STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395834	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King of Prussia Skilled Nursing and Rehabilitation	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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure residents were free from significant medication errors, resulting in actual harm when Resident R1 required transfer to the hospital with the need for intubation and admission to the Intensive Care Unit, this was found to be a past noncompliance incident for one of 15 residents reviewed. (Resident R1) Findings include:Review of the facility policy titled Medication Administration, dated January 2025, revealed that prior to medication administration, staff are required to review and confirm medication orders for each resident on the Medication Administration Record (MAR) and compare the medication label with the MAR.Review of Rights of Medication Administration, revealed the following:Right patient: you must have 2 resident identifiers prior to administering medications (examples: photo, name band, name/DOB verification)Right drug: this requires a triple check to ensure accuracyRight dose: this requires a triple check to ensure accuracyRight route: in which the medication is given (IV, PO, SQ, Topical, etc)Right time and frequencyRight to refuse: all residents have the right to refuse medications and treatments. If they do refuse, it must be documented as such.Resident R1 was admitted to the facility on [DATE], with diagnoses that include unspecified sequelae of cerebral infarction (stroke). Major Depressive Disorder (persistent feelings of sadness and loss of interest in activities), generalized anxiety disorder (persistent and excessive worry about various aspects of life), and adult Failure to Thrive.Review of information submitted to the state agency on January 12, 2026, revealed that on January 11, 2026, at approximately 8:00 p.m., Resident R1 was administered nine medications prescribed to another resident (Resident R2). The medications administered in error included:Hydralazine 50 mg (for high blood pressure)Buprenorphine 8 mg sublingual (for chronic pain) Quetiapine 25 mg (antipsychotic)Prazosin 1 mg (for high blood pressure)Clonidine 0.3 mg (for high blood pressure)Lorazepam 0.5 mg (antianxiety)Melatonin 5 mg (sleep aid)Mirtazapine 45 mg (antidepressant)Atorvastatin 40 mg (for high blood pressure)Further review of the Electronic Event submitted to the state agency on January 12, 2026 revealed The nurse notified the supervisor that she made a medication error. The supervisor immediately assessed the resident, and V/S (vital signs) were taken. The resident was awake but drowsy, has good po (oral) intake, b/p (blood pressure) 110/61 (normal 120/80), O2 sat (measurement of how much oxygen is in the blood) was 72% (normal above 90%). O2 2L (supplemental oxygen) was placed on the resident and pulse ox went up to 94%. The MD (medical doctor) was notified and gave the order to monitor, give oxygen, start neuro checks (a series of rapid or comprehensive evaluations assessing brain, spinal cord, and nerve function, typically including mental status (alertness/cognition), cranial nerve assessment (vision/pupils), motor strength, coordination, and reflexes) and call with any changes. The resident's RP (responsible party) was notified. Around 10:20 pm the supervisor called the MD back to report the resident is now lethargic and is only arousable to sternal rub and is now snoring. their B/P was 51/73. The MD gave an order to send to the ER (Emergency Room) for evaluation.Review of hospital records revealed (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 0760 Level of Harm - Actual harm Residents Affected - Few	Resident R1 was admitted with a diagnosis of accidental drug overdose, required intubation (flexible tube is inserted into the windpipe to maintain an open airway, deliver oxygen, or allow a ventilator to breathe for a patient) in the emergency department, and was subsequently transferred to the intensive care unit (ICU). Hospital records further revealed Resident R1 was discharged [DATE], and transferred to another skilled nursing facility.Interview was unable to be conducted due to Licensed staff member Employee E1 was unavailable for interview due to separation from employment and placement on the facility's do-not-hire list.Review of written statement provided by Licensed staff member Employee E1, dated January 11, 2026, revealed Employee E1 reported entering the Resident R2's room, asking the resident if they were Resident R2, receiving an affirmative response, and administering the 8:00 p.m. medications. The statement further revealed that Employee E1 was later alerted by another resident that the individual was not Resident R2 but Resident R1, after which Employee E1 obtained vital signs of Resident R1 and reported the incident to the supervisor.Interviews conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on January 29, 2026, at approximately 10:50 a.m. revealed the facility implemented facility-wide audits, change-in-condition training, and medication administration training, and the Rights of Medication Administration.Review of training documentation revealed 100% of Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) completed the identified training. Interviews conducted with licensed staff Employees E2, E3, E4, E5, E6, and E7 confirmed receipt of the training, which was verified through sign-in sheets.During a follow-up interview conducted with the DON and NHA at approximately 11:13 a.m., facility leadership confirmed the incident was identified as a medication error and acknowledged the resident required hospitalization as a result.The facility failed to ensure Resident R1 was not administered medications prescribed for another resident, resulting in a significant medication error with actual harm to Resident R1 who was transferred to the hospital and required intubation and care in the Intensive Care Unit. This was a past non-compliance situation with the facility completing the above interventions on January 12, 2026.28 Pa. Code: 201.14(a) Responsibility of licensee.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)(2)(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 facility policy review, observations and staff interview it was determined the facility failed to properly store medications for one resident reviewed. (Resident R6) Findings include:Review of facility policy storage of Medication dated January 2025. Revealed The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including those established by the United States Pharmacopeia (USP). Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers.During an onsite investigation conducted on January 29, 2026, at approximately 10:15 a.m., an unidentified pill on the floor outside the entrance of Resident R6's room.The pill was not labeled, packaged, or stored in a secure medication container.Interview with licensed employee E13 conducted on January 29, 2026, at 12:20 p.m. revealed staff were unable to identify the pill and could not determine which resident, if any, the medication was prescribed to.Interview with the Director of Nursing, conducted on January 29, 2026, at approximately 12:33 p.m. confirmed that medications are required to be secured at all times and acknowledged that an unidentified pill found outside a resident room posed a risk for unintended ingestion.The facility failed to ensure medications were properly controlled. 28 Pa Code 211.12(d)(1) Nursing services28 Pa Code 211.12(d)(5) Nursing services