

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Edgehill Nursing and Rehab Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 146 Edgehill Road Glenside, PA 19038	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of facility documents, it was determined that the facility failed to submit direct care staffing information in the Payroll-Based Journal system for one of one quarter reviewed (Quarter 2). Findings Included: Review of the Payroll-Based Journal staffing data reports revealed that the facility failed to submit data for Quarter 2 (January 1, 2026, thru March 31, 2026). Interview with Administer E1 on July 23, 206 at 02:00 p.m. confirmed no further documented evidence of submission. 28Pa 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

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Edgehill Nursing and Rehab Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 146 Edgehill Road Glenside, PA 19038	
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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documentation and staff interview it was determined that the facility failed to include active involvement from direct care staff and input from residents in the facility assessment process. Finding Included: Review of the facility's facility assessment, dated April 23, 2026, revealed there was no indication that the facility involved direct care staff, input from residents, resident representatives, and/or family members. Interview with Director of Nursing E2, on July 24, 2026, at approximately 11:00 a.m., confirmed there was no direct care staff, resident representatives, and/ or family members included in the facility assessment. 28 Pa. Code 201.18(b)(3) Management.		