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	03/13/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the main kitchen of the facility, main dining room, and on one of six nursing units (Little League Nursing Unit). Findings include: Initial tour of the facility's main kitchen with Employee 17, Dietary Manager, on March 10, 2026, at 8:25 AM revealed the following: A wall mounted heating / cooling unit near the dishwasher room entrance had a black-colored build-up on the vents and cobwebs on the exterior. There were dried food stains on the ceiling. There were dried food stains on a wall and the disposable gloves being stored over a stainless-steel prep area. There was a significant accumulation of dust on top of a commercial coffee machine. The covering on top of the coffee machine was peeling off. There was a broken overhead light cover in the dishwasher area. There was a significant accumulation of dust and debris on the top of the dishwasher that also included a discarded plastic bottle cap and a hair and beard retainer. There was an extensive build-up of dried stains on the wall and floor under the sink adjacent to the dishwasher. A black-colored plastic receptacle held used kitchen rags to be taken to the laundry per Employee 17. There was no liner or bag in the container. The kitchen dry storage area located in the basement of the facility had two large packages of raisins that expired in August 2025. The kitchen dry storage area had a smaller room attached to it that used to be an old bathroom per Employee 17. This room was being used for storage of items such as muffin mix and snacks. There was a pipe observed in the floor that had what appeared to be cloth rags in the pipe. A concurrent interview with Employee 17 revealed the pipe was not capped. There was a sewage-like smell coming from the pipe noted when near it. There was a built-in storage area above the pipe. There was a box of crackers on the floor next to the pipe. There were two empty snack-sized bags of chips and an empty snack-sized bag of cheese crackers discarded on top of items on the shelving. A second plastic pipe was observed behind storage shelving in this room. The pipe was not capped, and it was unclear what the pipe was for or where it originated. The walk-in cooler for the kitchen located in the basement had two single-serve butter condiment packs on the floor under the shelving. The attached walk-in freezer had ice accumulating on a box of pasta under the compressor area. Part of the freezer ceiling that was previously caulked was detached and separating at the seam. The following was observed in the main dining room: A prep area with drawers and cupboards had a drawer that was missing. The complete edge of the countertop was worn away and exposed the particle board underneath it. There was a drawer that contained salt and pepper shaker lids that had an extensive accumulation of debris in the bottom of it. A cupboard that held various items such as coffee pots, kitchen rags, and plastic lids had loose plastic lids scattered on top of the items. Another cupboard had two packages of hand sanitizer that expired in November 2025. A subsequent observation in the dining room on March 12, 2026, at 11:30 AM revealed that six of the seven observed overhead chandelier lights had cobwebs on them. Observation of the Country Kitchen Pantry Area on the Little League Nursing Unit on March 12, 2026, at 12:10 PM revealed two glass storage containers that were not labeled or dated, and one held a coffee like substance and the other held a sugar like substance. The refrigerator in the pantry area had black colored stains on the handle at the top of the (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	door. There was cheese and meat which appeared dried out being stored in the refrigerator in an unlabeled plastic container with a set of tongs. There were dried food stains on the door shelving and stains with a pooling liquid on the bottom of the interior refrigerator in front of the storage drawers. There was an unlabeled white-powdery substance being stored in a plastic cup near the sink. The above information for the kitchen, dining room, and pantry area was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:05 PM. A review of the tray-line food temperatures for December 2025, February 2026, and January 2026, revealed the following missing temperatures: December 1-14, 2025: all temperatures (breakfast, lunch, and dinner).December 15, 2025: missing breakfast and lunch temperatures.December 16, 2025: missing dinner temperatures.December 17, 2025: missing dinner temperatures.December 18, 2025: missing breakfast, lunch, and dinner temperatures.December 19, 2025: missing breakfast, lunch, and dinner temperatures.December 20, 2025: missing breakfast, lunch, and dinner temperatures.December 21, 2025: missing breakfast, lunch, and dinner temperatures.December 24, 2025: missing dinner temperatures.December 29, 2025: missing breakfast, lunch, and dinner temperatures. February 11, 2026: missing breakfast, lunch, and dinner temperatures.February 23, 2026: missing breakfast and lunch temperatures. An interview with Employee 17 on March 13, 2026, at 9:43 AM revealed that the missing tray-line food temperatures are unaccounted for. The Nursing Home Administrator was informed of the above missing temperatures on March 13, 2026, at 11:00 AM. 483.60(i)(1)-(2) Food safety requirementsPreviously cited deficiency 2/21/25 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that residents could make choices regarding aspects of their lives that were significant to them, such as smoking, for three of three residents reviewed for concerns related to resident choices (Residents 28, 39, and 101). Findings include: Interview with the Nursing Home Administrator and Director of Nursing during the entrance conference meeting on March 10, 2026, at 8:30 AM revealed that smoking is prohibited for the residents. They confirmed that staff are allowed to smoke on the facility property. Interview with Resident 28 on March 11, 2026, at 10:35 AM revealed that he would like to smoke. Resident 28 stated that three times a week he sees people smoking before entering the dialysis (medical procedure to filter waste and excess fluid out of the blood when the kidneys cannot perform that function adequately) provider's office; and he wishes that he could join them. Resident 28 stated that he sees staff at the facility smoking in the outside parking area to the left of the front entrance when he goes to dialysis treatments three times a week and wants to tell them that he would have one with them. Resident 28 stated that he was told that the facility was a smoke-free facility and that smoking was not permitted for him. Interview with Resident 28 on March 13, 2026, at 1:23 PM confirmed that he wanted to continue to smoke after his admission to the facility but was told he could not smoke on facility premises. He confirmed that since his admission he has seen staff smoking near the building on several occasions. Clinical record review for Resident 28 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 2, 2026, that assessed him as: Having no range of motion impairmentsRequiring no mobility devices (e.g., cane, wheelchair, or walker)Independent of staff for dressing, showering, personal hygiene, bed mobility, transfers, and ambulationHaving no cognitive impairments (Brief Interview for Mental Status, BIMS, score of 13) Nursing documentation dated December 4, 2025, at 1:35 PM indicated that staff, Spoke with resident that this is a non-smoking facility and that he is prohibited from smoking on the facility property. Nursing documentation dated December 17, 2025, at 7:03 PM indicated that staff educated Resident 28 that he needed to leave the facility to smoke off of the property and that, he got angry about it and walked away. Nursing documentation dated December 17, 2025, at 7:28 PM revealed that staff determined that Resident 28 was smoking on the facility premises. The documentation indicated that he had been educated multiple times about the facility policy and that Resident 28 consented to staff looking for cigarettes and lighters, that he, handed over what he had willingly. Resident 28's physician provided a verbal order for Resident 28 to utilize a nicotine patch (21 milligrams) once a day. Social services documentation dated January 2, 2026, at 11:01 AM revealed that Resident 28's advocate and pastor reported that Resident 28 wanted him to get him cigarettes. Interview with the Nursing Home Administrator and the Director of Nursing on March 12, 2026, at 2:00 PM confirmed that smoking is prohibited for residents; however, it is known that staff smoke near the building. Clinical record review revealed the facility admitted Resident 101 on November 25, 2025. Review of Resident 101's plan of care-initiated November 26, 2025, revealed that Resident 101 is a smoker. The intervention the facility implemented was to administer a smoking cessation patch per provider order if applicable. Resident 101 was unable to be interviewed due to expressive aphasia. Interview with the Nursing Home Administrator and Director of Nursing on March 13, 2026, at 1:49 PM, confirmed that Resident 101 has not been permitted to smoke since admission to the facility. Clinical record review for Resident 39 revealed that the facility admitted him on October 26, 2025. Review of Resident 39's admission agreement that he signed on October 27, 2026, revealed that the facility cares about the health of residents, staff, and others and are a non-smoking facility. A nursing progress note dated December 18, 2025, at 6:27 PM indicated that Resident 39's sister was in visiting and found a cigarette in his room and gave it to the nurse. The note indicated that Resident 39 was educated that (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility is a non-smoking facility. Interview with Resident 39 on March 11, 2026, at 1:52 PM revealed that he desires to smoke and that he does not think it is fair that staff are allowed to smoke but he is no allowed to. He indicated that he often sees 10 staff out smoking and it is unfair that he cannot have one (a cigarette). An interview with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 3:15 PM confirmed the above noted findings related to Resident 39, that he is not allowed to smoke on the facility property, but facility staff are allowed to. The facility failed to ensure that Residents 28, 39, and 101 could make choices regarding aspects of their lives that were significant to them, such as smoking. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 209.3(a) Smoking 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview, it was determined that the facility failed to monitor the use of psychotropic medications for three of five residents reviewed for potentially unnecessary medications (Residents 4, 14, and 15). Findings include: Clinical record review for Resident 4 revealed active physician orders for staff to administer the following psychotropic medications: Brexpiprazole (an atypical antipsychotic used along with antidepressant medicines to treat major depressive disorder (MDD) in adults) 0.5 milligrams (mg) in the morning for depression.Lorazepam 0.5 mg (an anti-anxiety medication) every 4 hours as needed (PRN) for anxiety for 14 DaysMirtazapine (an antidepressant) 15 mg in the morning for depressionFluoxetine (an antidepressant) 40 mg in the morning for depression A physician order instructed staff to monitor Resident 4's symptomatic target behaviors (delusions or hallucinations, unstable mood, signs and symptoms of changes, tearfulness, adjustment difficulty, and withdrawal) and non-medicinal interventions attempted (activity, backrub, position changes, fluids/food, redirection, change environment, and toileting) with Resident 4's response to those interventions until the order was discontinued on February 9, 2026. Resident 4's clinical record failed to provide evidence that the facility was monitoring for potential side effects from Resident 4's use of psychotropic medications. The surveyor confirmed during an interview with the Director of Nursing on March 13, 2026, at 8:35 AM that the facility failed to continue monitoring for potential side effects and distressing target behaviors for Resident 4's antipsychotic, antidepressant, and PRN antianxiety medication use after February 9, 2026. The interview also confirmed that Resident 4's plan of care did not instruct staff to monitor for potential side effects from Resident 4's antipsychotic medication use (only antidepressant medication use); and the facility did not develop a plan of care that included Resident 4's potential use of an antianxiety medication on an as-needed basis (PRN). Clinical record review for Resident 14 revealed active physician orders to administer the following psychotropic medications: Lexapro (an antidepressant) 5 mg daily for depressionRisperdal (an antipsychotic) 0.5 mg one time a day for schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking)Risperdal 0.25 mg one time a day for schizophrenia Resident 14's clinical record did not contain evidence that staff monitored for potential side effects of the antipsychotic medication use. Interview with the Director of Nursing on March 13, 2026, at 8:35 AM confirmed the above findings for Resident 14. Clinical record review for Resident 15 revealed active physician orders to administer the following psychotropic medications: Seroquel (antipsychotic medication) 25 mg two times a day for agitation Resident 15's clinical record did not contain evidence that staff monitored for potential side effects of the antipsychotic medication use. Interview with the Director of Nursing on March 12, 2026, at 9:54 AM confirmed the above findings for Resident 15. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on a review of select facility policies and procedures, clinical record review, review of employee personnel records, and staff interview, it was determined that the facility failed to develop written procedures for screening potential employees that included all necessary components, maintain documentation of potential employee employment history screening for three of five newly hired employees (Employees 5, 6, and 7), and failed to thoroughly investigate an injury of unknown origin for one of 24 residents reviewed (Resident 15). Findings include: Interview with the Nursing Home Administrator on March 13, 2026, at 11:14 AM confirmed that the facility's human resources and abuse prohibition program and policies do not include actions taken to screen prospective employees that include obtaining information from previous and/or current employers (e.g., dates of employment position or title, disciplinary actions, etc.), whether favorable or unfavorable. Review of Employee 5's (licensed practical nurse) personnel record revealed that the facility hired her on November 4, 2025. Review of the document entitled, Professional References, contained in Employee 5's personnel record revealed no documentation that the human resources director confirmed the dates of employment alleged by Employee 5; or that references provided favorable comments, unfavorable comments, or refused to participate in a screening review.Review of Employee 6's (activity aide) personnel record revealed that the facility hired her on November 18, 2025. There was no document entitled, Professional References, contained in Employee 6's personnel record. A dated initial (no full name or title provided) on Employee 6's application page related to previous employment noted, All verified. There was no documentation that any reference verified provided favorable comments, unfavorable comments, or refused to participate in a screening review. Review of Employee 7's (registered nurse) personnel record revealed that the facility hired her on February 3, 2026. The personnel record provided by the facility for Employee 7 did not include a history of previous employment that included the employer, employer's contact information, or dates of employment. A, Professional Reference Sheet, contained in Employee 7's personnel record listed three health care providers; however, did not include documentation of an individual contacted, dates of employment verified, or if a contacted person provided favorable comments, unfavorable comments, or refused to participate in a screening review. Interview with the Nursing Home Administrator on March 13, 2026, at 11:13 AM confirmed the above findings for Employees 5, 6, and 7. The facility policy entitled Protocol for Investigation of Injury of Unknown Origin, last reviewed without changes February 1, 2026, revealed the facility shall maintain and implement a clear investigative protocol for any injury of unknown origin to ensure the safety, dignity, and protection of all residents. Injuries of unknown origin may indicate underlying risks including unrecognized falls, environmental hazards, inadequate supervision, or potential abuse or neglect. A timely and thorough investigation allows the facility to determine the cause of the injury, implement appropriate interventions, and protect the residents from further harm. When any injury of unknown origin is identified, the staff member identifying the injury shall immediately report the findings to the supervisor. The registered nurse shall immediately assess the resident to determine the resident's current condition, ensure necessary treatment is rendered, and determine whether the resident requires additional medical evaluation. The attending physician and the resident's representative shall be notified as appropriate. The charge nurse should notify the Director of Nursing, and the facility will initiate the investigative process immediately upon identification of the injury. The facility shall take immediate steps to ensure the resident is protected from potential further harm while the investigation is conducted. The investigation shall seek to determine the cause, circumstances, and individual involved, if any. The investigation shall include interviews with the residents, when possible, staff members on duty during the suspected timeframe, and any potential witnesses. The facility shall evaluate whether the injury is consistent with abuse or neglect, if there is any reasonable suspicion of abuse or neglect, the facility shall report the allegation in accordance with federal and state reporting requirements. Clinical record review revealed the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility admitted Resident 15 on April 1, 2025. Nursing documentation dated November 4, 2025, at 3:23 PM revealed observation of Resident 15's hand, noting his left knuckle was swollen and blue/purple in color Nursing documentation dated November 4, 2025, at 3:30 PM the registered nurse assessment noted Resident 15's hand was swollen at the first base knuckle, and tender upon palpitation. Resident 15 was noted to be guarding her hand. Resident 15's physician was updated and ordered a stat X-ray of Resident 15's left hand. Nursing documentation dated November 4, 2025, at 10:31 PM revealed the results of the X-rays to Resident 15's left hand revealed no acute fracture or dislocation, but an irregular alignment of the ulna (long bone in the forearm) that could represent dislocation. Resident 15's physician recommended to send Resident 15 to the emergency department for further testing and treatment of her left hand. Nursing documentation dated November 5, 2025, at 1:45 AM revealed Resident 15 returned from the emergency department. Resident 15 X-rays of her left hand showed a contusion. Nursing documentation dated November 5, 2025, at 1:22 PM revealed the facility received a call from the emergency department stating that Resident 15's X-rays showed an anomaly (abnormality) that was not seen by the emergency department provider and the radiologist recommended Resident 15 return to the emergency department immediately for re-evaluation and ortho/trauma consult. Review of emergency department notes dated November 5, 2025, at 4:31 PM revealed Resident 15 was sent back to the emergency department after a radiology discrepancy showing a questionable dorsal (back) dislocation of the ulnar head without fracture. X-ray imaging was reviewed by the orthopedic trauma team, and they recommended Resident 15 wear a Velcro splint and follow up with outpatient. Review of the facility's investigation into Resident 15's swelling and bruising to her left hand revealed that they did not obtain any witness statements from staff relating to how the injury may have occurred. Interview with the Director of Nursing on March 13, 2026, at 12:53 PM, confirmed that the facility did not complete a thorough investigation into Resident 15's swollen and bruised left hand to rule out the potential for abuse and/or neglect. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(1)(10) Personnel policies and procedures 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, review of facility documentation, and staff and resident interview, it was determined that the facility failed to provide the highest practical care regarding physician ordered medications and/or devices for four of 24 residents reviewed (Residents 4, 11, and 12); and implement resident-directed care and treatment consistent with the resident's care plan for one of 24 residents reviewed (Resident 101). Findings include: A review of the current physician orders for Resident 11 revealed an order dated December 7, 2025, at 8:00 AM for Vitamin Deficiency System - B12 injection Kit; inject 1000 micrograms (mcg) intramuscularly one time a day every 30 days. A review of the Medication Administration Record (MAR) for Resident 11 for December 2025 to March 2026 revealed that the vitamin injection was not administered per the physician order for the following dates: February 5, 2026: no documentation on the MAR; blank.January 6, 2026: no documentation on the MAR; blank. There was no documentation for Resident 11 to indicate a rationale for why the medication was not documented as administered on the above dates per the physician orders. The above information for Resident 11 was reviewed in a meeting with the Nursing Home Administrator on March 12, 2026, at 2:05 PM. Clinical record review for Resident 12 revealed a diagnosis list that included essential hypertension (high blood pressure). A review of the current physician orders for Resident 12 revealed an order dated September 12, 2025, for Lisinopril (a medication used to treat high blood pressure and heart failure) oral tablet give one tablet by mouth in the morning. Hold for systolic blood pressure (SBP, the top number of a blood pressure reading where the heart contracts) less than 120. A review of the Medication Administration Record (MAR) for Resident 12 for September 2025 to March 2026 revealed that the Lisinopril was marked as administered outside of the physician specified parameters for the following dates: September 23, 2025; the blood pressure was documented as 118/58.November 21, 2025; the blood pressure was documented as 116/62.November 26, 2025; the blood pressure was documented as 118/62.February 3, 2026; the blood pressure was documented as 119/66.February 9, 2026, the blood pressure was documented as 117/74. There was no documentation for Resident 12 to indicate a rationale for why the medication was administered outside of the specific stated parameters. The above information for Resident 12 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 2:01 PM. Clinical record review for Resident 4 revealed pre-admission hospital documentation dated January 6, 2026, that identified that he required an amiodarone (heart rhythm medication used to treat and prevent a number of cardiac dysrhythmias) drip (intravenous administration) for an irregular heart rhythm (questioned to be atrial fibrillation (chaotic rhythm of the upper chamber of the heart) with rapid ventricular (fast rhythm of the lower chamber of the heart) response versus ventricular tachycardia (irregular heartbeat that starts in the lower chambers of the heart that can be life-threatening)). The document also noted Resident 4's history included ventricular tachycardia with a surgically inserted cardiac pacemaker (medical device that helps regulate the heart's rhythm by impulses to the heart muscle, ensuring it beats at a normal rate). The document indicated that Resident 4 had an ablation due to his atrial fibrillation (medical procedure that creates a scar in the heart muscle to stop abnormal electrical impulses in the heart). Other cardiac diagnoses for Resident 4 included left bundle branch block (BBB, electrical impulses to the heart are delayed or blocked) and bradycardia (slow heart rate). Facility physician progress note documentation dated January 22, 2026, at 12:42 PM noted that an AV node ablation with pacemaker insertion (permanent medical procedure that destroys the atrioventricular node/heart's natural electrical pathway to control heart rhythms that requires a lifelong pacemaker and requires long-term management of pacemaker monitoring) in 1999. The documentation indicated that Resident 4 reported, heart racing at night of unclear etiology. Interview with Resident 4 on March 11, 2026, at 11:22 AM confirmed that he has had an internal cardiac pacemaker for about 20 years and has a pacemaker machine (medical device that enables ongoing remote monitoring of a pacemaker that allows healthcare providers to receive (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transmitted data from implanted pacemakers to track heart health and device performance efficiently) at home; however, he did not have the cardiac pacemaker machine while at the facility. Resident 4 stated, Thanks for bringing it up. Review of plans of care developed by the facility to address Resident 4's care needs revealed no plan of care focused on Resident 4's implanted cardiac pacemaker (type, intended heartrate, frequency and method of monitoring, etc.). The surveyor reviewed the above concerns regarding Resident 4's pacemaker monitoring during an interview with the Nursing Home Administrator and the Director of Nursing on March 11, 2026, at 2:30 PM. Nursing documentation dated March 11, 2026, at 4:58 PM (following the surveyor's questioning) revealed that facility staff attempted to contact Resident 4's representative to speak to him regarding Resident 4's pacemaker transmitter device. Clinical record review revealed the facility admitted Resident 101 on November 26, 2025, with diagnosis including metabolic encephalopathy. A care plan-initiated November 26, 2025, revealed Resident 101 has a communication problem related to expressive aphasia. An intervention the facility implemented on January 21, 2026, was Resident 101 is to utilize a communication device to communicate her wants and needs. Interview with the Director of Nursing on March 12, 2026, at 2:05 PM confirmed Resident 101 is nonverbal, and utilizes an iPad to communicate. Review of Resident 101's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated February 27, 2026, revealed Resident 101 uses a wheelchair for mobility, and is a substantial to maximum assist of one staff member for transfers. Staff also assessed Resident 101 as having a BIMS of 7 (Brief Interview for Mental Status, score 7 indicates serious cognitive impairment, suggesting significant difficulties with memory, orientation, and daily functioning). Nursing documentation dated January 16, 2026, at 3:41 PM revealed that the facility staff spoke with a nurse at the neuroscience office regarding Resident 101's recent appointment. Review of a Record of Visit to Consulting Physician with no date, revealed Resident 101 had a follow up appointment with neuroscience, but was unable to be completed due to Resident 101 being nonverbal. Review of the facility investigation into why Resident 101 was not seen at her neuroscience appointment on January 16, 2026, revealed the following. On January 16, 2026, Resident 101 was sent out to a neurology appointment at 2:00 PM. Resident 101 was dropped off by the transportation personnel. The investigation revealed the transportation driver asked the registered nurse supervisor if it is okay to send Resident 101 to an appointment without assistance and the registered nurse supervisor said yes. Resident 101 was sent back to the facility without being assessed due to Resident 101 being nonverbal and having no means of communication. The registered nurse supervisor told the staff from the neuroscience office that the facility does not have enough staff to send to resident appointments. The facility failed to provide Resident 101 with the highest practical care and implement care and treatment consistent with Resident 101's care plan. Interview with the Director of Nursing on March 12, 2026, at 8:37 AM, confirmed the above findings for Resident 101. 483.25 Quality of CarePreviously cited deficiency on 2/21/25, 5/13/25, and 10/31/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate and implement interventions to prevent falls for three of eight residents reviewed for fall concerns (Residents 14, 39, and 101). Findings include: The facility policy entitled, Falls - Clinical Protocol, reviewed without changes on February 10, 2026, revealed that the facility identified that many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. The staff and practitioner will review each resident's risk factors for falling and document in the medical record the examples of risk factors. Staff will document where and when they happen and any observations of the events. The staff and practitioner will begin to try to identify possible causes within 24 hours. Based on the assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to, those that have already been identified) and reconsider the current interventions. Clinical record review for Resident 14 revealed nursing documentation dated December 6, 2026, at 8:00 AM that Resident 14 had an unwitnessed fall. He was on the ground in the hallway outside his room door. Resident 14 stated that he fell out of bed. Review of the facility's incident/accident investigation dated December 6, 2025, at 7:50 AM revealed the facility identified no predisposing physiological factors (e.g., impaired memory, non-compliance with safety interventions, etc. Although Resident 14 reported that he rolled out of bed, the facility noted that situation factors were that Resident 14 ambulated without assistance and was non-compliant with safety instructions. There was no indication on the document that the facility implemented any new interventions to deter future falls for Resident 14. Review of Resident 14's plan of care revealed that on November 3, 2021, the facility developed a plan of care to address Resident 14's impaired cognition and that he was at risk for further decline in cognitive status. A plan of care also initiated November 3, 2021, identified Resident 14's risk for falls due to confusion, altered mobility, poor vision, deconditioning, and bilateral foot drop (foot muscle abnormality that makes it difficult to lift the front part of the foot and the front of the foot might drag on the ground when walking). On August 14, 2023, the facility developed a plan of care to address Resident 14's noncompliance with using an assistive device or requesting assistance with transfers. There were no new interventions/tasks implemented on the plans of care following Resident 14's fall that indicated an investigation or alteration of Resident 14's bed despite his report that his fall occurred because he fell out of bed. Nursing documentation dated December 30, 2025, at 6:45 PM indicated that staff found Resident 14 on the floor in his room and that he, landed on his fall mat. Review of the facility's incident/accident investigation dated December 30, 2025, at 6:30 PM revealed the facility identified predisposing physiological factors included: confusion, gait imbalance, impaired memory, non-compliance with safety interventions, and weakness. Predisposing situation factors included: self-removal of safety devices, non-compliance with care plan, and non-compliance with safety instructions. Statements obtained from staff indicated that staff last observed Resident 14 in his bed with his dinner tray table over him. The investigation did not indicate that the facility investigated or altered Resident 14's bed despite the staff report that his fall occurred after he was last noted in his bed. The investigation did not include a statement from Resident 14 as to how the fall occurred. Review of Resident 14's physician orders and plans of care indicated no intervention that indicated the facility utilized a fall mat for Resident 14 although staff statements indicated there was one in place. Nursing documentation dated January 14, 2026, at 6:11 PM revealed that staff observed Resident 14 on the floor when they were delivering his dinner tray and the licensed practical nurse was going to give medications to him. He had slid out of his chair. The facility implemented dycem (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(fabric that increases resistance between surfaces to reduce sliding/slipping) under his wheelchair cushion. Nursing documentation by the licensed practical nurse dated February 20, 2026, at 1:24 PM for Resident 14 noted only, as per staff fell in his room supervisor to room and assessed. Nursing documentation by the registered nurse dated February 20, 2026, at 2:24 PM indicated that staff called Resident 14's responsible party and left a voicemail to notify the person of a fall. The documentation included no additional details regarding the fall or assessment for potential injuries. Review of the facility's incident/accident investigation dated February 20, 2026, at 12:28 PM revealed that the nurse aide called the registered nurse to Resident 14's room as he was found on the floor alongside of his bed. Resident 14 did not give any response or reason as to why he was on the floor but stated that he hit his head. The document indicated that this was an isolated event, even though Resident 14 had repeated falls in two months. The document again noted that, Resident has a fall mat on the floor beside the bed on the opposite side of the bed that he fell out of, although, no physician order or care plan intervention indicate the use of a fall mat. Interview with the Director of Nursing on March 12, 2026, at 11:36 AM indicated that the facility had no further evidence of thorough investigations following Resident 14's falls or the implementation of new interventions following the falls to reduce the likelihood of repeated falls for Resident 14. Interview with Employee 20 (physical therapist assistant/director of rehabilitation) on March 13, 2026, at 10:50 AM confirmed that the facility could not provide evidence of new interventions implemented after Resident 14's repeated falls on December 6 and 20, 2025, and February 20, 2026. The interview also confirmed that a fall mat mentioned in December 30, 2025, and February 20, 2026, investigation details had no corresponding physician order or care plan intervention for Resident 14. Clinical record review revealed the facility admitted Resident 101 on September 16, 2025. Review of Resident 101's care plan-initiated November 26, 2025, revealed Resident 101 is a high risk for falls related to her gait/balance issues. Review of nursing documentation dated January 3, 2026, at 9:14 PM revealed Resident 101 was found on the floor, lying next to her bed. Review of the facility investigation into Resident 101's January 3, 2026, fall revealed that the intervention the facility implemented to prevent further falls was a referral to physical therapy. Further review of Resident 101's clinical record revealed no documentation that Resident 101 was screened following her January 3, 2026, fall. Interview with the Director of Nursing on March 13, 2026, at 11:15 AM confirmed there was no evidence of physical therapy screening Resident 101 at the time of the fall. Nursing documentation dated January 12, 2026, at 7:02 PM revealed Resident 101 was observed on the floor in front of her wheelchair. Resident 101 scooched herself up and was leaning out of the wheelchair and fell to the floor with her cushion. Review of the facility investigation into Resident 101's January 12, 2026, fall revealed that the intervention the facility implemented to prevent further falls was to place dycem under her wheelchair cushion. Further review of Resident 101's clinical record revealed no evidence that the facility implemented the dycem to Resident 101's wheelchair until March 9, 2026, and was also not added to Resident 101's plan of care until March 11, 2026, after the surveyor's questioning. Interview with the Director of Nursing on March 13, 2026, at 10:56 AM confirmed these findings. Clinical record review revealed nursing documentation dated March 8, 2026, at 5:50 PM, noting Resident 101 fell out of her wheelchair in the hallway. The staff brought Resident 101 to the nurse's station for closer monitoring. Review of the facility investigation into Resident 101's March 8, 2026, fall revealed is she is currently on therapy caseload. Interview with the Director of Nursing on March 13, 2026, at 10:56 AM, revealed that the facility did not implement the dycem recommended after the January 12, 2026, fall, until after the March 8, 2026, fall. The facility failed to implement interventions to prevent falls for Resident 101. Clinical record review for Resident 39 revealed a nursing progress note date December 25, 2025, at 7:37 AM that indicated Resident 39 was found on the floor in his bathroom. The note stated that Resident 39 said he was trying to go to the bathroom. He did not ring his call bell. No injuries were noted. Review of the facility's investigation into Resident 39's fall on December 25, 2025, at 7:15 AM revealed that the staff assisted him off the floor and onto the toilet and obtained vital signs and neuro (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checks. The fall investigation form had non-compliant handwritten on the bottom right corner. The investigation did not implement a new intervention to potentially prevent the fall from happening again. Clinical record review for Resident 39 revealed a nursing progress noted dated December 30, 2025, at 12:15 AM that indicated Resident 39 was found on the floor of his bathroom. He stated that he did not hit his head and there were no injuries noted. The note indicated that Resident 39 did not ring his bell even though the call bell was in reach, and he self-transferred to go to the restroom. A nursing progress note dated December 31, 2026, at 11:27 AM indicated that resident continues to self-transfer and has been reminded multiple times to ring the call bell. Review of the facility's investigation into Resident 39's fall on December 30, 2025, at 12:15 AM revealed that Resident 39 indicated that he tripped on his oxygen cord and fell. There was no evidence that facility implemented a new intervention to prevent further falls. Clinical record review for Resident 39 revealed a nursing progress note dated December 30, 2025, at 6:30 PM that indicated resident was observed by staff on the floor. He was assessed and noted to have no injuries. The note indicated he was non-compliant with his call bell. Review of the facility's investigation into Resident 39's fall on December 30, 2025, at 6:00 PM revealed that he stated he got up to get his remote for the television. The immediate action was to educate him that his slippers are not safe, and he needed to wear non-skid socks. There is no evidence that the non-skid socks were provided or put on resident after the fall, or that the slippers were removed or replaced. There was no evidence the facility implemented new interventions to potentially prevent further falls for the resident. Clinical record review for Resident 39 revealed a nursing progress note dated December 31, 2025, at 4:15 PM revealed that Resident 39 was again observed on the floor in his room. The note indicated that he had non-skid socks on and everything was in reach. The note also indicated that he had been re-educated many times about ringing his call bell and not getting up by himself. Review of the facility's investigation into Resident 39's fall on December 31, 2025, at 4:15 PM revealed a new intervention was then noted to keep the resident in an area that he can be monitored closely. There was no evidence new fall interventions were implemented for Resident 39 after his falls on December 25 or 30, 2025, only after his fall on December 31, 2025, when he fell at 4:15 PM. Interview with the Director of Nursing on March 13, 2026, at 1:15 PM confirmed the above noted information related to Resident 39's falls. The facility failed to thoroughly investigate and implement interventions to prevent falls for Residents 14, 39, and 101. