



Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>
--------------------------------------------------------	-------------------------------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>
----------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 1  Nursing services.  (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.  This REGULATION is not met as evidenced by:	P 5520	<ol style="list-style-type: none"> <li>1. All residents received care in accordance with their plan of care and attending physician orders.</li> <li>2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff.</li> <li>3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted.</li> <li>4. To monitor and maintain ongoing compliance the DON or designee will</li> </ol>	Completion Date: <b>03/15/2025</b> Status: <b>APPROVED</b> Date: <b>01/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
STATE LICENSE NUMBER: <b>125902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 2	P 5520	<p>audit staffing weekly x4 weeks then monthly for two months.</p> <p>Results will be taken to the QAPI for review and revision as needed.</p> <p>Date of compliance for this case: Monday, March 17th, 2025.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	<p>Continued from page 3</p> <p>Based on a review of facility staffing data, it was determined that the facility failed to ensure a minimum of one nurse aid per 10 residents on the day shift for ten days, a minimum of one nurse aide per 11 residents on the evening shift for four days and a minimum of one nurse aide per 15 residents on the night shift for one day for the period of December 30, 2024 through January 8, 2025.</p> <p>Findings include:</p> <p>Review of facility staffing data for the period from December 30, 2024 through January 8, 2025, revealed the following dates and shifts that did not meet the requirements of one nurse aid per 10 residents on the day shift, one nurse aide per 11 residents on the evening shift and a minimum of one nurse aide per 15 residents on the nights shift.</p> <p>Day shift 12/30/2024 12/31/2024</p>	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
STATE LICENSE NUMBER: <b>125902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 4  1/1/2025 1/2/2025 1/3/2025 1/4/2025 1/5/2025 1/6/2025 1/7/2025 1/8/2025  Evening shift 12/30/2024 12/31/2024 1/2/2025 1/8/2025  Night shift 12/31/2024  The aforementioned data was confirmed with the Nursing Home Administrator in a telephone interview on January 16, 2025.	P 5520		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
STATE LICENSE NUMBER: <b>125902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
STATE LICENSE NUMBER: <b>125902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 6  Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	<ol style="list-style-type: none"> <li>1. All residents received care in accordance with their plan of care and attending physician orders.</li> <li>2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff.</li> <li>3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted.</li> <li>4. To monitor and maintain ongoing compliance the DON or designee will</li> </ol>	Completion Date: <b>03/17/2025</b> Status: <b>APPROVED</b> Date: <b>01/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 7	P 5530	<p>audit staffing weekly x4 weeks then monthly for two months.</p> <p>Results will be taken to the QAPI for review and revision as needed.</p> <p>Date of compliance for this case: Monday, March 17th, 2025.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	<p>Continued from page 8</p> <p>Based on a review of facility staffing data, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 30 residents on the evening shift for one day and one LPN per 40 residents on the night shift for two days for the period from December 30, 2024 through January 8, 2025.</p> <p>Findings include:</p> <p>A review of facility staffing data for the 10 day period from December 30, 2024 through January 8, 2025, revealed the following dates and shifts that did not meet the minimum requirements of one LPN per 30 residents on the evening shift and one LPN per 40 residents on the night shift.</p> <p>Evening shift 1/5/2025</p> <p>Night shift 1/6/2025</p>	P 5530		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	Continued from page 9  1/7/2025  The aforementioned data was confirmed with the Nursing Home Administrator in a telephone interview on January 16, 2025.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 10  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> <li>1. All residents received care in accordance with their plan of care and attending physician orders.</li> <li>2. The Clinical Leadership Team and scheduler review the schedule daily. In the event of call offs the facility follows staffing policies including exhausting all possible replacements from internal staffing pool and contracted agency staff. Facility continues to offer incentives, coordinate staffing schedules, and replace call-offs per policy while actively continuing to hire for all open positions and additional pool staff.</li> <li>3. All Nursing Staff have been educated on the 7/1/2024 Nursing Ratios and PPD requirements and the importance of maintaining the schedule as posted.</li> <li>4. To monitor and maintain ongoing compliance the DON or designee will</li> </ol>	Completion Date: <b>03/17/2025</b> Status: <b>APPROVED</b> Date: <b>01/21/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
STATE LICENSE NUMBER: <b>125902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	Continued from page 11	P 5640	<p>audit staffing weekly x4 weeks then monthly for two months.</p> <p>Results will be taken to the QAPI for review and revision as needed.</p> <p>Date of compliance for this case: Monday, March 17th, 2025.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395834</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/17/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>KING OF PRUSSIA SKILLED NURSING AND REHABILITATION CENTER</b>  STATE LICENSE NUMBER: <b>125902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>600 WEST VALLEY FORGE ROAD KING OF PRUSSIA, PA 19406</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5640	<p>Continued from page 12</p> <p>Based on a review of facility staffing data, it was determined that the facility failed to meet the required Per Patient Day (PPD) for four days in the ten day period from December 30, 2024 through January 8, 2025.</p> <p>Findings include:</p> <p>A review of the facility's staffing data from December 30, 2024 through January 8, 2025, revealed that on the following days the facility had a PPD below 3.20.</p> <p>12/31/2024 - 2.80 1/2/2025 - 3.11 1/4/2025 - 3.12 1/6/2025 - 2.98</p> <p>The aforementioned data was confirmed with the Nursing Home Administrator in a telephone interview on January 16, 2025.</p>	P 5640		



# Certified End Page

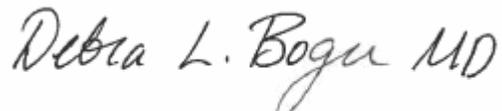
**KING OF PRUSSIA SKILLED NUSING AND REHABILITATION CENTER**

**STATE LICENSE NUMBER: 125902**

**SURVEY EXIT DATE: 01/17/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY