated her vagina. Licensed Practical Nurse 4 stated that she immediately went to Registered Nurse 5 and reported this to her. She said that she told Registered Nurse 5 that he digitally penetrated her and she was upset.An interview with Registered Nurse 5 on April 13, 2026 at 4:50 p.m. revealed that when Licensed Practical Nurse 4 told her that Nurse Aide 1 put his finger inside Resident 1's vagina she immediately went to the Director of Social Services and told her what Resident 1 said. She said she told the Director of Social Services that Resident 1 said that Nurse Aide 1 put his hand in her brief and his finger inside her vagina. She stated that the Director of Social Services and the Assistant Director of Nursing said that they were already aware of this so Registered Nurse 5 did not do anything further regarding this issue.An interview with Registered Nurse 6 on April 13, 2026 at 10:44 a.m. revealed that (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	a nurse aide asked her if there was a hole in the schedule for the night shift since they thought that Nurse Aide 1 would not be reporting to work that night after the allegations that were made by Resident 1. Registered Nurse 6 stated she went to the Nursing Home Administrator and asked if Nurse Aide 1 needed replaced on the night shift and the Nursing Home Administration asked her why he would. She stated that she said because a resident says that he fingered her two nights ago but the Nursing Home Administrator was not aware of the allegation. Registered Nurse 6 stated that Nurse Aide 1 did come to work that night.An interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026 at 1:04 p.m. revealed that they did not feel the allegation regarding Resident 1 and Nurse Aide 1 was abuse and they just wrote the incident up as a grievance. The acting Director of Nursing stated that she was not aware of any sexual abuse allegations. The Nursing Home Administrator stated that when he was made aware of the allegation he had the Director of Social Services talk with Resident 1. He said that the Director of Social Services stated that Resident 1's story had changed and therefore the incident did not happen. An interview with the Director of Social Services on April 14, 2026 at 9:55 a.m. revealed that she did not believe any abuse occurred. She stated emphatically that she knew there was no abuse, that no abuse took place, and that the resident was not sexually abused. She stated she wished people would stop saying that. She stated that she had a very good rapport with Resident 1 and that Resident 1 would have told her if that happened. She denied that Family Member 1, Registered Nurse 5, and the Nursing Home Administrator told her that Nurse Aide 1 touched Resident 1's crotch; or that he digitally penetrated her; or that he fingered her, as they all said they told her. She again said emphatically that she would take an allegation very seriously and she knew there was no way this happened.An interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026, at 1:04 p.m. revealed that the facility did not investigate the allegations of abuse made by Residents 1, 6, 7, or 14 because they did not believe that it happened and therefore did not need to do an investigation. The Nursing Home Administrator stated that he filled out a grievance form instead of conducting an investigation.28 Pa. Code 201.14(c) Responsibility of licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of policies, clinical records, observations, resident interviews, and staff interviews, it was determined that the facility failed to report multiple incidents of alleged sexual abuse for four of 15 residents reviewed (Residents 1, 6, 7, 14). Findings include:The facility's policy regarding abuse, neglect, exploitation or misappropriation - reporting and investigation, dated August 21, 2025, indicated that the administrator or the individual making the allegation immediately reports his or her suspicion to the state licensing agency; the local/state ombudsman; the resident's representative; adult protective services; law enforcement officials; the resident's attending physician; and the facility medical director.A mandatory Medicare 5-day Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated December 16, 2025, revealed that the resident was cognitively intact, required minimal help from staff for her daily care needs, and was always continent of urine.A review of a grievance filed on December 18, 2025 by Resident 14 revealed that she reported that Nurse Aide 1 entered her room around 5:00 a.m. while she was sleeping and put his hand inside her pants to see if she was wet. She was upset because he did not tell her what he was doing, she was able to tell him that she was not wet, and she had no history of being incontinent. She felt that this was a violation of her dignity and rights.An interview with Resident 14 on April 14, 2026 at 1:47 p.m. revealed that she was upset that Nurse Aide 1 woke her up around 5:00 a.m. by putting his hand inside her pants to see if she was wet. She stated that he touched her genitalia inappropriately in doing so and she felt violated. She said she immediately asked to speak to the nurse, however, the nurse did not come in until around 7:30 a.m. She stated she told Licensed Practical Nurse 2 what happened and that she was upset about it. An interview with Licensed Practical Nurse 2 on April 14, 