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on a review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to assess all potential risks for entrapment for four of 13 residents reviewed for accident hazards (Residents 5, 8, 9, and 16) and failed to conduct ongoing assessments to assure appropriate maintenance with bedrail usage for two of 13 residents reviewed (Residents 8 and 16). Findings include: The facility policy titled, Enabler Bar Utilization for Bed Mobility, last reviewed on February 10, 2026, revealed (in part) that a nursing designee shall refer to maintenance for installation. Maintenance designee shall perform a complete bed system audit at time of installation/removal. Facility to ensure that no mattress, bolster/wedge, or enabler bar has gaps that are larger than recommended. All maintenance staff will be trained on how to properly measure the open spaces between the bed system components and assess the seven potential zones for entrapment as detailed by the Food and Drug Administration (FDA). Further review of the policy revealed a section titled, Reassessment and Ongoing Monitoring, that noted a Bed Enabler Assessment Form shall be completed quarterly at minimum and as needed for significant changes. Nursing and therapy shall monitor residents for continued appropriate use of enabler bars. Clinical record review for Resident 16 revealed an annual Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated January 30, 2026, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 4, which indicated cognitive impairment. Observation of Resident 16 on March 10, 2026, at 2:00 PM revealed the resident had a right sided enabler bar attached to the resident's right side of the bed. The bed had both a headboard and foot board. Review of the current physician orders for Resident 16 revealed an order dated December 4, 2025, for a right sided enabler bar to assist with bed mobility. Review of facility documentation dated February 22, 2024, revealed a document titled, Enabler Bar Bed configuration / Bed Rail / Enabler Bar, that noted Resident 16's name. The room written on the sheet was a previous room. The type of rail requested/evaluating was written in as halo's. Entrapment zones evaluated were checked as Zones 1, 2, 3, 4, and 7. Zone 6 was not checked as evaluated for entrapment risks per the documentation. The form was signed by maintenance staff. Requests for Resident 16's most recent enabler bar assessments were made during the meeting with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 2:01 PM and the facility reported the documents are in the resident's electronic health record (EHR). There was no additional documentation for Resident 16 to indicate Zone 6 was assessed or the facility conducted ongoing assessments to assure an ongoing evaluation of risks associated with bedrail usage or regularly check to ensure the bedrails remain installed properly. Clinical documentation dated December 2, 2025, at 9:34 AM and January 21, 2025, at 1:49 PM revealed therapy notes that indicated the resident benefits from use of right-side bed enabler for increased bed mobility and independence. An interview with Employee 20, Director of Rehab, on March 13, 2026, at 10:46 AM revealed that therapy staff do not assess the enabler bars for entrapment zone risks. Therapy only assesses the resident for bed mobility. An interview with the Nursing Home Administrator on March 13, 2026, at 12:22 PM revealed there was no further documentation regarding Resident 16's enabler bars. Observation of Resident 8 on March 10, 2026, at 2:51 PM revealed her in her bed that was equipped with bilateral assist bars at the head of her bed, a footboard, and a headboard. Clinical record review for Resident 8 revealed a Bed System Measurement Device Test Results Worksheet provided by facility March 12, 2026, that indicated facility staff completed the assessment on April 3, 2025 (almost one year ago) that assessed only one potential zone for entrapment, zone one. There was no evidence that the facility completed a thorough assessment of all potential zones for entrapment (e.g., zones one, two, three, four, and six) with Resident 8's assistance device use. There was no evidence that the facility (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regularly checked Resident 8's mattress and bed rails for potential gap areas created by movement or compression of the mattress that may have been caused by changes in Resident 8's weight, movement abilities, bed position tendencies, or device shifting or loosening over the year. Interview with the Nursing Home Administrator and the Director of Nursing on March 12, 2026, at 2:00 PM confirmed that the facility did not assess all potential zones that could potentially present an entrapment risk for Resident 8. Observation of Resident 5 on March 11, 2026, at 9:26 AM revealed him in his bed that was equipped with a circular assist device bilaterally at the head of his bed, a headboard, and a footboard. A physician order dated December 11, 2025, directed the use of an enabler bar to Resident 5's bed bilaterally to assist with bed mobility. Review of a Bed System Measurement Device Test Results Worksheet dated December 11, 2025, indicated that the facility assessed only zones one through four. The assessment did not include a review of zone six which would include the space between the device and the edge of Resident 5's headboard bilaterally. Interview with the Nursing Home Administrator and the Director of Nursing on March 12, 2026, at 2:00 PM reviewed the above siderail concerns for Resident 5. Clinical record review for Resident 9 revealed a physician's order dated January 15, 2026, for the use of an enabler bar bilaterally to assist her with bed mobility. Observation of Resident 9 on March 10, 2026, at 12:52 PM revealed her in her bed with a circular assistance device mounted to the head of her bed on each side. Review of a Bed System Measurement Device Test Results Worksheet dated January 16, 2026, revealed an assessment of zones one through four. The assessment did not include a review of zone six which would include the space between the device and the edge of Resident 9's headboard bilaterally. The surveyor reviewed the above concerns regarding bed assistive device use for Residents 5 and 9 during an interview with the Director of Nursing on March 12, 2026, at 11:36 AM. 483.25(n)(1)-(4) Bed RailsPreviously cited deficiency 2/21/25 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, who utilize a lift, catheter care, medication administration, donning and doffing PPE (personal protective equipment), and dressing changes for four of four employees reviewed for competencies (Employees 13,14, 10, and 16).Findings include: A review of the facility documentation revealed that the facility had a total of 119 residents receiving medications, 28 residents that utilize lifts, nine residents with indwelling urinary catheters (insertion of a tube into the bladder to remove urine), 17 residents with dressing changes, two residents with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube), and eight residents on transmission based precautions. A request for nursing staff competencies for enteral tube feeding, lifts, catheter care, medication administration, donning and doffing PPE, and dressing changes revealed the facility was unable to provide any competencies for Employee 13 (licensed practical nurse) and Employee 10 (registered nurse). The only competency the facility completed for Employees 14 (licensed practical nurse) and Employee 16 (registered nurse) was wound care. The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:30 PM They confirmed the facility could provide no documentation that ensured Employees 13, 14, 10, and 16 had specific competencies and skill sets to care for the residents' needs listed above. 483.35(a)(3) Nursing ServicesPreviously cited 2/21/25 28 Pa. Code 201.20 (a) Staff Development

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate of less than five percent (Resident 51).Findings include: The facility's medication error rate was 9.68 percent based on 31 medication opportunities with three medication errors. Before commencing with the medication administration pass, Employee 10 (registered nurse) confirmed on March 11, 2026, at 8:32 AM knowledge of the instructions to alert the surveyor of any medications scheduled but not administered for this medication administration pass to avoid an error of omission. During the observation of a medication administration pass for Resident 51, Employee 10 reported that she would not administer Resident 51's scheduled Vitamin D (vitamin supplement) or Refresh tears (artificial lubrication drops for eyes) on March 11, 2026, at 8:32 AM due to their unavailability in the medication cart. Employee 10 prepared a dose of Clear Lax (polyethylene glycol, Miralax, stool softener) 17 grams (gm) for Resident 51. The labeling on the medication bottle instructed that the bottle top is a measuring cap marked to contain 17 grams of powder when filled to the indicated line (fill to the top of the white section in the cap). Employee 10 filled the bottle cap approximately three-quarters full; she did not fill the cap to the top of the white section inside the cap as required. Before Employee 10 mixed the measured powder into water, the surveyor requested clarification of the amount of powder prepared. Employee 10 confirmed that she utilized the groove of the cap lining (that permits the cap to screw onto the bottle) rather than the top of the section utilized for measurement. Employee 10 confirmed that the depth of the groove inside the cap changed as the cap was turned; therefore, would result in a different dose depending on the angle viewed of the cap. Employee 10 confirmed that if administered as prepared, Resident 51 would receive less than 17 grams of the medication. Employee 10 prepared the following additional medications for Resident 51:Iron, ferrous sulfate (dietary supplement) 65 mg (milligrams), one tabletSenna-plus (combination of two laxatives to treat constipation) 8.6 mg-50 mg, two tabletsVitamin B12 (dietary supplement) 500 mcg (micrograms), one tabletClaritin (Loratadine, antihistamine that treats allergy symptoms) 10 mg, one tabletDuloxetine (antidepressant) 60 mg, two tabletsMetoprolol tartrate (medication used to lower blood pressure) 50 mg, one tabletPotassium Chloride (dietary supplement) 20 mEq (milliequivalents), one tabletRopinirole (prescription dopamine used for restless legs) 1 mg, one tabletTorsemide (diuretic used to reduce fluid retention) 100 mg, one tabletSpironolactone (diuretic) 25 mg, two tabletsDiltiazem (medication used to lower blood pressure) 240 mg, one tabletZyprexa (antipsychotic medication) 5 mg, one tabletDiclofenac sodium topical gel (Voltaren, non-steroidal anti-inflammatory topical gel used to relieve pain and inflammation) for application to Resident 51's knees Before leaving the medication cart to enter Resident 51's room on March 11, 2026, at 8:52 AM Employee 10 confirmed that she had 15 tablets in the medicine cup in addition to the Miralax and Voltaren gel medications for administration to Resident 51. Resident 51 took all medication tablets provided with her yogurt on March 11, 2026, at 9:00 AM.Clinical record review for Resident 51 revealed active physician orders for staff to administer the above medications at 9:00 AM. The active physician orders instructed staff to administer the following medications that were omitted by Employee 10: Baclofen (muscle relaxant) 10 mg oral tablet, two tablets by mouth three times a dayMometasone Furoate (steroidal nasal spray) 50 mcg/activation