

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

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Form Approved OMB  
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395834	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  King of Prussia Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  600 West Valley Forge Road King of Prussia, PA 19406	
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 0557  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>47968</p> <p>Based on observations and interviews, it was determined the facility failed to ensure treatment with dignity and respect for one of five residents observed (Resident R1)</p> <p>Findings include the following:</p> <p>Review of Resident R1's clinical record including medical diagnoses revealed diagnoses including but not limited to Dementia, Diabetes II, Peripheral Vascular Disease, muscle disorder, Peripheral Vascular Angioplasty status, Chronic Kidney Disease, Hypertension, Hyperlipidemia, and Anemia.</p> <p>Review of Resident R1's clinical record including MDS assessments revealed resident's BIMs score was 99 which indicates severe impaired cognitive function.</p> <p>Observation conducted on April 16, 2024, at 10:56 am, revealed Resident observed from the hallway laying without clothes on in bed. Resident R1's door and privacy curtain were both open, revealing Resident R1's body to anyone who walked past the room. A female housekeeper was mopping the room at the time of observation. This surveyor inquired if the resident was naked, the housekeeper stated that she was. As this surveyor turned to get staff to attend to the resident, a male housekeeper was about to enter the room, this surveyor informed that he could not enter the room because the resident was not dressed.</p> <p>Interview conducted with Nurse Aide, Employee E3 who was observed sitting at the nurse's station and was informed of the resident was laying exposed. Employee E3 stated the resident was getting ready to be washed up. Employee E3 went into the resident's room then closed the door.</p> <p>Deficient practice was confirmed during interview with DON and NHA on April 17, 2024, at 2:30 pm.</p> <p>28 Pa. Code: 201.18(b)(2) Management.</p> <p>28 Pa. Code: 201.29(j) Resident's rights.</p>		

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 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47968</p> <p>Based on observations and interviews with staff it was determined that the facility failed to provide hot water for all residents residing in the facility for two of two days observed, April 16, 2024, and April 17, 2024.</p> <p>Findings include the following:</p> <p>Tour of facility on April 16, 2024, at 11:45 am., revealed the shower rooms and bathrooms were not receiving sufficient hot water for comfort.</p> <p>Interview with Maintenance staff, Employee E confirmed the hot water temperatures were approximately 98 degrees in the shower rooms, bathrooms, and kitchen.</p> <p>Employee E6 indicated the hot water temperatures will be increased but the temperatures may take a few hours to circulate throughout the facility.</p> <p>Tour of the facility of April 17, 2024, at 1:00 pm., revealed no water in the shower rooms and low flowing water in the bathrooms. Interview conducted with maintenance staff, Employee E6, revealed a recent water pipe burst caused the need to turn the water off. Employee E6 provided documentation from the repair company indicating their estimated time of arrival was April 17, 2024, at 3:30 pm.</p> <p>REview of documentation provided by Nursing Home Administrator On April 18, 2024, at 9:31 am. of a receipt attached from the repair company, indicating the repair was made to hot water return line. Service representative verified leak was stopped, monitored as building pressure returned to normal and recorded hot water temperature at 106.</p> <p>Deficient practice was confirmed during interview with Director of Nursing and Nursing Home Administrator on April 17, 2024, at 2:30 pm.</p> <p>Previously cited 12/8/23</p> <p>28 Pa. Code 201.29(j) Resident rights</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</p>		

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F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47968</p> <p>Based on observations and staff interview, it was determined that the facility failed ensure three medication carts were locked and secured out of six medication carts observed.</p> <p>Findings include:</p> <p>Observations conducted within the facility on [DATE], at 11:16 am., revealed three medication carts were unlocked. Observations of medication cart located behind the nurses' station and contained various creams, ointments, bandages, gauge, and powders.</p> <p>Observation conducted within the facility of two other medication carts located adjacent to the nurses' station, revealed one contained bottles of medications, which was later established to be expired house medications, the other was labeled emergency cart and contained medical supplies but no medications.</p> <p>Observations conducted on [DATE], at 11:35 pm., accompanied by the Director of Nursing (DON) revealed the Director of Nursing was unaware of the unlocked medication carts. Interview and observations with the DON confirmed the house medications were expired and should not have been in the unlocked cart. The DON stated the cart would be removed.</p> <p>Tour of the facility conducted on [DATE], at 1:30 pm., revealed the carts containing medications was removed and the emergency cart was locked.</p> <p>Per DON education to be provided to staff regarding medication safety.</p> <p>Deficient practice was confirmed during interview with DON and NHA on [DATE], at 2:30 pm.</p> <p>Previously cited [DATE]</p> <p>28 Pa. Code 211.9(h) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		