2026 at 2:16 p.m. revealed that Resident 14 did tell her about what happened to her with Nurse Aide 1 as soon as she got on shift the morning of December 18, 2026. She stated that she immediately went to the Director of Nursing and reported this to her. She stated that the Director of Nursing did not take the allegation seriously and that Nurse Aide 1 was back to work that night.A quarterly MDS assessment for Resident 6, dated March 27, 2026 revealed that the resident was cognitively intact and required assistance from staff for daily care needs, including incontinence, and that she was usually incontinent of urine and bowel. A grievance form for Resident 6, dated January 2, 2026, revealed that the resident was upset because of her interaction with Nurse Aide 1 during incontinence care. She stated that when he answered her call bell he told her that daylight staff would change and reposition her, however it was midnight and daylight staff would not come in for another six hours. She told him that was too long to wait and he needed to change her. He then told her that she was not allowed to poop and oh my gosh, you pooped everywhere. He then proceeded to take her nightgown off and her brief off. He then left the room to gather supplies leaving her naked on her bed with the curtain and the door open. She was upset that she was exposed. He then returned, proceeded to start to provide care for her and again left the room to get supplies while she was naked and exposed on the bed with the curtain and door open. After providing care for the resident he asked her if she slept in the nude. She felt this was a violation of her right to privacy and dignity. She also grieved that he often made statements regarding personal things, such as that he was suspended and the days were split up so that they did not affect his paycheck, that a co-worker accused him of touching her inappropriately, and that other resident's have complained about his care and things he says.Interview with Resident 6 on April 13, 2026 at 3:42 p.m. revealed that she felt exposed when Nurse Aide 1 left her naked on her bed with the door open and the curtain open two times while he gathered supplies. She stated that she told him she did not like being left exposed and he asked her if she slept in the nude at home. She stated this made her feel awkward and she asked him not to talk like that. He then told her that he liked looking at naked women, while looking at her naked, and that there was another woman there that he liked to look at naked and she didn't like him (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Johnstown	807 Goucher Street Johnstown, PA 15905

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing it either. She said that he also told her that a nurse aide accused him of touching her and that he was supposed to be suspended because of that, but that staffing was so bad they needed him and could not suspend him the right way. She said she told him that if he was doing those things he needed to stop and get himself some help. She stated that she was not afraid for herself, but she feared for other residents who could not speak for themselves.A comprehensive MDS assessment for Resident 7, dated April 5, 2026, revealed that the resident was cognitively intact, required help from staff to get in and out of the bathroom, and that she was always incontinent of urine and bowel.An interview with Resident 7 on April 13, 2026 at 1:19 p.m. revealed that she did not want Nurse Aide 1 to provide care for her. She stated that he startled her awake by sticking his hand inside her brief to see if she was wet. She said that he did not need to do that because he should have just asked her like all of the other staff. She stated she did not like him putting his hand in her brief and that she did not want him back in her room.A quarterly MDS assessment for Resident 1, dated January 21, 2026 revealed that the resident was cognitively intact, required observation from staff for ambulation, and that she was frequently incontinent of urine and bowel.A grievance filed by Resident 1, dated March 27, 2026, revealed that Family Member 1, Resident 1's daughter-in-law and Power of Attorney, phoned the Director of Social Services on March 25, 2026 and asked her why a staff member went into Resident 1's room around 1:00 a.m. in the morning and startled her awake by turning on the light and pulling her blanket off.An interview with Resident 1 on April 13, 2026 at 9:58 a.m. revealed that she did not want to talk about the grievance or any details of the incident.An interview with Family Member 1 revealed that she called the Director of Social services because she wanted to know what went on during the night. She stated that Resident 1 called her at 1:00 a.m. crying and stated that Nurse Aide 1 had put his hand inside her brief while she was sleeping and his fingers penetrated her vagina. Family Member 1 stated that Resident 1 told her that he had done this 2 or 3 other times and that she was afraid she was going to be raped by him. She said that Resident 1 was crying and afraid. She said that she phoned the Director of Social Services and told him that Resident 1 was crying and said that Nurse Aide 1 stuck his hand in her crotch while she was sleeping. She stated that Resident 1 told her later that day that Nurse Aide 1 had been fired, but he had not been. She stated that Resident 1 felt safe