STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395624	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Rolling Meadows Rehab and Nursing Ce	107 Curry Road Waynesburg, PA 15370

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 0604 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility provided policies and documentation, clinical records, and staff interviews, it was determined that the facility failed to ensure residents were free from physical restraints. This failure resulted in the actual harm of staff members restraining a resident to a bed with a bed sheet which caused abdominal bruising for one of eight residents (Resident R1). This was identified as past noncompliance. Findings include: Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 1/20/26, previously reviewed 1/21/25, indicated that each resident has the right to be free from abuse, neglect, and misappropriation of resident property and exploitation. Thisincludes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Review of facility policy Identifying Involuntary Seclusion and Unauthorized Restraint dated 1/20/26, previously reviewed 1/21/25, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:Is attached or adjacent to the resident's body;Cannot be removed easily by the resident (in the same manner it was applied by staff); andRestricts the resident's freedom of movement or normal access to his/her body. The policy further indicated that Sometimes the use of restraints is not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) include: (Provided in the list of examples was) tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted. Review of the facility Nurse Aid Job Description indicated, To provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - federally mandated assessment of a resident's abilities and care needs) dated 1/16/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), anxiety, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 9. Review of Resident R1's plan of care for risk of falls related to gait/balance problems initiated 10/13/25, indicated staff should follow the facility fall protocol. Review of (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident R1's clinical record progress noted dated 1/8/26, at 10:26 a.m. stated Head to toe assessment completed on resident. Noted scattered fading discolorations to bilateral upper extremities and scabbed areas, 0.5x 4cm left lower abdomen/pelvis linear purple discoloration. Scattered bruising to bilateral lower extremities with scabbed areas. Review of a Shower/Skin Weekly Evaluation completed on 1/2/26 (prior to incident), failed to reveal any new skin issues. Review of nurse aide skin observations, scheduled to be completed each shift from 1/1/26, through 1/8/26, revealed each documentation as Not applicable or None of the above observed (scratched, red area, discoloration, skin tear, or open area). Review of documentation submitted by the facility on 1/8/26, revealed It was reported to this DON (Director of Nursing) that resident [Resident R1] was found to be in bed with a sheet over her tied to the bed to hold her down at the beginning of 6a-2pm shift. Staff interviews being completed at this time. Alleged perpetrators noted as Nurse Aide (NA) Employee E1, NA Employee E2, and NA Employee E3, who all three worked the 10p-6a shift. No other residents were affected. Review of an employee statement written by NA Employee E4 dated 1/8/26, indicated, After NA Employee E5 got report from NA Employee E1, NA Employee E5 told me that NA Employee E1 had tied [Resident R1] into the bed. Me and NA Employee E6 went int the room and saw that the sheet was tied from left to right to the bed frame, across her abdomen. I reported it to the RN (registered nurse) supervisor. Me and NA Employee E6 untied her. Review of an employee statement written by NA Employee E5 dated 1/8/26, indicated, During report NA Employee E1 took me back to Resident R1's room and showed me the sheet across Resident R1's abdomen, tied to the bedframe. I told NA Employee E4 and NA Employee E6 about the sheet. They went in and untied the sheet while I was with another resident. NA said Resident R1 fell on first round on night shift. Review of an employee statement written by NA Employee E6 dated 1/8/26, indicated, NA Employee E5 told NA Employee E4 that in report NA Employee E1 said Resident R1 was tied down to the bed. I told NA Employee E1 lets go untie her. When we went in she had a sheet rolled up tight going across her with the hands underneath to where she couldn't move them. The sheet was tied from one side to another. When we went to go untie it we had a hard time getting the knot out. After we asked if she was okay. We didn't get a response. We reported to RN. Review of an employee statement written by RN Employee E7 dated 1/8/26, indicated, It has been brought to my attention by my DON about abuse allegations on a resident (Resident R1). I did not witness nor am I aware of this. I checked on this resident at 1915 (7:15) p.m. and again at 6:30 a.m. She was covered both times. Review of a second employee statement written by RN Employee E7 dated 1/8/26, indicated, It has been reported to me by my DON that a fall happened at 2230 (10:30) p.m. I was not to my knowing of this incident. It was not reported to me that any residents fell on my shift, 7p-7a 1/7/26. Review of an employee statement written by RN Employee E8 dated 1/8/26, indicated, I worked overnight Jan. 7th with my shift beginning at 11 p.m. Approximately 20 minutes into my shift, I obtained vital signs on Resident R1. At that time, I did straighten out Resident R1's upper body because she was leaning to the left. I did not notice anything abnormal at that time, and I did not re-enter Resident R1's room again during my shift. Review of an employee statement written by LPN Employee E9 dated 1/8/26, indicated, Checked resident multiple times my shift. Resident noted