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	06/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on two of six nursing units (Sycamore Boulevard and Maple Lane; Resident 2), and provide a safe and clean environment in the common intersection between Maple Lane, [NAME] Lane, and Little League Boulevard.Findings include: Observation on Sycamore Boulevard on June 6, 2026, at 9:00 AM revealed a pest control light secured on the wall, below the ceiling. There were a large number of dead insects noted inside the light, stuck to an adhesive. Directly below the pest control light was a drink tray which included two carafes and a mug filled with a brown powder. Concurrent interview with Employee 2, licensed practical nurse, revealed that the drink tray is where staff mix and serve hot drinks for the residents. Employee 2 confirmed that the brown powder in the mug was hot chocolate mix. Observation on June 26, 2026, at 11:35 AM of Resident 2's room revealed that dark brown dried drops were splashed/scattered on the wall to the right of the resident's bed that spanned an area of 3 feet. Resident 2's family indicated that those marks had been there since she moved into the room (clinical record review indicated the resident moved to this room on April 27, 2026). Continued observation of Resident 2's bathroom revealed that the floor had dried brown stains in front of the covered tub. The water line, which connected from a metal box to under the sink was noted to have rust-colored stains, and the metal box was also noted to have rust-colored stains. Observation of the intersection between Maple Lane, [NAME] Lane, and Little League Boulevard, on June 26, 2026, at 12:30 PM revealed that multiple flooring tiles were beginning to lift and buckle. Three separate tiles were noted to have the corner of the tile broken off, leaving a small hole in the flooring that appeared to be filled with black debris/dirt. The above findings were reviewed with the Nursing Home Administrator and Employee 1, Regional Clinical Operator on June 26, 2026, at 2:30 PM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan regarding denture care for one of two residents reviewed (Resident 2). Findings Include: During an interview with Resident 2 on June 26, 2026, at 11:35 AM, they indicated that they had dentures. The resident showed their mouth and revealed they had a full set of upper dentures and a lower partial in place. Clinical record review for Resident 2 revealed they had been admitted on [DATE]. Further review revealed that the resident had no care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) implemented since admission relating to denture care. The above information was reviewed with the Nursing Home Administrator and Employee 1, Regional Clinical Operations, on June 26, 2026, at 2:30 PM 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of select facility policies and procedures, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of one resident reviewed (Resident 4).Findings include: Review of the facility's current policy entitled Answering the Call Light last revised September 2022, revealed that it is the facility's purpose to ensure timely responses to the resident's requests and needs. Clinical record review revealed the facility admitted Resident 4 on January 28, 2026. A review of Resident 4's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated May 19, 2026, indicated nursing staff assessed Resident 4 as substantial to maximum assistance in toileting, showering, toilet transfers, upper and lower body extremity dressing, personal hygiene, siting to lying and lying to siting, chair/bed-to-chair transfers, and rolling left to right. Clinical record review of Resident 4's task documentation (ADL, activities of daily living charting) for June 2026, revealed the resident is a two person assist with chair/bed-to-chair transfer, and sit to stand. Interview and observation of Resident 4 on June 26, 2026, at 9:10 AM revealed the resident in bed, in her night clothes. Resident 4 indicated she likes to be dressed and out of bed by 9:30 AM, and that she requires two staff to assist. Observation of Resident 4 on June 26, 2026, at 9:33 AM, revealed the resident remained in her bed, in her night clothes, crying, with her call light activated. Concurrently, an unknown staff member was observed entering the room, speaking to the resident, turning the call light off, and exiting the resident's room, Resident 4 remained in bed with her night clothes on. Further observations of Resident 4 revealed the following: 9:35 AM call light was activated and an unidentified staff member responded, spoke to the resident, turned the call light off and exited the room. 9:38 AM call light was activated and an unidentified staff member responded, spoke to the resident, turned the call light off and exited the room. 9:42 AM call light was activated and an unidentified staff member responded, spoke to the resident, turned the call light off and exited the room. 9:47 AM call light was activated and an unidentified staff member responded, spoke to the resident, turned the call light off and exited the room. 9:58 