because she believed he was no longer working there.An interview with Nurse Aide 3 on April 13, 2026 at 10:44 a.m. revealed that when he went to provide care for Resident 1 in the morning that she said to him did you hear what happened to me? That man (later identified as Nurse Aide 1) put his hand in my pants and touched my private area. He said that she was upset when she was telling him about this. He stated that he went to his nurse, Licensed Practical Nurse 4 and told her immediately. An interview with Licensed Practical Nurse 4on April 13, 2026 at 2:50 p.m. revealed that she entered Resident 1's room and Resident 1 told her that the male nurse aide on night shift put his hand inside her brief and that his fingers penetrated her vagina. Licensed Practical Nurse 4 stated that she immediately went to Registered Nurse 5 and reported that Nurse Aide 1 and reported this to her. She said that she told Registered Nurse 5 that he digitally penetrated her and she was upset.An interview with Registered Nurse 5 on April 13, 2026 at 4:50 p.m. revealed that when Licensed Practical Nurse 4 told her that Nurse Aide 1 put his finger inside Resident 1's vagina she immediately went to the Director of Social Services and told her what the Resident 1 said. She said she told the Director of Social Services that Resident 1 said that Nurse Aide 1 put his hand in her brief and his finger inside her vagina. She stated that the Director of Social Services and the Assistant Director of Nursing said that they were already aware of this so Registered Nurse 1 did not do anything further regarding this issue.An interview with Registered Nurse 6 on April 13, 2026 at 10:44 a.m. revealed that a nurse aide asked her if there was a hole for the night shift since they thought that Nurse Aide 1 would not be reporting to work that night after the allegations that were made by Resident 1. Registered Nurse 6 stated she went to the Nursing Home Administrator and asked if Nurse Aide 1 needed replaced on the night shift and the Nursing Home Administration asked her why he would. She stated that she said because a resident says that he fingered her two nights ago and that he was not aware of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation.An interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026 at 1:04 p.m. revealed that they did not feel the allegation regarding Resident 1 and Nurse Aide 1 was abuse and they just wrote the incident up as a grievance. The acting Director of Nursing stated that she was not aware of any sexual abuse allegations. The Nursing Home Administrator stated that when he was made aware of the allegation he had the Director of Social Services talk with Resident 1. He said that Director of Social Services stated that Resident 1's story had changed and therefore the incident did not happen. An interview with the Director of Social Services on April 14, 2026 at 9:55 a.m. revealed that she did not believe any abuse occurred. She stated emphatically that she knew there was no abuse, that no abuse took place, and that the resident was not sexually abused. She stated she wished people would stop saying that. She stated that she had a very good rapport with Resident 1 and that Resident 1 would have told her if that happened. She denied that Family Member 1, Registered Nurse 5, and the Nursing Home Administrator told her that Nurse Aide 1 touched Resident 1's crotch, or that he digitally penetrated her, or that he fingered her, as they all said they told her. She again said emphatically that she would take an allegation very seriously and she knew there was no way this happened.There was no documented evidence that the allegations of sexual abuse by Nurse Aide 1 were reported to the Department of Health, the local/state ombudsman, the resident's representatives, adult protective services, law enforcement officials, the resident's attending physician, or the medical director. Interview with the Nursing Home Administrator and the acting Director of Nursing (was the Assistant Director of Nursing when the incidents occurred) on April 13, 2026 at 1:04 p.m. revealed that they did not report these incidents to the necessary entities because they did not think that abuse occurred and that it would not need reported.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of policies, clinical records, family member interview, resident interviews, and staff interviews, it was determined that the facility failed to complete thorough investigations of incidents to rule out sexual abuse, which led to three more residents being sexually abused by a staff member for four of 15 residents reviewed (Residents 1, 6, 7, 14). Findings include:The facility's policy regarding abuse, neglect, exploitation or misappropriation - reporting and investigating, dated August 21, 2025, revealed that all allegations were thoroughly investigated and that the employee who was accused of resident abuse would be placed on leave with no resident contact until the investigation is complete.A review of Nurse Aide 1's personnel file revealed that he completed facility orientation on December 3, 2025. On December 7, 2025 Nurse Aide 7 accused Nurse Aide 1 of talking sexually to her and smacking her on her buttock. On December 18, 2025 Nurse Aide 1 received suspension for unprofessional conduct and a violation of resident rights for Resident 14. However, his suspension was scattered for one day on