nasal spray, two sprays in both nostrils one time a day Interview with Employee 10 on March 11, 2026, at 12:03 PM indicated that she did not see the additional two medications during the medication administration pass with the surveyor and confirmed that she did not attempt to report the omissions to the surveyor until questioned. The surveyor reviewed the three medication errors above (one incorrect dose and two omissions) with the Director of Nursing on March 12, 2026, at 11:36 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on a review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection on three of five nursing units (Maple Court, Sycamore, and Little League; Residents 4, 11, 15, 37, 51).Findings include: Review of the facility policy entitled, Coronavirus Disease (COVID-19)- Testing Residents, last reviewed without changes on February 10, 2026, revealed that residents are to be tested for the SARS-CoV-2 virus (Severe Acute Respiratory Syndrome Coronavirus 2) to detect the presence of current infections and to help prevent the transmission of COVID-19 in the facility. Asymptomatic residents who have had close contact with someone that has the SARS-CoV-2 infection, will have a series of three viral tests for SARS-CoV-2 infection. Testing is conducted immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test, and if negative again, 48 hours after the second negative test. An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. Viral testing of all residents (regardless of vaccination status) is conducted if there is an outbreak in the facility. Testing approaches may consist of contact tracing (focused testing) or broad-based (facility-wide or group-level) testing. If the outbreak investigation is broadened to either a facility-wide or unit-based broad-based testing is conducted. Residents who have had close contact are tested immediately. Review of the facility line listing for their current COVID-19 outbreak revealed that the outbreak started on February 2, 2026. The line listing also indicated that from March 2-5, 2026, the facility had 5 new cases of COVID-19 on the Maple Court unit. Interview with the Director of Nursing, who was responsible for infection control at the time of the survey, revealed that the residents on the Maple court unit (also known as their dementia unit) will not stay in their room and will not wear masks. She also indicated that the facility continues to have dining room and activities on that unit. Further interview of the Director of Nursing revealed that they did not test other residents on that unit since the initial outbreak on February 2, 2026, even though Resident 15, who tested positive on March 5, 2026, will not wear a mask or stay in her room and has been present in common areas with groups of other residents. The facility failed to test residents that had been exposed to the SARS-CoV-2 virus to ensure an environment free from the potential spread of infection on the Maple Court Unit. Clinical record review revealed Resident 15 tested positive for COVID-19 on March 5, 2026. A physician order dated March 5, 2026, noted staff should place Resident 15 on airborne precautions (specialized infection control measures used to prevent the spread of infections transmitted through tiny aerosolized particles that can remain suspended in the air and travel long distances) until March 15, 2026, with strict isolation and all services provided in Resident 15's room. Further review of Resident 15's clinical record revealed there was no plan of care in place addressing Resident 15's positive COVID-19 diagnosis, until after the surveyor's questioning on March 11, 2026. The plan of care implemented at this time revealed Resident 15 should be on airborne precautions until March 15, 2026, placing a face mask over Resident 15's mouth and nose if she leaves her room. Observation of Resident 15's room on March 10, 2026, at 9:30 AM, and March 11, 2026, at 8:27AM revealed there was no sign alerting staff, or visitors that Resident 15 was on airborne precautions. Observation of the Maple Court nursing unit on March 10, 2026, from 9:31 AM to 12:44 PM, revealed Resident 15 was observed walking throughout the unit, talking to other residents, and entering other resident rooms. Resident 15 did not have a mask on. There were no attempts by staff to keep Resident 15 in her room or place a mask on her mouth and nose. At 11:32 AM Resident 15 was observed seated at a table in the dining room eating lunch. There were four other residents seated at the table with Resident 15. Interview with Employee 15 (nurse aide) at this time revealed if a resident is on isolation precautions and they will not remain in their room staff are to place them at a table by themselves. Employee 15 confirmed Resident 15 should have been placed at a table by herself. Observation of the Maple Court nursing unit on March 11, 2026, from 8:37 to 11:57 AM, revealed (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 15 was seated in a chair across from the nurses' station by the television. There were 7 residents seated in a circle, including Resident 15. During this time there were no attempts by staff to keep Resident 15 distanced from other residents or place a mask on her mouth and nose. At 10:12 AM Employee 24 (occupational therapist) arrived on Maple Court without a mask. Employee 24 was within a few feet of Resident 15, working on another resident's wheelchair positioning. Interview with the Director of Nursing on March 12, 2026, at 2:20 PM confirmed that the facility does not require, but encourages staff to wear masks. The Director of Nursing confirmed that Employee 24 works with residents on all nursing units. The above findings for Resident 15 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on March 12, 2026, at 2:15 PM. Observation of Resident 4's room (on Sycamore nursing unit) on March 10, 2026, at 12:44 PM revealed a sign on his door instructing those who enter to implement contact precautions (infection control measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment). Interview with Resident 4 on March 10, 2026, at 3:23 PM revealed that he needed staff assistance to reposition in his bed. Observation made on the date and time of the interview revealed Employee 1 (licensed practical nurse) and Employee 2 (nurse aide) donned gloves and entered the room. Employees 1 and 2 repositioned Resident 4 (pulled him up higher in his bed) as he requested. Employees 1 and 2 did not don a gown before entering Resident 4's room or providing his direct contact care. Interview with Employee 1 on March 10, 2026, at 3:25 PM indicated that Resident 4 was, CRO positive in his stool, it is extremely rare. Employee 1 indicated that she and Employee 2 forgot to don a gown but that per Resident 4's condition and the signage on the door, they should have. Interview with Employee 2 on the date and time of the observation concurred that she should have donned a gown before coming in close contact with Resident 4 and his environment. Review of current CDC guidance, infection with a carbapenem-resistant organism (CRO, bacteria that have developed resistance to carbapenem antibiotics, making infections caused by these organisms difficult to treat) requires the implementation of targeted infection control measures that include isolation and enhanced barrier or contact precautions in nursing homes (depending on the situation), and to enforce policies for core infection control practices like hand hygiene, personal protective equipment and environmental cleaning. Remind healthcare personnel on the importance of adhering to these policies when caring for a patient with CRO. A physician's order dated January 8, 2026, instructed staff to implement contact precautions for CRO (no site or body system indicated). Clinical record review for Resident 4 revealed nursing documentation dated February 8, 2026, at 10:47 AM that indicated the facility admitted Resident 4 with a urinary tract infection and pneumonia (no infections related to his stool). Physician progress note documentation dated March 6, 2026, at 12:00 PM indicated that Resident 4 was hospitalized until February 11, 2026, for problems that included sepsis (bacteremia, blood infection) and a urinary tract infection. Review of plans of care developed by the facility to address Resident 4's needs indicated that the facility did not develop a plan of care to address his CRO infection or need for contact precautions. The surveyor reviewed the above infection control concerns for Resident 4 during an interview with the Director of Nursing and the Nursing Home Administrator on March 11, 2026, at 2:45 PM. Observation of a medication administration pass on March 11, 2026, at 8:53 AM revealed Employee 10 (registered nurse) gowned and gloved to enter Resident 51's room (on the Little League nursing unit). Employee 10 obtained a blood pressure assessment for Resident 51 and came in contact with Resident 51 and her environment when applying medicated gel to Resident 51's knees. Employee 10 left Resident 51's room on March 11, 2026, at 9:02 AM to seek clarification from the registered nurse supervisor. Employee 10 did not remove her PPE before entering the hallway. Employee 10 discarded her PPE (gown and gloves) in the trash receptacle secured to the medication cart. The receptacle did not have a lid. There were no bins visible inside Resident 51's room, by her door, to discard PPE before leaving her room. Employee 10 returned to Resident 51's room on March 11, 2026, at 9:07 AM to complete Resident 51's medications and treatments. Employee 10 exited (continued on next page)

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Wecare at Sycamore Rehabilitation and Nursing Cent	1445 Sycamore Road Montoursville, PA 17754

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 51's room on March 11, 2026, at 9:11 AM. Employee 10 did not remove her PPE before entering the hallway. Employee 10 discarded her PPE in the trash receptacle secured to the medication cart. Interview with Employee 10 on the date and time of the observation confirmed that she believed that there are supposed to be bins available for staff to discard PPE before exiting Resident 51's room. Clinical record review for Resident 51 revealed an active physician's order dated August 18, 2025, for staff to implement contact precautions for an ESBL infection (Extended-Spectrum Beta-Lactamase infection occurs when bacteria produce enzymes called ESBLs that break down and inactivate many commonly used antibiotics, including penicillins and cephalosporins, that make infections difficult to treat). Clinical record review for Resident 11 revealed an order dated August 18, 2025, for contact precautions for ESBL in the urine. Review of the care plan for Resident 11 revealed that the resident has a urinary tract infection related to decreased mobility and poor hygiene. An intervention dated August 18, 2025, included contact precautions for ESBL in the urine. Resident 11's Kardex (documentation by nursing to note important information and care planning and facilitate resident care) noted a section titled, Resident Care that indicated contact precautions for ESBL in urine. A review of the Medication Administration Record (MAR) / Treatment Administration Record (TAR) for March 2026 for Resident 11 revealed that staff were documenting contact precautions were in use as indicated with a checkmark. Clinical record review for Resident 37 (Resident 11's roommate) revealed an order dated September 4, 2025, for contact precautions related to ESBL. Review of the care plan for Resident 37 revealed that the resident has a urinary tract infection related to ESBL. An intervention dated September 5, 2025, included contact precautions for ESBL. Resident 37's Kardex noted a section titled, Resident Care that indicated contact precautions for ESBL. Observation of the room of Residents 11 and 37 on March 11, 2026 at 9:08 AM revealed a sign on the wall next to the door frame that indicated Enhanced Barrier Precautions (EBP, refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). There was also a tote on the door to the room that held various personal protective equipment (PPE) that included gloves and gowns. Continued observation of the room revealed Employee 22, therapy staff, was assisting Resident 11 from her wheelchair and into the bathroom and then back to the resident's bed. Employee 22 was observed to have only donned gloves and no gown. Upon Employee 22 leaving the room and when questioned about the signage, Employee 22 reported she believed the EBP signs were for Resident 11's roommate. An interview with Employee 10, registered nurse, on March 11, 2026, at 9:33 AM revealed that both Residents 11 and 37 were on contact precautions but stated she would have to check further when questioned about the EBP sign. The above discrepancy between the clinical record and EBP sign on the doorway was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 3:05 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & ControlPreviously cited deficiency 2/21/2025 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services .