to have legs out of bed multiple times during my shift. Resident was repositioned many times. Resident was not noted to be on the floor during my shift that I was aware of. Review of an employee statement written by NA Employee E1 dated 1/8/26, indicated, I was caring for the resident whenever I noticed the sheet was tied to the bed frame on the right and left side, at two points. As I was trying to look for the RN Supervisor and the LPN (licensed practical nurse) on shift, I was answering call lights. I noticed they were not around, and the LPN was in another resident's room providing care. I finished the last round and was (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	charting whenever dayshift CNA (nurse aide) came in. As I was giving report, I got to the resident's name, and I pulled the dayshift CNA to look at the resident. I showed her the way it was tied and asked if she wanted to help me undo it. She told me to leave it. Apparently while I was off the floor, the other CNAs were making sure she didn't fall out of the bed. I did not witness anyone tie the sheet, and I did not tie the sheet in any way to the bed frame and/or the resident. Review of a second employee statement written by NA Employee E1 dated 1/8/26, indicated, When I saw NA Employee E3, the CNA, she told me NA Employee E2 came and got her to help while I was off the floor. NA Employee E3 told me they tied the sheet to the frame to make sure the resident didn't fall out of the bed. Review of an employee statement written by NA Employee E2 dated 1/8/26, indicated, I was working 10p-6a. Resident R1 had fell out of bed twice onto her fall mat around 10:20 p.m. The RN Supervisor did not want to do a incident report and we were afraid Resident R1 would get hurt. Myself and NA Employee E3 put a bed sheet across her hips and just lightly looped it through the bed so she couldn't fall. There was no intent to hurt this resident we just didn't want her to fall, get hurt and it not get reported. We didn't know what else to do to keep her safe. We then told NA Employee E1 it was there and if she wanted to remove it she could. I did not know that the bed sheet could be considered a restraint. Review of an employee statement written by NA Employee E3 dated 1/9/26, indicated, NA Employee E2 came back to (nursing unit) because she needed help getting Resident R1 up off the floor. When I got in the room Resident R1 was laying on the fall mat. We got her back in bed. NA Employee E2 handed me a sheet and we looped it around the bed to try to keep Resident R1 safe. I didn't realize this is a restraint. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 1/12/26, indicated, Staff were called to facility and interviewed completed. statements reviewed. Resident has had multiple falls. Staff did not think that placing a sheet over her was a restraint. They felt they were doing it to keep resident safe due to falls. RN supervisor was in room during shift and did not note sheet over resident's abdomen but did state that resident was moving around in bed and that he had to straight her top half up because she was leaning after getting her VS (vital signs). Resident was able to move freely within the bed with the sheet over her abdomen. CNA's claim that the sheet was looped on side of the bed and over resident's abdomen and looped on the other side of the bed through the bedframe. CNA's have been with the facility long term and have no attendance issues or any other disciplines on file. Review of the facility's plan of correction initiated 1/8/26, included:Interview with all alert and oriented residents about possible resident concerns of abuse, neglect, and restraint of movement. Skin observations on all residents not able to be interviewed for possible skin integrity concerns. In depth reeducation for NA Employees E1, E2, and E3.Education to all staff on resident rights, abuse and neglect prevention, and involuntary seclusion and restraints.Audits of resident and staff care.Review of this incident and similar during QAPI (quality assurance and performance improvement) meetings. The facility was back in compliance on 1/28/26. During an interview on 2/18/26, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure residents were free from physical restraints. This failure resulted in a staff member restraining a resident to a bed with a bed sheet and caused abdominal bruising for one of eight residents (Resident R1). This was identified as past noncompliance. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop written policies and procedures that include training new and existing nursing home staff on abuse, neglect, misappropriation of resident property, and exploitation. This failure resulted in the actual harm of staff members being unaware that unauthorized physical restraints can be a form of physical abuse and restraining a resident to a bed with a bed sheet which caused abdominal bruising for one of eight residents (Resident R1).Findings include: Review of the United Stated Code of Federal Regulations S483.95 indicated that the facility must have written policies and procedures that include training new and existing nursing home staff in the following topics which include: Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation.Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property.Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators.Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; andUnderstanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. Review of facility policy Identifying Involuntary Seclusion and Unauthorized Restraint dated 1/20/26, previously reviewed 1/21/25, defined a physical restraint as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the resident's body;Cannot be removed easily by the resident (in the same manner it was applied by staff); andRestricts the resident's freedom of movement or normal access to his/her body. The policy further indicated that Sometimes the use of restraints in not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) include: (Provided in the list of examples was) tucking in a sheet tightly so that the resident cannot get out of bed or fastening fabric or clothing so that a resident's freedom of movement is restricted. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - federally mandated assessment of a resident's abilities and care needs) dated 1/16/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), anxiety, depression, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R1's score to be 9. Review of Resident R1's plan of care for risk of falls related to gait/balance problems initiated 10/13/25, indicated staff should follow the facility fall protocol. Review of Resident R1's clinical record dated 1/8/26, at 10:26 a.m. stated Head to toe assessment completed on resident. Noted scattered fading discolorations to bilateral upper extremities and scabbed areas, 0.5x 4cm left lower abdomen/pelvis linear purple discoloration. Scattered bruising to bilateral lower extremities with scabbed areas. Review of documentation submitted by the facility on 1/8/26, revealed It was reported to this DON (Director of Nursing) that resident [Resident R1] was found to be in bed with a sheet over her tied to the bed to hold her down at the beginning of 6a-2pm shift. Staff interviews being completed at this time. Alleged perpetrators noted as Nurse Aide (NA) Employee E1, NA Employee E2, and NA Employee E3, who all three worked the 10p-6a shift. No other residents were affected. Review of an employee statement written by NA Employee E1 dated 1/8/26, indicated, I was caring for the resident whenever I noticed the sheet was tied to the bed frame e on (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the right and left side, at two points. As I was trying to look for the RN Supervisor and the LPN (licensed practical nurse) on shift, I was answering call lights. I noticed they were not around, and the LPN was in another resident's room providing care. I finished the last round and was charting whenever dayshift CNA (nurse aide) came in. As I was giving report, I got to the resident's name, and I pulled the dayshift CNA to look at the resident. I showed her the way it was tied and asked if she wanted to help me undo it. She told me to leave it. Apparently while I was off the floor, the other CNAs were making sure she didn't fall out of the bed. I did not witness anyone tie the sheet, and I did not tie the sheet in any way to the bed frame and/or the resident. Review of a second employee statement written by NA Employee E1 dated 1/8/26, indicated, When I saw NA Employee E3, the CNA, she told me NA Employee E2 came and got her to help while I was off the floor. NA Employee E3 told me they tied the sheet to the frame to make sure the resident didn't fall out of the bed. Review of an employee statement written by NA Employee E2 dated 1/8/26, indicated, I was working 10p-6a. Resident R1 had fell out of bed twice onto her fall mat around 10:20 p.m. The RN Supervisor did not want to do a incident report and we were afraid Resident R1 would get hurt. Myself and NA Employee E3 put a bed sheet across her hips and just lightly looped it through the bed so she couldn't fall. There was no intent to hurt this resident we just didn't want her to fall, get hurt and it not get reported. We didn't know what else to do to keep her safe. We then told NA Employee E1 it was there and if she wanted to remove it she could. I did not know that the bed sheet could be considered a restraint. Review of an employee statement written by NA Employee E3 dated 1/9/26, indicated, NA Employee E2 came back to (nursing unit) because she needed help getting Resident R1 up off the floor. When I got in the room Resident R1 was laying on the fall mat. We got her back in bed. NA Employee E2 handed me a sheet and we looped it around the bed to try to keep Resident R1 safe. I didn't realize this is a restraint. Review of a facility submitted Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 1/12/26, indicated, Staff did not think that placing a sheet over her was a restraint. They felt they were doing it to keep resident safe due to falls. On 2/18/26, the facility was asked to provide what literature was used to educate staff on abuse and neglect prevention, and evidence that NAs Employee E1, E2, and E3 received that education. On 2/18/26, the facility provided sign-in sheets that indicated that NA Employee E1 received education on abuse and neglect prevention on 10/29/25, and NA Employees E2 and E3 received education on abuse and neglect prevention on 10/28/25. Review of the facility provided literature used during the above education, the facility provided a copy of the facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program. Review of the policy stated the facility will Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. During an interview on 2/18/26, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the policy utilized for abuse and neglect prevention education stated the topics that staff will have training on, but the policy did not in itself include that information, and education on those topics was not provided. During an interview on 2/18/26, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to develop written policies and procedures that include training new and existing nursing home staff on abuse, neglect, misappropriation of resident property, and exploitation. This failure resulted in the actual harm of staff members being unaware that unauthorized physical restraints can be a form of physical abuse and restraining a resident to a bed with a bed sheet which caused abdominal bruising for one of eight residents. 28 Pa. Code 201.14(a): Responsibility of licensee.28 Pa. Code (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	201.18(b)(1)(e)(1): Management.28 Pa Code: 201.20 (b): Staff development.