December 18, 2025, one day on January 5, 2026, and one day on January 8, 2026, instead of consecutive days as the facility's policy stated. On January 3, 2026 Nurse Aide 1 received a written warning for unprofessional conduct and abuse/inappropriate language regarding Resident 6. On March 27, 2026 Nurse Aide 1 received a last and final written warning for unprofessional conduct, failure to follow procedure, refusal to follow instructions after having been educated two times, and violation of resident rights regarding Resident 1. There was no indication in Nurse Aide 1's personnel file that he was disciplined for an incident involving Resident 7. A mandatory Medicare 5-day Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated December 16, 2025, revealed that the resident was cognitively intact, required minimal help from staff for her daily care needs, and was always continent of urine.A review of a grievance filed on December 18, 2025 by Resident 14 revealed that she reported that Nurse Aide 1 entered her room around 5:00 a.m. while she was sleeping and put his hand inside her pants to see if she was wet. She was upset because he did not tell her what he was doing, she was able to tell him that she was not wet, and she had no history of being incontinent. She felt that this was a violation of her dignity and rights.An interview with Resident 14 on April 14, 2026 at 1:47 p.m. revealed that she was upset that Nurse Aide 1 woke her up around 5:00 a.m. by putting his hand inside her pants to see if she was wet. She stated that he touched her inappropriately and she felt violated. She said she immediately asked to speak to the nurse, however, the nurse did not come in until around 7:30 a.m. She stated she told Licensed Practical Nurse 2 what happened and that she was upset about it. Resident 14 stated the Director of Nursing did not take her seriously and that she felt that her complaint was dismissed.A quarterly MDS assessment for Resident 6, dated March 27, 2026 revealed that the resident was cognitively intact and required assistance from staff for daily care needs, including incontinence, and that she was usually incontinent of urine and bowel. A grievance form for Resident 6, dated January 2, 2026, revealed that the resident was upset because of her interaction with Nurse Aide 1 during incontinence care. She stated that when he answered her call bell he told her that daylight staff would change and reposition her, however it was midnight and daylight staff would not come in for another six hours. She told him that was too long to wait and he needed to change her. He then told her that she was not allowed to poop and oh my gosh, you pooped everywhere. He then proceeded to take her nightgown off and her brief off. He then left the room to gather supplies leaving her naked on her bed with the curtain and the door open. She was upset that she was exposed. He then returned, proceeded to start to provide care for her and again left the room to get supplies while she was naked and exposed on the bed with the curtain and door open. After providing care for the resident he asked her if she slept in the nude. She felt this was a violation of her right to privacy and dignity. She also grieved that he often made statements regarding personal things, such as that he was suspended for being accused of touching another nurse aide and the days were split up so that they did not affect his paycheck and because the facility was so short of staff, (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	that another co-worker accused him of touching her inappropriately and he got away with it, and that other residents have complained about his care and things he says.Interview with Resident 6 on April 13, 2026 at 3:42 p.m. revealed that she felt exposed when Nurse Aide 1 left her naked on her bed with the door open and the curtain open two times while he gathered supplies. She stated that she told him she did not like being left exposed and he asked her if she slept in the nude at home. She stated this made her feel awkward and she asked him not to talk like that. He then told her that he liked looking at naked women, while looking at her naked, and that there was another woman there that he liked to look at naked and she didn't like him doing it either. She said that he also told her that a nurse aide accused him of touching her and that he was supposed to be suspended because of that, but that staffing was so bad they needed him and could not suspend him the right way. She said she told him that if he was doing those things he needed to stop and get himself some help. She stated that she was not afraid for herself, but she feared for other residents who could not speak for themselves.A comprehensive MDS assessment for Resident 7, dated April 5, 2026, revealed that the resident was cognitively intact, required help from staff to get in and out of the bathroom, and that she was always incontinent of urine and bowel.An interview with Resident 7 on April 13, 2026 at 1:19 p.m. revealed that she did not want Nurse Aide 1 to provide care for her. She stated that he startled her awake by sticking his hand inside her brief to see if she was wet. She said that he did not need to do that because he should have just asked her like all of the other staff. She stated she did not like him putting his hand in her brief and that she did not want him back in her room.A quarterly