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Wecare at Sycamore Rehabilitation and Nursing Cent	1445 Sycamore Road Montoursville, PA 17754

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview it was determined that the facility failed to maintain documentation of staff COVID-19 vaccination status, and provide evidence that staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine for three of three staff reviewed. (Employees 11, 18, and 19) Findings include: Interview with the Director of Nursing on March 13, 2026, at 2:53 PM revealed that she is unable to provide evidence that the facility maintained staff documentation of screening, education, offering of COVID-19 vaccinations, and their current COVID-19 vaccination status. She indicated that she had a call out to the previous infection preventionist to see where the documentation may be but has not received a response. There was no evidence of the above for information for Employee 11 (housekeeper), Employee 18 (licensed practical nurse), or Employee 19 (nurse aide). The facility failed to offer staff the COVID-19 vaccine or provide them with information on where to obtain the vaccine, and failed to maintain staff documentation of screening, education, offering of COVID-19 vaccinations, and their current COVID-19 vaccination status. The surveyor reviewed the above noted findings with the Director of Nursing on March 13, 2026, at 3:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211.12(d)(1) Nursing services

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, and staff and resident interview, it was determined that the facility failed to accommodate resident needs, creating a homelike environment for one of 24 residents reviewed (Resident 7). Findings include: Observation and interview with Resident 7 on March 10, 2026, at 12:29 PM revealed upon entering the room Resident 7's eyes were closed and the light above his bed was on. Resident 7 stated that the light is on all the time. He stated he sleeps with the light on because he cannot reach it to turn it off. He stated staff are busy, so he stopped asking them. Further observation revealed the switch is on the wall behind Resident 7's bed, out of his reach. Resident 7 stated that he sleeps with the light on every day. Further observations on March 11, 2026, at 8:09 AM and March 12, 2026, at 8:13 AM revealed Resident 7 was in his bed with his light on. The facility failed to accommodate Resident 7's needs, creating a homelike environment, relating to his light. The surveyor reviewed the above concern regarding Resident 7's light during an interview with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 2:40 PM 28 PA Code 211.12 (d)(1)(5) Nursing services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of select facility policies and procedures, clinical record review, review of the facility's grievance log, and staff interview, it was determined that the facility failed to address a grievance promptly and implement effective actions to resolve the reported grievance for one of 24 residents reviewed (Resident 90).Findings include: The facility policy entitled Skilled Nursing Facility Grievance Policy, last reviewed without changes on February 10, 2026, revealed every grievance will be addressed promptly and appropriately, in accordance with federal and state regulations. Residents or representatives may submit grievances verbally, in writing, or anonymously. The grievance official, or designee will acknowledge receipt of the grievance within three business days. The acknowledgement will include the date the grievance was received, the name and title of the grievance official, steps being taken to investigate, and an expected timeframe for resolution. All grievances will be investigated promptly, objectively, and thoroughly. Documentation of interviews, evidence, and findings shall be documented and retained. A written decision will be issued within one week unless extenuating circumstances are documented. The resident and/or responsible party shall be included in resolution findings. Clinical record review revealed the facility admitted Resident 90 on October 2, 2024, with diagnosis including dementia. Review of Resident 90's most recent MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated March 2, 2026, revealed staff assessed Resident 90 as requiring substantial to maximum assistance for toileting. Interview with Resident 90's responsible party on March 12, 2026, at 1:35 PM revealed that she filed a grievance on November 20, 2025. Review of the facility grievance binder confirmed Resident 90's responsible party filed a grievance noting that Resident 90 requested to use the bathroom and the nurse aide refused to take her to the bathroom, stating she would change her at bedtime. Resident 90's responsible party also noted that Resident 90's linens were soiled, and no one came to change her linens. Review of the November 20, 2025, grievance filed by Resident 90's responsible party revealed the summary of grievance, steps taken to investigate, pertinent findings/conclusion, and corrective action were not completed. Further interview with Resident 90's responsible party confirmed that no one acknowledged her grievance, the steps they would take to investigate the grievance, or a resolution. The above findings for Resident 90 were reviewed with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:33 PM. 483.10(j) GrievancesPreviously cited 10/31/2025 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code: 201.18(b)(2)(3)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and family and staff interview it was determined that the facility failed to provide written notice of transfer that included all the necessary contents to residents' responsible parties at the time of transfer for four of eight residents reviewed for hospitalizations (Residents 4, 5, 9, and 7); failed to provide timely written notice of the facility bed-hold policy to residents' responsible parties at the time of transfer for three of eight residents reviewed for hospitalizations (Resident 5, 9, and 7); and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for three of eight residents reviewed for hospitalizations (Residents 5, 9, and 7). Findings include: Interview with Resident 9's daughter on March 10, 2026, at 9:58 AM indicated that she did not receive any written notices related to the facility's bed-hold policy or the reasons for Resident 9's transfer to the hospital when she went to the hospital recently. Resident 9's daughter confirmed that someone from the facility telephoned her to report her mother's transfer to the hospital. Nursing documentation dated January 6, 2026, at 5:42 AM revealed that Resident 9 was displaying increased effort to breathe and had low oxygen levels despite administering oxygen via a mask. Staff contacted the physician and were instructed to send Resident 9 to the emergency room. Nursing documentation dated January 6, 2026, at 5:56 AM revealed that emergency medical services transported Resident 9 to the emergency room. Nursing documentation dated January 6, 2026, at 6:07 AM indicated that Resident 9's daughter was made aware of her transfer to the emergency room. Social services documentation dated January 6, 2026, at 3:20 PM reiterated that Resident 9 was discharged to the hospital that morning. Documentation by Employee 4 (business office manager) dated January 7, 2026, at 6:54 AM indicated that she mailed a copy of a Discharge/Transfer Notice and Bed Hold Policy to Resident 9's responsible party. The documentation indicated that she included a cover letter with the State Agencies Contact Information. Interview with the Director of Nursing on March 11, 2026, at 3:56 PM revealed that Resident 9's electronic medical record did not have either the Discharge/Transfer or Bed-Hold Notice scanned into the record as per the facility's practice. Review of a Notification of Bed Hold Policy Upon Transfer form for Resident 9 provided by the facility following the surveyor's questioning dated January 6, 2026, revealed a handwritten note, Verbal to (Resident 9's daughter's name), on the line designated for the Resident/Agent Signature. Resident 9's daughter did not sign the notice attesting to the receipt of the notice. Review of a Discharge/Transfer Notice addressed to Resident 9's daughter on January 6, 2026, also revealed a handwritten note, Verbal to (Resident 9's daughter's name, on the line designated for the Resident/Representative. The Discharge/Transfer Notice had the physical address for the office of the Pennsylvania State Long Term Care Ombudsman; however, did not include an email address. Resident 9's daughter did not sign the notice attesting to the receipt of the notice. Review of the email provided by the facility addressed to the State Long Term Care Ombudsman dated February 2, 2026, revealed that Resident 9 was not listed on the attached list of residents transferred from the facility for the month of January 2026. Interview with Employee 4 on March 13, 2026, at 9:46 AM confirmed that Resident 9's daughter visits the facility frequently and would be easily accessible to obtain a signature on the Bed-Hold and Discharge/Transfer Notices. The interview also confirmed that the notices provided for Resident 9's hospitalization in January 2026 did not include all the required contents (e.g., email address). Clinical record review for Resident 4 revealed nursing documentation dated January 24, 2026, at 4:24 PM that Resident 4 had a fall, had increased weakness, had abnormal laboratory values, and staff notified Resident 4's physician who instructed staff to send Resident 4 to the emergency room. Staff documented a telephone call to Resident 4's son (emergency contact) to update him on Resident 4's status and review the facility's bed-hold policy (verbally). Clinical record review for Resident 4 revealed nursing documentation dated February 2, 2026, at 6:42 PM that Resident 4, pulled his JPEG (J-tube, flexible tube inserted through (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the stomach wall into the small intestine for the purpose of administering food, medications, and fluids) out. Staff contacted the physician who instructed staff to send Resident 4 to the hospital. Nursing documentation dated February 7, 2026, at 7:30 AM indicated that Resident 4 was having difficulty breathing, was short of breath, had abnormal lung sounds, and that the physician instructed staff to send him to the emergency room. The documentation indicated that staff called Resident 4's son to update him regarding Resident 4's transfer to the emergency room. The documentation indicated that the facility's bed-hold policy was explained and they would like to hold the bed. Interview with Employee 4 on March 13, 2026, at 9:46 AM confirmed that with each of Resident 4's transfers to the hospital, she would print an electronic transfer form completed by nursing staff, attach the cover letter that she believed included all the state ombudsman information, and mail them to Resident 4's son. The interview confirmed that the cover letter did not include the state ombudsman email address. Clinical record review for Resident 5 revealed nursing documentation dated November 30, 2025, at 2:34 PM that Resident 5 stated he had chest pain that radiated to his back and armpit area. Resident 5 requested to go to the hospital and the physician instructed staff to send Resident 5 to the hospital. Nursing documentation dated November 30, 2025, at 2:57 PM indicated that staff notified Resident 5's stepdaughter of his changes in condition and transfer to the hospital because attempts to contact all his other emergency contacts were unsuccessful. Documentation by Employee 4 dated December 2, 2025, at 10:03 AM (more than 24 hours after Resident 5's transfer to the hospital) revealed that she mailed a copy of a Discharge/Transfer Notice and a Bed Hold Policy notice to Resident 5's power-of-attorney on that day that included a cover letter with the State Agencies Contact Information. The facility did not mail the notices to Resident 5's representative within 24 hours as required. Interview with Employee 4 on March 13, 2026, at 9:46 AM confirmed that she used the facility form letter and the electronic transfer documentation completed by nursing staff to provide notice to Resident 5's representative. She believed that she had 48 hours to mail the notices. The interview confirmed that the cover letter did not include the state ombudsman email address. Review of the email provided by the facility addressed to the State Long Term Care Ombudsman dated December 2, 2025, revealed that Resident 5 was not listed on the attached list of residents transferred from the facility for the month of November 2025. Interview with the Nursing Home Administrator on March 13, 2026, at 12:21 PM confirmed the above findings for Residents 4, 5, and 9. Clinical record review revealed nursing documentation dated November 13, 2025, at 1:24 PM, noting the certified nurse practitioner ordered Resident 7 to be sent to the emergency department for further evaluation. Resident 7 remained in the hospital until November 16, 2026. There was no documentation in Resident 7's clinical record indicating the Discharge/Transfer Notice and a Bed Hold Policy notice were provided to Resident 7 and his responsible party in writing. Review of the email provided by the facility addressed to the State Long Term Care Ombudsman dated December 2, 2025, revealed that Resident 7 was not listed on the attached list of residents transferred from the facility for the month of November 2025. Interview with Employee 4 on March 13, 2026, at 12:37 PM confirmed the above findings for Resident 7 findings. 28 Pa. Code 201.14(a) Responsibility of license28 Pa. Code 201.29(a) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 24 residents reviewed (Resident 43). Findings include: Clinical record review for Resident 43 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 1, 2026, that facility staff assessed Resident 43 as receiving an antibiotic medication during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 43 received an antibiotic medication during the assessment period for the MDS noted above. Interview with Employee 9 (registered nurse assessment coordinator) on March 12, 2026, at 9:54 AM confirmed that Resident 43's February 1, 2026, MDS was coded in error regarding receiving an antibiotic medication. Review of a significant change MDS dated [DATE], revealed staff assessed Resident 43 as having no impairments of her upper extremities. Review of Resident 43's next quarterly MDS dated [DATE], staff assessed Resident 43 as having bilateral impairment to her upper extremities. Interview with the Employee 9 on March 12, 2026, at 9:54 AM, revealed that Resident 43 did not have a decline in her range of motion. Employee 9 confirmed Resident 43's functional limitation in her range of motion was coded in error on the MDS dated [DATE]. The above findings for Resident 43 were reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2026, at 12:38 PM. The facility failed to accurately assess Resident 43's MDS assessments as noted above. 