Printed: 06/25/2026
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 04/30/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on a review of facility's policy, facility documentation, clinical records, and staff interview, it was determined the facility failed to follow wound physician's treatment orders/recommendations and provide consistent and appropriate treatment for an Unstageable Pressure Ulcer on the right heel (obscured full-thickness skin and tissue loss), resulting in wound deterioration and actual harm for one of four residents reviewed. (Resident 1)Findings include:Review of the facility's policy titled Skin Integrity and Wound Management, reviewed September 15, 2025, revealed Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Review of Resident 1's diagnosis list includes Dementia (term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life), Anemia (lower than normal amount of healthy red blood cells) and unspecified abnormalities of gait and mobility (person exhibits irregularities in walking and movement but the exact cause cannot be determined or specified). Review of Resident 1's Braden Scale Assessment (assessment tool used for predicting pressure ulcer risk) dated January 26, 2026, revealed a score of 12 (score of 12 or less represents high risk). Review of Resident 1's skin care plan revealed interventions including weekly wound assessment to include measurements and description of wound status, provide wound treatment as ordered, and observing skin for signs of skin breakdown (redness, cracking, blistering, decreased sensation, and skin that does not blanche easily). Review of Resident 1's clinical record revealed weekly skin assessments were conducted and issues with skin integrity were noted. Review of Resident 1's clinical record revealed a progress note dated January 22, 2026 (08:30 a.m.) Skin Issues Late Entry indicating resident had an in-house acquired pressure ulcer (localized damage to skin and underlying tissue caused by prolonged pressure, friction, or shear, usually over bony prominences like the hips, heels, or tailbone) to the right heel. Further review failed to reveal measurements or description of the wound with this assessment. Review of Resident 1's Physician Orders revealed an order dated January 25, 2026, skin prep right heel X shift. Off load right heel every shift for skin alteration which was discontinued on February17, 2026. Review of Resident 1's wound consult report dated January 30, 2026, revealed provider comments Right Heel - Deep tissue injury (type of pressure injury characterized by localized, purple/maroon discolored intact skin or blood-filled blisters) with intact skin and dark purple discoloration. No drainage was noted. Recommend discontinue current wound care orders, see new wound care recommendations. Resident 1's wound right heel pressure ulcer was measuring L(length) x W(width) x D(depth) 2.8 x 4.4 x 0. Review of Resident 1's physician order dated March 21, 2026, revealed Right heel paint with betadine and cover with Foam dressing daily & PRN (as needed) every day and evening shift for wound care. Review of Resident 1's wound consult report dated April 10, 2026, revealed provider comment indicating Right heel unstageable pressure injury is stable noted with 100% lifting eschar (thick, dry, leathery layer of dead, necrotic tissue that forms over severe wounds, burns, infections, or pressure ulcers) and malodor (a strong indicator of infection, necrotic (dead) tissue, or bacterial buildup). Peri (around) wound dry/scaly. Targeted debridement (removal) of eschar was performed without complications. Discontinue prior wound care orders, please see new recommendations. Resident 1's wound right heel pressure ulcer was measuring L x W x D 3x 3.2 x 0 and a malodorous odor. (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

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	04/30/2026

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment recommendations from wound provider stated cleanse the area with Vashe Wound Solution. Primary dressing: Honey (medical grade) Gel; Secondary Dressing: Silicone foam adhesive dressing. This treatment will be done daily and as needed until discontinued. Review of Resident 1's wound consult report dated April 15, 2026, revealed provider comment indicating Right heel unstageable pressure injury has worsened in appearance. Noted with 100% slough and malodor. Periwound dry/scaly. Auto fluorescent imaging (real-time, non-invasive technology that detects bacterial burden (biofilm/planktonic) in wounds by illuminating them with safe violet light) was utilized and was positive for cyan fluorescence (indicating infection). Targeted sharp debridement (cutting away of dead tissue) was performed without complications. Discontinue prior wound care orders, please see new recommendations. Resident 1's wound right heel pressure ulcer measurement of L x W x D is 2.8 x4.5 x1.2. Treatment recommendations cleanse the area with Dakin's 0.125% (1/4 strength) solution. Primary dressing Dakin's 0.125% solution dampened gauze (1/4 strength). Secondary Dressing: Silicone foam adhesive dressing. This treatment will be done daily and as needed until discontinued. Review of Resident 1's wound consult report dated April 22, 2026, revealed Resident 1's wound right heel pressure ulcer was Stage Unstageable measuring Lx W x D 3x4.5.x1. Unchanged Wound status. There is moderate exudate (drainage) amount; wound margin is well defined; peri-wound is dry/scaly and necrotic material 50%. Granulation (moist soft red bumpty tissue) between 0% and 25%- confluent (where multiple linear scratches or scrapes merge together into a single, large, and often haphazardly shaped wound)-beefy red. Treatment recommendations ?cleanse the area with Dakin's 0.125% (1/4 strength) solution. Primary dressing Dakin's 0.125% solution dampened gauze (1/4 strength). Secondary Dressing: Silicone foam adhesive dressing. This treatment will be done daily and as needed until discontinued. Review of Resident 1's wound consult report dated April 29, 2026, revealed Resident 1's wound right heel pressure ulcer categorized as Stage Unstageable measuring L x W x D 3.7x5.x1. There is malodorous odor Unchanged Wound status. Treatment recommendations ?cleanse the area with Dakin's 0.12.5% (1/4 strength) solution. Primary dressing Dakin's 0.125% solution dampened gauze (1/4 strength). Secondary Dressing: Silicone foam adhesive dressing. This treatment will be done daily and as needed until discontinued'. Review of Resident 1's March 2026 and April 2026, Treatment Administration Record (TAR) revealed the April 10, 2026, and April 29, 2026, treatment recommendation/order of the wound doctor were not followed and the resident continued to receive the original treatment of Betadine and a foam dressing initiated on March 21, 2026, during which the pressure wound deteriorated. Interview with the Director of Nursing on April 30, 2026, at 2:45pm confirmed the wound care recommendations from the wound specialist were not followed and the resident's wound care was never changed as recommended on April 10th, 2026, and April 29th, 2026. The facility failed to ensure Resident 1's wound care changes were followed resulting in a harm of unstageable right heel pressure ulcer with wound deterioration. 28 Pa. Code 211.11(d) Resident care plan28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 211.10 (d) Resident care policies