MDS assessment for Resident 1, dated January 21, 2026 revealed that the resident was cognitively intact, required observation from staff for ambulation, and that she was frequently incontinent of urine and bowel.A grievance filed by Resident 1, dated March 27, 2026, revealed that Family Member 1, Resident 1's daughter-in-law and Power of Attorney, phoned the Director of Social Services on March 25, 2026 and asked her why a staff member went into Resident 1's room around 1:00 a.m. in the morning and startled her awake by turning on the light and pulling her blanket off.An interview with Resident 1 on April 13, 2026 at 9:58 a.m. revealed that she did not want to talk about the grievance or any details of the incident.An interview with Family Member 1 revealed that she called the Director of Social services because she wanted to know what went on during the night. She stated that Resident 1 called her at 1:00 a.m. crying and stated that Nurse Aide 1 had put his hand inside her brief while she was sleeping and his fingers penetrated her vagina. Family Member 1 stated that Resident 1 told her that he had done this 2 or 3 other times and that she was afraid she was going to be raped by him. She said that Resident 1 was crying and afraid. She said that she phoned the Director of Social Services and told him that Resident 1 was crying and said that Nurse Aide 1 stuck his hand in her crotch while she was sleeping. She stated that Resident 1 told her later that day that Nurse Aide 1 had been fired, but he had not been. She stated that Resident 1 felt safe because she believed he was no longer working there.An interview with Nurse Aide 3 on April 13, 2026 at 10:44 a.m. revealed that when he went to provide care for Resident 1 in the morning that she said to him did you hear what happened to me? That man (later identified as Nurse Aide 1), put his hand in my pants and touched my private area. He said that she was upset when she was telling him about this. He stated that he went to his nurse, Licensed Practical Nurse 4 and told her immediately. An interview with Licensed Practical Nurse 4 on April 13, 2026 at 2:50 p.m. revealed that she entered Resident 1's room and Resident 1 told her that the male nurse aide on night shift put his hand inside her brief and that his fingers penetrated her vagina. Licensed Practical Nurse 4 stated that she immediately went to Registered Nurse 5 and reported that Nurse Aide 1 and reported this to her. She said that she told Registered Nurse 5 that he digitally penetrated her and she was upset.An interview with Registered Nurse 5 on April 13, 2026 at 4:50 p.m. revealed that when Licensed Practical Nurse 4told her that Nurse Aide 1 put his finger inside Resident 1's vagina she immediately went to the Director of Social Services and told her what the Resident 1 said. She said she told the Director of Social Services that Resident 1 said that Nurse Aide 1 put his hand in her brief and his finger inside her vagina. She stated (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	that the Director of Social Services and the Assistant Director of Nursing said that they were already aware of this so Registered Nurse 5 did not do anything further regarding this issue.An interview with Registered Nurse 6 on April 13, 2026 at 10:44 a.m. revealed that a nurse aide asked her if there was a hole for the night shift since they thought that Nurse Aide 1 would not be reporting to work that night after the allegations that were made by Resident 1. Registered Nurse 6 stated she went to the Nursing Home Administrator and asked if Nurse Aide 1 needed replaced on the night shift and the Nursing Home Administration asked her why he would. She stated that she said because a resident says that he fingered her two nights ago and that the Nursing Home Administrator was not aware of the allegation.An interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026 at 1:04 p.m. revealed that they did not feel the allegation regarding Resident 1 and Nurse Aide 1 was abuse and they just wrote the incident up as a grievance. The acting Director of Nursing stated that she was not aware of any sexual abuse allegations. The Nursing Home Administrator stated that when he was made aware of the allegation related to Resident 1 he had the Director of Social Services talk with her. He said that Director of Social Services stated that Resident 1's story had changed and therefore the incident did not happen. An interview with the Director of Social Services on April 14, 2026 at 9:55 a.m. revealed that she did not believe any abuse occurred. She stated emphatically that she knew there was no abuse, that no abuse took place, and that the resident was not sexually abused. She stated she wished people would stop saying that. She stated that she had a very good rapport with Resident 1 and that Resident 1 would have told her if that happened. She denied that Family Member 1, Registered Nurse 5, and the Nursing Home Administrator told her that Nurse Aide 1 touched Resident 1's crotch, or that he digitally penetrated her, or that he fingered her, as they all said they told her. She again said emphatically that she would take an allegation very seriously and she knew there was no way this happened.Interview with Nurse Aide 1 on April 14, 2026 at 5:15 p.m. revealed that he denied touching any of the residents in appropriately. He said why would I do something like that? He further