483.20(g), F641, Accuracy of AssessmentsPreviously cited 2/21/25 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to revise a resident's comprehensive care plan for one of 24 residents reviewed (Resident 3) and failed to invite and ensure resident and/or responsible party participation in care plan meetings for 1 of 24 residents reviewed (Resident 28).Findings include: Clinical record review for Resident 3 revealed a current care plan that was initiated on November 20, 2025, and indicated she had an indwelling urinary catheter related to a neurogenic (a dysfunction of the bladder due to nerve damage) bladder. Further clinical record review revealed her indwelling urinary catheter was discontinued on November 22, 2025. Clinical record review for Resident 3 revealed a current care plan that was initiated on November 28, 2025, and indicated that she was utilizing a psychotropic medication. Further clinical record review revealed that her psychotropic medication was discontinued on January 29, 2026. Further clinical record review for Resident 3 revealed that the facility staff discontinued Resident 3's care plan for her indwelling catheter and psychotropic medications on March 12, 2026, after the surveyor made them aware of it in a meeting March 12, 2026, at 2:22 PM. The facility failed to ensure Resident 3's care plan was revised and up to date with her current condition and care needs. Interview with Resident 28 on March 11, 2026, at 10:23 AM revealed that he denied any participation in care plan meetings. Resident 28 stated, I never hear nothing about it. Resident 28 indicated that he has spoken to the Veterans Administration contact person and facility staff about community living resources and availability of apartments that he and his wife might be able to move to. Clinical record review for Resident 28 revealed that the facility admitted him on November 1, 2025. An electronic Care Conference - Multidisciplinary Complete Admission, form dated November 7, 2025, indicated that there was a meeting on November 6, 2025, at 11:30 AM that Resident 28 attended, however, the form instructed to please ensure that the attendee signed next to his/her title and there was no signature from Resident 28 next to the, Please sign next to your title Resident, section. Review of social services documentation by Employee 8 (social services) dated January 30, 2026, at 1:36 PM indicated that there was a meeting with Resident 28, a homeless coordinator/social worker from the VA (Veterans Administration) Medical Center to discuss Resident 28's housing opportunities. The coordinator-initiated VA required paperwork in order to facilitate a housing VA voucher for Resident 28. During the conference, there were several areas that required additional attention from the social worker in order to expedite and facilitate an ease of transfer to independent living (such as Resident 28's state identification/social security, a medical evaluation, coordination with a landlord on the application, and a housing authority application). There was a phone conference held with the county housing authority, the social worker, a leasing assistant, etc. The coordinator and social worker discussed application status as well as residential conditions that would aid Resident 28's approval. The documentation indicated that all required releases were obtained. Social services documentation dated February 10, 2026, at 8:52 AM revealed that as of the date of the entry, Resident 28 obtained his state identification, his social security number was corrected, his previous housing provider no longer collected his social security payments, two local county housing applications were submitted, and that he had a VA housing appointment via phone scheduled for the next day. A quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated February 2, 2026, noted that Resident 28 participated in the assessment and goal setting. Employee 8 signed the assessment on February 16, 2026, at 2:02 PM. The assessment indicated that there were no referrals to the Local Contact Agency (LCA) because they were not wanted by the resident. Employee 9 (registered nurse assessment coordinator) signed the assessment section on February 5, 2026, at 1:39 PM. Review of the MDS Resident Assessment Instrument (RAI) manual revealed that for Section Q. Participation in Assessment and Goal Setting, close collaboration between the NH (nursing home) and the LCA is (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to evaluate the resident's medical needs, finances and available community transition resources. The LCA can provide information to the SNF/NH (skilled nursing facility/nursing home) on the available community living situations, and options for community-based support and services including the level and scope of what is possible. The LCA team will explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible. Resident support and interventions by the NH staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, problems with securing appropriate caregiving supports, community resource gaps, etc., preventing discharge to the community. Interview with Employees 8 and 9 on March 13, 2026, at 10:00 AM confirmed that there was no care conference documentation from the February 2, 2026, MDS assessment to evidence that Resident 28 participated in the review. The interview confirmed that the data captured on the MDS did not reflect the resident's wishes as he does desire referrals to agencies that provide housing in the community. The interview also confirmed that there was no resident signature on the November care conference documentation to show evidence that he attended. 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 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 four residents reviewed (Resident 7).Findings include: Observation of Resident 7 on March 10, 2026, at 12:32 PM revealed he was in bed and his hair appeared long and disheveled. Interview with Resident 7 at this time revealed he has been waiting to get his hair cut. Resident 7 stated that he prefers his hair to be short, stating that he was in the military. Clinical record review revealed the facility admitted Resident 7 on March 2, 2023. Review of Resident 7's care plan-initiated March 3, 2023, revealed Resident 7 wished to use the facility's beautician. Further review of Resident 7's plan of care-initiated July 22, 2025, revealed Resident 7 has an activity of daily living self-care performance deficit, noting he requires substantial to maximum assistance for personal hygiene. The findings for Resident 7 were reviewed with the Director of Nursing on March 12, 2026, at 12:07 PM. She was unable to provide any documentation of Resident 7 receiving a haircut in the last year or provide an explanation as to why Resident 7 has not received a haircut for an extended period. There was no evidence that the facility offered, or Resident 7 refused to have his hair cut. 483.24(a)(2) ADL Care Provided for Dependent ResidentsPreviously cited deficiency 2/21/25 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for two of seven residents reviewed for ROM concerns (Resident 3 and 45). Findings include: Interview of Resident 3 on March 11, 2026, at 10:46 AM revealed that she has an impairment to her left hand, limiting her range of motion in two of her fingers. She indicated that since she came off of therapy, she does not get any exercise. On March 12, 2026, at 12:10 PM the facility provided surveyor with a copy of a home exercise program that was provided to Resident 3 to do in her room. The program was provided to her on February 5, 2026, and addressed exercise for her lower extremities. Concurrent interview with the director of nursing revealed that the exercise program was for Resident 3 to do on her own and that there is no documentation that she does the program and there is no one assigned to make sure she does the program. Interview of Resident 3 on March 12, 2026, at 12:20 PM revealed that she does not do any exercise and that she was unaware of a home exercise program that she was to be doing. Clinical record review for Resident 45 revealed an MDS (minimum data set, an assessment completed at intervals by the facility to determine the resident's care needs) assessment dated [DATE], indicated that she had bilateral upper and lower extremity range of motion impairments. Employee 20 (physical therapy assistant/rehab director) provided surveyor with an active assist range of motion program for Resident 45 on March 13, 2026, at 11:50 AM. She indicated that the program had just been developed and initiated that day, after the surveyor ask about it. The facility failed to provide Resident's 3 and 45 with a range of motion program to allow them to maintain and prevent a decrease in their current level of range of motion. Interview with the Director of Nursing confirmed the above noted findings for Resident 3 and 45 on March 13, 2026, at 1:10 PM. 483.25(c)(2) MobilityPreviously cited 2/21/25 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review, review and staff interview, it was determined that the facility failed to provide appropriate treatment and services regarding incontinence management for one of one resident reviewed (Resident 3). Findings include: Clinical record review for Resident 3 revealed that the facility admitted her on November 20, 2025, with a urinary catheter (a flexible tube inserted into the bladder to drain urine) in place due to a diagnosis of neuromuscular dysfunction of the bladder (a loss of bladder control caused by nerve damage from illnesses or injuries). Further clinical record review for Resident 3 revealed that her urinary catheter was discontinued on November 21, 2025. Her clinical record also indicated that she had a three-day bowel and bladder pattern tool (a worksheet completed by staff documenting continent and incontinent episodes in order to determine a pattern) completed November 21-23, 2025. Review of the 3-day bowel and bladder pattern tool revealed that on November 21, 2025, staff did not document after 3:00 PM, on November 22, 2025, staff did not document after 2:00 PM, and on November 23, 2025, staff documentation was completed for the entire day. The form provided and area for staff to determine a recommendation related to Resident 3's urinary continence, this area of the form was left blank and the there was no signature on the form indicating it had been reviewed by staff. Interview of the Director of Nursing on March 12, 2026, at 2:21 PM revealed that after the three-day bowel and bladder pattern tool is completed, a licensed nurse should compile the findings of each day on to a form (one for each day) entitled bowel and bladder assessment day 1, 2, and 3. The licensed nurse will then complete a bowel and bladder assessment day 4 that will conclude with a determination whether the resident is appropriate for toileting or if the resident requires to be checked and changed. Review of Resident 3's bowel and bladder day 4 assessment revealed that she was appropriate for toileting. Review of Resident 3's task and current care plan revealed no evidence indicating that she was currently on a toileting program and there was no documented evidence that she was on a toileting program at any time since removal of her urinary catheter on November 21, 2025. Interview of Resident 3 on March 12, 2026, at 11:30 AM revealed that she still has urinary incontinent episodes if she is not taken to the bathroom timely because she can't hold her urine that long. Review of Resident 3's task documentation on March 12, 2026, for urinary continence revealed that she was incontinent of urine at least once daily on six days of the past 30 days. There was no documented evidence in Resident 3's clinical record to indicate that the facility developed a bladder program to improve her incontinence. Interview with the Director of Nursing on March 13, 2026, at 10:00 AM confirmed the above findings for Resident 3. 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTIPreviously cited deficiency 2/21/25. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and family and staff interview, it was determined that the facility failed to implement interventions to maintain nutritional status for one of seven residents reviewed for nutritional concerns (Resident 9).Findings include: Interview with Resident 9's daughter on March 10, 2026, at 10:03 AM revealed that she believed that her mother had lost weight. Clinical record review for Resident 9 revealed the following weight assessments: December 3, 2025, 202.4 pounds December 10, 2025, 200 poundsDecember 17, 2025, 199.7 poundsDecember 23, 2025, 186 pounds (a 16.4-pound, 8.1 percent, severe weight loss in the three weeks since her admission)December 29, 2025, 190.4 poundsDecember 30, 2025, 190.4 poundsJanuary 3, 2026, 184.6 poundsJanuary 15, 2026, 184.6 poundsJanuary 31, 2026, 185.2 poundsFebruary 1, 2026, 185.2 poundsFebruary 2, 2026, 185.2 poundsFebruary 10, 2026, 176.8 pounds (a 7.8-pound, 4.2 percent loss in one month)February 13, 2026, 158.4 pounds (an 18.4-pound, 10.4 percent loss in three days; a 26.2-pound, 14.19 percent loss in one month)February 19, 2026, 150.4 pounds March 12, 2026, 149.6 pounds A nutritional assessment completed by the registered dietitian dated December 26, 2025, confirmed that Resident 9 had an 8.6 percent weight loss in 30 days and was at risk for malnutrition. The assessment also noted that Resident 9 had fair nutritional intake (25 to 49 percent). The goal was weight stability for Resident 9. The re-weights obtained December 29 and 30, 2025 (190.4 pounds), confirmed that Resident 9 sustained a severe weight loss (12 pounds, 5.92 percent) since her admission. Documentation by Resident 9's physician assistant dated December 29, 2025, at 6:24 AM noted that Resident 9 was obese and needed weight management, however, did not note an acknowledgement that Resident 9 had exhibited a severe weight loss since her admission to the facility. Dietary documentation by the registered dietitian dated December 29, 2025, at 3:29 PM noted the 5.9 percent weight loss over 30 days and noted that there were weekly weight assessments to verify significant weight changes. There was no indication of any new nutritional interventions to intervene in Resident 9's weight loss. Resident 9's clinical record did not indicate that an interdisciplinary decision between Resident 9, her representative (daughter), her physician, and other clinical staff, determined that the weight loss was desired and beneficial. A nutritional assessment by the dietitian dated January 15, 2026, at 11:59 AM noted that Resident 9 had a severe weight loss of 8.6 percent in the last month and was on weekly weight checks for four weeks with a goal for weight stability. Review of Resident 9's weight assessments indicated that staff failed to obtain weekly weight assessments between January 3 and 15, 2026. Staff also did not continue weekly weight assessments between January 15 and 31, 2026. A quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated January 16, 2026, noted Resident 9's weight loss and that she was not on a prescribed weight loss regimen. A review of Resident 9's plan of care initiated December 8, 2025 (revised on December 26, 2025), indicated that Resident 9 had a potential nutritional problem related to obesity. The goal established for Resident 9 was that she would maintain adequate nutritional status as evidenced by maintaining her weight within five percent of 186 pounds. The plan of care did not note that Resident 9 had a severe weight loss since her admission to the facility. A significant change MDS dated [DATE], again noted Resident 9's weight loss and that she was not on a prescribed weight loss regimen. Despite that Resident 9 fell below her goal of within five percent of 186 pounds (which would be 176.7 pounds) on February 13, 2026, when staff assessed her as 158.4 pounds, the facility did not update her nutritional plan of care. A nutritional assessment by the registered dietitian on February 18, 2026, listed planned interventions that included a referral to a speech-language therapist. A physician's order dated February 26, 2026, instructed staff to obtain weekly weight assessments. Review of the weight assessments in Resident 9's clinical record revealed that staff failed to obtain any weight assessments after that order. Observation of Resident 9 on March 10, 2026, at 12:50 PM revealed her to be in bed with her lunch tray in front of her. Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9 was not actively eating. There was no evidence in Resident 9's clinical record that a speech-language therapist evaluated Resident 9 after the dietitian's referral. A physician's order dated March 10, 2026, at 1:33 PM (almost three weeks after the dietitian's assessment and after the surveyor's above observation) requested skilled speech-language treatment. The surveyor reviewed the above concerns regarding Resident 9's weight loss during an interview with the Director of Nursing on March 13, 2026, at 8:35 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 provide respiratory care consistent with professional standards of practice for one of one resident reviewed with oxygen concerns (Resident 7) and maintain respiratory related equipment supplies in a safe and sanitary manner in one of one dining room observed (main dining room).Findings include: Observation of the main dining room on [DATE], at 8:25 AM during the initial tour of the kitchen revealed a suction unit on a red colored wheeled cart. Two bottles of sterile water kept with the suction unit were expired on [DATE]. The cart also had extensive debris noted on the shelving. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:05 PM. Clinical record review revealed the facility admitted Resident 7 on [DATE], with a diagnosis of chronic obstructive pulmonary disease added [DATE]. Observation of Resident 7 on [DATE], at 11:02 AM, and [DATE], at 2:19 PM revealed Resident 7 was in bed with a nasal cannula (NC, tubing to deliver oxygen to the nose) on and running at 3.0 liters per minute (LPM). Further review of Resident 7's clinical record revealed there was no physician order for staff to administer Resident 7 oxygen. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on [DATE], at 3:49 PM. The Director of Nursing confirmed there was no order for staff to administer Resident 7 oxygen. 483.25(i) Respiratory/tracheostomy Care and SuctioningPreviously cited deficiency [DATE] 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement appropriate care and services related to dialysis care for one of one resident reviewed for dialysis concerns (Resident 28).Findings include: Clinical record review for Resident 28 revealed the following active physician orders: Dialysis (medical procedure to filter blood outside the body to remove waste and excess fluids when the kidneys can no longer function adequately) three times a week Obtain a full set of vital signs (typically temperature, pulse, respiration, and blood pressure assessments) before and after dialysis every day and evening shift every Tuesday, Thursday, and Saturday; no BP (blood pressure) in right arm Do not take B/P (blood pressure) on right arm Monitor catheter site for pain, redness, swelling, bleeding. If noted bleeding, apply pressure dressing and notify provider every day and evening shift for dialysis Renal (kidney) diet, regular texture, thin consistency (for fluids), 1200 ml (milliliter) fluid restriction Fluid restrictions: 1200 ml document total amount for each; nursing to provide 480 ml (days 240 ml), (evenings 180 ml), (nights 60 ml); dietary to provide 720 ml (240 ml/meal) every shift for fluid restrictions Interview with Resident 28 on March 11, 2026, at 10:35 AM revealed that he had a left arm dialysis access (a fistula, or graft, surgically created to connect an artery and a vein to increase blood flow, making it suitable for repeated needle insertions during dialysis). Resident 28 stated that he reminds staff to not utilize his left arm for blood pressure assessments or to obtain blood work samples. Resident 28 stated that he had one incident when he forgot to limit lifting an object after dialysis which resulted in the access site bleeding a large amount. Resident 28 stated that he did not have any dietary or fluid restrictions. A large (approximately 16-ounce, 480 ml) Styrofoam cup filled with ice water was on Resident 28's bedside furniture. Observation of Resident 28's room revealed no signage or alerts to inform caretakers of Resident 28's left arm restrictions. Review of Documentation Survey Report (electronic documentation by nurse aide staff for a resident's activities of daily living) data dated March 2026 revealed that Resident 28 consumed more than 240 milliliters per meal (720 ml total) daily as follows: March 1, 2026, 1320 mlMarch 4, 2026, 1080 mlMarch 6, 2026, 840 mlMarch 8, 2026, 960 mlMarch 9, 2026, 960 mlMarch 11, 2026, 960 ml Observation of Resident 28's room on March 11, 2026, at 11:07 AM revealed a large (16-ounce Styrofoam) cup filled with ice water at his bedside. Resident 28 confirmed that staff provided the ice water to him and that he did not believe that he had any fluid restrictions that would prevent him from drinking it. Interview with Employee 3 (licensed practical nurse) on March 11, 2026, at 11:10 AM in Resident 28's room, confirmed that there was no indication that Resident 28 had restrictions limiting the use of his left arm, however, Resident 28's dialysis access was in his left arm. Employee 3 confirmed that Resident 28's active physician orders instructed staff to prevent use of his right arm for blood pressure assessments. Employee 3 also noted the 16-ounce cup of fluid provided by facility staff to Resident 28. Employee 3 confirmed that typically staff would not include residents on fluid restrictions during water pass activities. 483.25(l) DialysisPreviously cited deficiency 2/21/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for two of two residents reviewed for mood and behaviors (Residents 12 and 43). Findings include: Clinical record review for Resident 12 revealed a diagnosis of Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) dated March 10, 2023. Clinical record review for Resident 12 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated January 23, 2026, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 10, which indicated cognitive impairment. The MDS further revealed that the resident was assessed as yes to having a PTSD diagnosis. A Psychosocial Evaluation for Resident 12 dated July 30, 2025, at 2:16 PM revealed that the resident identified trauma as a teenager. Medical provider documentation for Resident 12 dated March 10, 2026, at 2:30 PM and February 9, 2026, at 4:00 PM revealed an assessment / plan that noted PTSD. Social service documentation for Resident 12 dated July 25, 2025, at 11:32 AM revealed documentation that noted a diagnosis of PTSD. Review of Resident 12's current care plan revealed no current care plan to address the resident's PTSD, identify triggers (everyday situations that cause a person to re-experience a traumatic event as if it was reoccurring), person-centered interventions, or interventions to alleviate individualized triggers. The above information for Resident 12 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 11, 2026, at 2:01 PM. Clinical record review revealed the facility admitted Resident 43 on December 9, 2022. Review of a psychiatric progress note dated April 4, 2023, noted Resident 43 had a history of being mugged. The psychiatrist note revealed Resident 43 has a significant past medical history of dementia and anxiety disorder. The psychiatrist noted Resident 43 had increased paranoia lately. Review of Resident 43's current care plan on March 10, 2026, revealed no care plan to address the resident's PTSD, identify triggers, person-centered interventions, or interventions to alleviate individualized triggers until after the surveyor's questioning. The above findings for Resident 43 were reviewed with the Director of Nursing on March 13, 2026, at 1:26 PM. The facility failed to develop a comprehensive, person-centered care plan for Residents 12 and 43 related to their PTSD. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, it was determined that the facility failed to properly store resident medications on two of six nursing units reviewed (Little League Nursing Unit and Sycamore Nursing Unit). Findings include: Observation during the medication pass on the Little League Nursing Unit and Sycamore Nursing Unit on March 12, 2026, at 9:06 AM revealed a medication cart being utilized by Employee 21, licensed practical nurse. Observation of the medication cart revealed the following: There were several unsecured and unidentified medication tablets found in the bottom of the drawers that included: a pink colored round pill, a white colored round pill, a blue colored oblong tablet, a half a pink tablet, a half of a round white colored pill, a large white colored round pill, a smaller white colored round pill, a scored pink pill, and numerous other loose medications in the bottom of the drawers that held the pre-packaged pill packets. There was also a significant accumulation of debris in the bottom of the drawers that held the loose medications. A concurrent interview with Employee 21 revealed that it was third shift that cleaned the carts, but all shifts are responsible for ensuring a clean cart. The above findings were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:01 PM. 483.459(h) Storage of drugs and biologicalsPreviously cited 2/21/25 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1) Nursing services

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	03/13/2026

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and staff interview, it was determined that the facility failed to assure essential kitchen equipment is maintained in a safe, operating condition in the facility's main kitchen. Findings include: Initial tour of the facility's main kitchen with Employee 17, dietary manager, on March 10, 2026, at 8:25 AM revealed the following: Staff were observed serving breakfast from a steam table located in the facility's main kitchen. A large cooking pan that was more than halfway filled with water was observed on the floor under the steam table. A concurrent interview with Employee 17 revealed that there was a leak from the steam table that has been present since at least December 2025. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:05 PM. A walk-in cooler for the main kitchen located in the basement of the facility had a light receptacle in the ceiling of the cooler that had no light bulbs in it. There was water observed dripping off the receptacle and pooling on the ground. It was unclear on the source of the water. An alternative light source was being utilized from a light attached to an electrical cord coming from outside of the cooler. An interview with the Nursing Home Administrator (NHA) on March 10, 2026, at 9:25 AM about the leak revealed the NHA was not aware of the issue. An interview with Employee 23, maintenance director, on March 10, 2026, at 9:35 AM and concurrent observation revealed there was no power currently to the light upon testing it with an electrical device and they were not aware of the issue or the source of the leak. 28 Pa. Code 201.14(a) Responsibility of licensee

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	03/13/2026

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Wecare at Sycamore Rehabilitation and Nursing Cent	1445 Sycamore Road Montoursville, PA 17754

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of posted daily nurse staffing data, and staff interview, it was determined that the facility failed to accurately post information regarding daily nurse staffing data as required. Findings include: Observation on March 10, 2026, at 2:44 PM revealed the facility's posted nursing time was on Sycamore Boulevard. There are six nursing units (Little League, [NAME], Sycamore, Maple Court, Grampian, and Maple Lane) in the facility. The posted nursing time was not in a prominent place readily accessible to all residents, staff, and visitors. Further Observation on March 11, 2026, at 2:13 PM revealed the posted nursing time did not include the actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care. Interview with the Director of Nursing on March 12, 2026, 11:03 AM confirmed these findings, noting staff were not including the actual hours worked on the posted nursing time. 28 Pa. Code 201.14(a) Responsibility of licensee

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	03/13/2026

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

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage at the observed facility trash dumpster.Findings include: Observation of the facility's main dumpster on March 10, 2026, at 8:50 AM revealed the following: There was a significant accumulation of dryer lint on the ground behind the dumpster located closer to the building. There were various debris observed discarded on the ground: plastic cups, paper debris, two straws, multiple cigarette butts, a plastic bag, an empty milk carton, and a large accumulation of dried leaves with various paper products mixed in. There was a medical glove hanging off the dumpster and another medical glove observed discarded on the ground. There were multiple paper debris observed in a grate in the ground. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 12, 2026, at 2:05 PM. 28 Pa. Code 201.14(a) Responsibility of licensee