STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395379	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Sycamore Rehabilitation and Nursing Cent	1445 Sycamore Road Montoursville, PA 17754

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on review of select facility policies and procedures, clinical record review, and family and staff interview, it was determined that the facility failed to ensure that a resident was free from physical restraint for one of six residents reviewed (Resident 4).Findings include: The facility policy entitled, Identifying Involuntary Seclusion and Unauthorized Restraint, last reviewed February 10, 2026, revealed that as part of the abuse prevention strategy, volunteers, employees, and contractors, hired by the facility, are expected to be able to identify involuntary seclusion and/or unauthorized restraint of residents. Residents are free from the use of any physical restraints not required to treat their medical condition. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: is attached or adjacent to a resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body. Inappropriate or unauthorized use of restraint occurs when it is used for discipline or convenience; unnecessarily inhibits a resident's freedom of movement or activity; is not the least restrictive option or used for the least amount of time needed; and/or is not accompanied by ongoing re-evaluation of the need for the restraint. Examples of physical restraints include 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. Risk of falling is not considered a medical symptom or self-injurious behavior that warrants the use of restraints. Restraints that are used as a last resort to protect the safety of the resident and others must be accompanied by an order from the practitioner and documentation reflecting the circumstances that led to the decision to restrain him or her. Interview with Resident 4's daughter on April 16, 2026, at 1:56 PM indicated that the facility notified her that staff observed her mother in her wheelchair with her yellow shawl that she normally wears around her shoulders tied in a knot in the back of her chair. Resident 4's daughter understood that staff allegedly restrained her mother to her wheelchair with the explanation that they worried that she might lean too far forward and fall out of the chair. Clinical record review for Resident 4 revealed an active physician's order dated October 2, 2024, that she is not capable of understanding her rights and responsibilities. Nursing documentation dated March 25, 2026, at 9:40 PM revealed that the registered nurse supervisor entered the nursing unit and nurse aide staff reported that she found Resident 4 sitting in her wheelchair at the nurses' station with her shawl wrapped around her wheelchair and tied in a knot. Resident 4 was unable to verbalize what had happened. Resident 4's clinical record did not provide evidence of a physician's order for the use of a restraint. There was no evidence of an assessment to warrant the use of a restraint to treat a medical symptom. Interview with the Nursing Home Administrator and the Director of Nursing on April 16, 2026, at 12:13 PM confirmed that the facility investigated the incident of March 25, 2026, for Resident 4 and determined that she was inappropriately restrained in her wheelchair. 28 Pa. Code 211.8(c.1)(2)(d)(e) Use of restraints 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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
	395379	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at Sycamore Rehabilitation and Nursing Cent	1445 Sycamore Road Montoursville, PA 17754

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of select facility policies, clinical record review, and staff interview, it was determined that the facility failed to ensure medication availability for two of six residents reviewed (Residents 2 and 3).Findings include: The facility policy entitled, Electronic Emergency Kit, reviewed February 10, 2026, revealed that the purpose of the policy is to provide access to medications that are needed before the next pharmacy delivery through an electronic Emergency Medication Kit (EKIT), to meet the immediate needs of a resident. The provider pharmacy will provide medications for use in STAT/emergency situations at the facility. The contents of the EKIT will be determined/approved by the pharmacy/facility and in accordance with state regulations governing EKIT, emergency, and stock medications. Each EKIT unit will be filled and maintained with controlled medications, non-controlled medications, and other supplies in accordance with state laws and statutes. The nurse/authorized personnel will document the medication administration, and any other applicable information, in the eMAR/MAR and resident's medical record per facility policy and procedure. Clinical record review for Resident 3 revealed a physician's order active March 9, 2026, to April 7, 2026, for staff to administer the anticoagulant (medication used to delay blood clotting), Eliquis, 2.5 milligrams (mg) two times a day. Review of Resident 3's MAR (Medication Administration Record, electronic documentation completed by licensed staff to attest to the administration of medications) dated April 2026 revealed that staff documented a code, 17 (Held per MD order), on April 7, 2026, for the 8:00 AM dose of the medication. Nursing documentation dated April 7, 2026, at 9:54 AM noted that Resident 3's Eliquis medication was, on order (from pharmacy). Interview with the Nursing Home Administrator and the Director of Nursing on April 16, 2026, at 12:13 PM confirmed that there was no evidence Resident 3 received her Eliquis medication as ordered as nursing staff determined there was no supply of the medication for administration. Clinical record review for Resident 2 revealed a physician order active October 4, 2025, to April 11, 2026, for staff to administer Clonazepam (Klonopin, an antianxiety medication) 0.5 mg in the morning (8:00 AM) for anxiety. A physician order active October 3, 2025, to April 11, 2026, instructed staff to administer Clonazepam 1 mg daily at 4:00 PM. Review of Resident 2's MAR dated April 2026 revealed that staff failed to administer the medication on April 2, 9, and 10, 2026, at 8:00 AM, and April 8 and 9, 2026, at 4:00 PM. Staff coded, 17, as the reason for not administering the Clonazepam medication on the following dates and times:April 8, 2026, at 4:00 PMApril 9, 2026, at 8:00 AM and 4:00 PMApril 10, 2026, at 8:00 AM Nursing documentation dated April 8, 2026, at 7:57 PM noted that the licensed practical nurse notified the supervisor that Resident 2's Clonazepam was out of stock. Nursing documentation dated April 8, 2026, at 9:42 PM noted that the pharmacy rejected an attempt to pull the Clonazepam from the, omnicell (EKIT). Nursing documentation dated April 9, 2026, at 10:09 AM noted that the Clonazepam was not administered because, awaiting (pharmacy supply). Nursing documentation dated April 9, 2026, at 7:31 PM noted that the Clonazepam was not administered because, Medication not available. Nursing documentation dated April 10, 2026, at 1:16 PM noted that the Clonazepam was not administered because, medication not on hand, RN (registered nurse) supervisor made aware. Interview with the Nursing Home Administrator and the Director of Nursing on April 16, 2026, at 12:13 PM confirmed that staff did not administer Resident 2's Clonazepam medication on the above dates and times due to an interruption in the medication availability to nursing staff. 28 Pa. Code 211.9(a)(1)(4)(k)(l)(1)(2) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services