

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Dresher Hill Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1390 Camp Hill Road Fort Washington, PA 19034	
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 properly store food and maintain sanitary conditions in the dietary department and on two of four nursing units. (First floor, Second floor) Findings include: Observations during the tour of the dietary department on January 27, 2026, at 10:10 a.m., and January 29, 2026, at 9:35 a.m., revealed the following: In the dry storage area, there was a bottle of Realemon Juice with a best buy date of October 21, 2025. On the lower shelf of the cook's prep table, a container had lemon extract with a best by date of October 10, 2024, and a box of food dye with an expiration date of November 3, 2023. The container also had dirty measuring spoons. In the walk-in freezer there was a box of Harborbanks seafood shrimp that was open with no open date or expiration date and one box of gluten free breaded mini shrimp bags that was open with no open date or expiration date. The back splash of the griddle and stove had thick dry discolored splatter. The oven doors and knobs had dry thick discolored splatter. The shelf over the cooking surface was dusty. The flat griddle, that was confirmed not used for breakfast, had food debris and crumbs on the griddle and the front scrap disposal area. The stove top had charred debris crumbs and a white powdery dusty debris. The meat slicer table had crumbs and was sticky. There was debris and crumbs on the meat slicer. The top of the steamer was dusty. The steam table and prep table bottom shelf had crumbs, debris and a paper clip. The cook's prep table was dusty and had a dried slice of bread on the lower shelf. A wall shelf that contained the cooking spices had thick dust and debris. The lower shelf of the food prep table next to the dish area was dusty with dirt and debris. Observation of the first floor pantry January 27, 2026, at 1:53 p.m., revealed ice built up in the refrigerator freezer and the refrigerator floor had dried discolored staining and debris. In the microwave there was thick food splatter that contained crumbs and debris. During an interview on January 27, 2026, at 1:57 p.m., the Director of Nursing confirmed that the microwave is used to reheat resident food. Observation of the second floor pantry January 27, 2026, at 12:18 p.m., revealed ice built up in the refrigerator freezer and the refrigerator floor had dried liquid staining and debris. In the microwave there was food splatter that contained crumbs and debris. In an interview on January 27, 2026, at 12:23 p.m., a nurse aide (NA 3) confirmed that the microwave is used to reheat resident food. The ice scoop was observed on the dusty lower shelf of the rolling table for the ice cooler instead of being placed in the attached ice scoop pocket. In the cabinet below the sink there was a stained bath blanket. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment on two of four nursing units. (1st floor low side, 2nd floor high side) Findings include: Observation throughout the facility January 27 through 29, 2026, from 10:00 a.m. to 2:45 p.m., revealed the following: A tube feeding pole in room [ROOM NUMBER] had a dried brown substance on it. There was a displaced floor tile in room [ROOM NUMBER] by bed 1. A mechanical lift (used to transfer residents from surface to surface) was observed with dirty wheels with knotted/intertwined thick [NAME] of hair and debris. A sit to stand lift (used to assist a resident to a standing position) was observed with dirty wheels with knotted/intertwined thick [NAME] of hair and debris and dirt and debris on the foot boards. The large shower chair back had a built up brown and pink substance on it. The shower room ceiling exhaust fan had heavy dust on it. A dried brown substance was observed on a tube feeding pole, bedside table, and privacy curtain in room [ROOM NUMBER]. Dust, debris, a hair ball and a dried brown substance were observed behind the oxygen concentrator and fall mat on the left side of the bed. The privacy curtain in room [ROOM NUMBER] was stained with a dark yellow substance and dust, crumbs and lint were observed on the left fall mat. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent a fall for one of nine sampled residents. (Resident 8) Findings include: Clinical record review revealed that Resident 8 had diagnoses that included dementia, end stage renal disease, and muscle weakness. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident 8 was cognitively impaired and fully dependent on staff for assistance getting in and out of the shower and bathing. Review of Resident 8's care plan revealed that the resident had a problem with mobility and in his ability to perform activities of daily living such as bathing and required assistance with bathing. Review of facility documentation revealed that on January 8, 2026, at 4:00 p.m., Resident 8 was being assisted with a shower by a nurse aide (NA 1). During the shower, NA 1 left the shower room with no other staff present. During that time Resident 8 slipped out of the shower chair onto the floor. In an interview on January 29, 2026, at 1:34 p.m., the Director of Nursing and Administrator confirmed that a staff member should have been in the shower room throughout Resident 8's shower. 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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to implement enhanced barrier precautions and the use of personal protective equipment (PPE) to prevent the spread of infection for two of 22 sampled residents. (Residents 10 and 53) Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, last reviewed June 2, 2025, revealed that enhanced barrier precautions were to be used with any high-risk resident with a wound or indwelling device during high contact care activities even when exposure to body fluids and blood is not anticipated, including during wound care, the care of feeding and tracheostomy tubes, providing hygiene, and changing briefs and linens. Standard precautions such as hand hygiene always apply and precautions include the use of protective gowns and gloves during high-risk activities. Clinical record review revealed that Resident 10 had diagnoses that included paraplegia and a pressure ulcer of the lower back region related to a recurrent abscess (an area under the skin where pus (infected fluid) collects). The Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident 10 had a chronic left ischial (part of left hip bone) stage four pressure ulcer and was dependent on toileting and personal hygiene. On January 26, 2026, the wound nurse noted the reopening of the abscess. Observations on January 28, 2026, at 10:10 a.m. revealed a nurse aide (NA 2) entered Resident 10's room without wearing a protective gown prior to changing the resident's briefs. Clinical record review revealed that Resident 53 had diagnoses that included traumatic brain injury, quadriplegia, neurogenic bladder, and gastronomy status. Resident 53 required devices including a suprapubic catheter and an enteral feeding tube according to the MDS assessment dated [DATE]. Observations on January 28, 2026, at 10:00 a.m. revealed a physical therapist (PT 1) performed leg stretches on Resident 53 without wearing a protective gown. On January 29, 2026, at 1:00 p.m., the Director of Nursing confirmed that staff did not follow the facility infection control policy. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		