stated that he could tell when a resident was wet by looking at their brief because there is a line on the brief that indicates if it is wet or not. He denied that he put his hand inside any of the resident's briefs. He could not recall who Resident 14 was. He stated that Resident 1 was simply mad at him for waking her up the way he did, which was by turning the light on and yelling her name. He denied that he put his hand inside Resident 1's brief.There was no documented evidence that statements were obtained from the residents who made accusations of sexual abuse, the staff who were told about the incidents by the residents, or any staff that interviewed the residents. There was no documented evidence that a thorough investigation was completed for Residents 1, 6, 7, and 14's allegations of sexual abuse, including interviews with all pertinent staff to rule out that the abuse may have occurred. Interview with the Nursing Home Administrator and acting Director of Nursing on April 13, 2026 at 1:04 p.m. revealed that they did not conduct an investigation into Residents 1, 6, 7, or 14's allegations because they did not feel that the abuse occurred. The Nursing Home Administrator stated that he had a grievance filled out instead of doing an investigation.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the Pulmonologist wrote, signed, and dated progress notes with each visit for one of 15 residents reviewed (Resident 2).Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 18, 2026, revealed that the resident was cognitively impaired, was dependent on staff for her daily care needs, and received tracheostomy (open airway directly into the trachea) care. A physician's order, dated February 4, 2026, included an order for the resident to see a Pulmonologist.A nursing note, dated February 4, 2026, at 1:35 p.m. indicated that the Pulmonologist was just in and evaluated the resident.As of April 14, 2026, there was no documented evidence in Resident 2's clinical record that the Pulmonologist had completed a progress note for the visit on the above date.Interview with the Acting Director of Nursing on April 14, 2026, at 6:45 p.m. confirmed that she could not find any documented evidence of a progress note from the Pulmonologist visit on February 4, 2025.28 Pa. Code 211.5(f) Clinical Records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for one of 15 residents reviewed (Resident 1). Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for one of 15 residents reviewed (Resident 1).Findings include:The facility's policy regarding discarding and destroying medication, dated August 21, 2025, indicated that Schedule IV controlled substances will be disposed of in accordance with state regulations and federal guidelines.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 21, 2026, indicated that the resident was cognitively intact and required assistance from staff for all daily care needs.Physician's orders for Resident 1, dated October 28, 2025 , included an order for the resident to receive one 0.5 milligram (mg) tablet of Lorazepam (an anti-anxiety medication) three times daily.A review of Resident 1's Medication Administration Record, dated February and March 2026, revealed that on March 21, 2026 the Director of Nursing destroyed five tablets of Resident 1's Ativan, however, she did not have a witness for the destruction of the Scheduled IV controlled substance (Ativan). Interview with the Acting Director of Nursing on April 13, 2026 at 2:38 p.m. confirmed that there were not two nurses signatures on the controlled drug log for Resident 1 when destroying her Ativan and there should have been.28 Pa. Code 211.9(h) Pharmacy Services.28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the residents' environment remained free of abuse.Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the residents' environment remained free of abuse.Findings include:The current job description for the NHA indicated that the primary purpose of this position was to direct the day to day functions of the facility in accordance with current federal, state, and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care be provided to our residents at all times. The administrative functions included planning, developing, organizing, implementing, evaluating, and directing the facility's programs and activities in accordance with guidelines issued by the Regional Manager, and review incident and accident reports (falls, injuries of unknown origin, abuse, etc.) and monitor to determine the effectiveness of the facility's risk management program.The current job description for the DON indicated that the primary purpose of this position was to plan, organize, develop, and direct the overall operation of the nursing department in accordance with current, federal, state, and local standards, guidelines, and regulations that govern the facility and as may be directed by the Administrator of the Medical Director to ensure that the highest degree of quality care was maintained at all times. The administrative functions included ensuring that all nursing staff follow established departmental policies and procedures.The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.12 Freedom from Abuse, Neglect, and Exploitation (F600), revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free from abuse.Refer to F600. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing services.