AM call light was activated and Employee 6 (activity director) responded to the call light, spoke to the resident, turned the call light off and exited the room. Concurrent interview with Employee 6 indicated she was going to tell Employee 7 (nurse aide) Resident 4 was ready to get dressed and out of bed. Resident 4's call light was observed as activated again at 10:01 AM. Resident 4 was still in bed, in her night clothes. Employee 5 (nurse aide) entered the room and told Resident 4 that Employee 7 was aware she wanted to get out of bed. Employee 5 turned off the call light and exited the room. Resident 4's call light was again observed activated at 10:06 AM, Employee 7 was then observed entering the room and proceeded to begin providing care for the resident. Resident 4 required staff assistance for hygiene, dressing, and getting out of bed and was not assisted per her preference prior to 9:30 AM. Resident 4 was then not assisted after alerting staff at 9:33 AM until greater than a half hour later at 10:06 AM when assistance began. The above findings for Resident 4 were reviewed with the Nursing Home Administrator and Employee 1, the Regional Clinical Operations, on June 26, 2026, at 2:30 PM. S483.24(a)(2) ADLsPreviously cited 3/13/26 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to maintain nutritional status for one of three residents reviewed for nutritional concerns (Resident 3).Findings include: Clinical record review for Resident 3 revealed the following weight assessments: December 16, 2026, 162.2 poundsJanuary 3, 2026, 161 poundsFebruary 3, 153.4 pounds (7.6-pound, 4.7 percent weight loss)February 8, 2026, 153 poundsMarch 5, 2026, 159 poundsApril 7, 2026, 158 poundsMay 29, 2026, 145.8 pounds (12.2 pounds, 7.7 percent and severe weight loss from previous month) Further clinical record review for Resident 3 revealed no evidence of nutrition notes or assessments between February 2026 (after the resident's 4.7 percent weight loss), until a quarterly nutritional assessment completed on May 29, 2026, by a registered dietitian. Resident 3's May 29, 2026, nutrition assessment indicated the weights noted above, although there was no evidence the resident's severe weight loss from April to May 2026, was acknowledged or addressed as a severe weight loss. Review of Resident 3's care plan revised on May 29, 2026, indicated that the resident had a potential for nutritional risk and a history of weight changes. One of the goals established for the resident was to maintain weight within five percent, although, no new interventions were added. There was no evidence that facility staff implemented any interventions to either monitor or treat the severe weight loss. As of June 26, 2026, there was no evidence resident 3 had been weighed again since May 29, 2026. Resident 3 was weighed upon request by the surveyor on June 26, 2026, at a weight of 147 pounds consistent with the resident's May 2026, weight, and loss from April 2026. The above information was reviewed with the Nursing Home Administrator and Employee 1, Regional Clinical Operator, on June 26, 2026, at 2:30 PM 483.25(g)(1) Maintains acceptable parameters of nutritional statusPreviously cited 3/13/26 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, review of facility documents, and resident and staff interview, it was determined that the facility failed to provide menu items as indicated for three of three residents reviewed (Residents 2, 3 and 4).Findings include: Observation on June 26, 2026, at 8:54 AM revealed Resident 3 had completed about half of her breakfast meal. Resident 3's meal ticket indicated they should receive six fluid ounces of hot chocolate. There was no evidence hot chocolate had been served on the resident's tray. Concurrent interview with Employee 3, nurse aide, revealed that dietary had not sent any hot chocolate packets to the unit this morning, so they were not able to make hot chocolate for Resident 3. Observation of Resident 4 eating lunch on June 26, 2026, at 12:56 PM, revealed the resident's meal tray ticket indicated the resident was to receive eight fluid ounces of Lactaid (a lactose-free milk substitute). There was no Lactaid served on the resident's tray. Clinical record review for Resident 2 revealed a physician's order dated February 23, 2026, indicating the resident was to receive a Magic Cup two times a day for variable meal intake and weight loss one carton at lunch and dinner. Observation of Resident 2 eating lunch on June 26, 2026, at 1:05 PM, revealed Resident 2's lunch meal ticket indicated the resident was to receive a Magic Cup (a dietary supplement to provided additional calories/protein). There was no Magic Cup on the resident's lunch tray. A concurrent interview with a family member of Resident 2 confirmed the Magic Cup had not been provided, but a cup a fortified (added nutrients) pudding was provided, although, the resident did not like it and would not eat it. The above information was reviewed with the Nursing Home Administrator and Employee 1, Regional Clinical Operator, on June 26, 2026, at 2:30 PM 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management