Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

May 18, 2026

CA SENIOR VALLEY FORGE OPERATOR LLC

RE: REVELLE SENIOR LIVING KING OF PRUSSIA
350 GUTHRIE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 14788

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/24/2026, 02/24/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *REVELLE SENIOR LIVING KING OF PRUSSIA* **License #**: *14788* **License Expiration**: *01/16/2027*

Address: *350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *CA SENIOR VALLEY FORGE OPERATOR LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*
Type: *I-2* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*
Type: *Other* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *103* **Waking Staff**: *77*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint, Incident* **Exit Conference Date**: *02/25/2026*

Inspection Dates and Department Representative

02/24/2026 - On-Site:
02/24/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *4th floor* **Capacity**: *28* **Residents Served**: *19*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

02/24/2026 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/09/2026*

Inspections / Reviews *(continued)*

04/14/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *05/16/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *05/18/2026*

05/18/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *05/16/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated , for resident indicates severe problems with judgment and with orientation to time, place, and person. Direct care staff are to "provide supervision and redirection when resident makes unsafe or inappropriate decisions."
Resident assessment and support plan dated indicates that residents has a moderate need for supervision in the community, and a moderate need for judgement and needs assistance because makes decisions that are harmful to themself or others. Direct Care Staff to provide oversight and supervision for safety by monitoring actions and reorienting resident and staff are to provide supervision and redirect when makes unsafe decisions and inappropriate decisions.

On at approximately 8:30 pm, and again on at 9:45 pm, staff found resident engaging in intimate behaviors with resident in resident room. While the residents did not appear distressed at the time they were discovered, both residents have a documented cognitive impairment that affects their ability to consent and make appropriate judgement. Neither resident was able to recall the encounters, recognize each other or express desire for intimate relations with each other when asked. Staff did not provide sufficient supervision of residents and on these dates as required by their support plans.

Plan of Correction ***Accept - 04/14/2026)***

On 2/10/2026 the Health Care Director increased monitoring on Resident and on 2/12/2026 immediately placed a 1:1 with sitter for resident. RASP updated accordingly, documentation shall kept.

By 4/15/2026, the Health Care Director, or designee shall educate current care associates on 2600.23a. Documentation shall be kept.

On 2/13/2026 and 2/17/2026 the Resident Director educated associates conducting 1:1 with Resident Documentation shall be kept.

On 3/3/2026, the Residence Director conducted resident abuse training with current care staff. Associates who did not attend training on 3/3 will have it by 4/15/2026. Documentation shall be kept.

Beginning 4/13/2026, Health Care Director or designee shall observe care provided for two residents, requiring supervision to validate care provided matches the supervision indicated on the RASP, daily for 7 days and then weekly for 4 weeks. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.23a, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 05/18/2026)

42c - Treatment of Residents

2. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident who has a diagnosis of requires total assistance with ambulating and most other ADL's. On the night of , staff person E was in resident s room to assist with putting the resident to bed. The resident pointed out an object on the floor and asked the staff person several times to pick it up, as the resident feared tripping on it. Staff person E did not respond to the residents request despite being asked several times. Resident finally asked, "Did you hear me?" Staff person E replied, "I hear you, but I just don't care." Staff person E then abruptly put resident in to bed, left the resident uncovered and left the room.

Repeat Violation Date: et al.

Plan of Correction ***Accept - 04/14/2026)***

On 1/27/2026, upon learning of the incident that occurred the Residence Director immediately suspended staff person E pending investigation. After investigation completion, on 2/27/2026 the Residence Director terminated Staff person E.

On 1/29/2026, the Residence Director conducted training on 2600.42c with current staff. Associates who did not attend training on 1/29 will have it by 4/15/2026. Documentation shall be kept.

Beginning, 4/13/2026 the Residence Director shall conduct 2 resident interviews per week for 2 weeks and then monthly for 2 months to validate that residents are feeling treated with dignity and respect. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.42c, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented - 05/18/2026)

65d - Initial Direct Care Training

3. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.

65d - Initial Direct Care Training *(continued)*

v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person F, hired on [redacted] provided unsupervised ADL services the week of [redacted] However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeat Violation Date: [redacted] - et al, [redacted] et al.

Plan of Correction ***Accept [redacted] 04/14/2026)***

Staff person F was removed from the schedule upon notification of the Residence Director, during the survey, on 2/24/2026. Staff person F completed [redacted] Direct Care training on 2/26/2026. Certificate will be maintained in the staff person's file.

On 4/9/2026, the Director of Compliance and Survey Management educated the Residence Director on 2600.65d. Documentation shall be kept.

By 4/13/2026, the Residence Director shall complete a current direct care staff audit. Any staff person found to be out of compliance will be removed from the schedule until compliance can be met. "Non-compliance identified during Direct Care audit completed on XX/XX/XXXX by WHO as part of a plan of correction for survey on 2/24/2026" written on the bottom of the certificate. The Residence Director or Healthcare Director will review the direct care certificate for all new staff prior to them being placed on the schedule weekly for 2 weeks and then monthly for 2 months. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.65d, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented ([redacted] - 05/18/2026)

225c - Additional Assessment

4. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

225c - Additional Assessment *(continued)*

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident initial assessment, completed on stated that the resident had no problem with Staff documented resident "combative behaviors" on , when the resident lifted their walker and attempted to hit caregivers. On , resident had a physical altercation with resident , resident spouse, in the room they share. Resident # had not had an updated assessment of their behavior needs since the altercation occurred.

Plan of Correction ***Accept - 04/14/2026)***

After the event, a team member immediately separated Resident and Resident . Memory Care Director assessed for injury.

On 3/1/2026, the Health Care Director reassessed Resident and it was determined that could benefit from memory care unit. Prescreen, DME and RASP were all obtained and completed at that time. Documentation shall be kept.

4/9/2026, the Health Care Director was educated by the Director of Compliance and Survey Management on the requirements of 2600.225c. Documentation shall be kept.

By 4/15/2926, the Health Care Director will review residents with behaviors to validate that updated assessments were completed per 2600.225c. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.225c, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Proposed Overall Completion Date: 05/15/2026

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented - 05/18/2026)

231c - Preadmission Screening

5. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's written cognitive preadmission screening was completed on

Resident was admitted to the Secure Dementia Care Unit (SDCU) on However, the resident's written cognitive preadmission screening was completed on .

231c - Preadmission Screening *(continued)*

Plan of Correction ***Accept - 04/14/2026)***

Resident and Resident prescreens completed, unable to update per requirements of 2600.231c. By 4/10/2026, the Health Care Director noted on the bottom "Resident Record identified by surveyors on 2/24/2026". Documentation shall be kept.

On 4/9/2026, the Health Care Director was educated by the Director of Compliance and Survey Management on the requirements of 2600.231c. Documentation shall be kept.

By 4/15/2026, Healthcare Director shall audit current SDCU resident preadmission screens and verify compliance with 2600.231c. Prescreens out of compliance shall have "Non-compliance identified during Resident Record audit completed on XXXXXX by who as part of a plan of correction for survey on 2/24/2026" written on the bottom of the prescreen. Documentation shall be kept.
Starting 4/10/2026 the Healthcare Director shall bring new SDCU resident prescreens to stand up, prior to resident move in, for the Residence Director to review and validate compliance. This will continue for the next 2 months. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.231c, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented - 05/18/2026)

234a - Admission Support Plan

6. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept - 04/14/2026)***

Resident admission support plan completed on 12/19/2025, unable to update per requirements of 2600.234a. By 4/9/2026, the Health Care Director noted on the bottom "Resident Record identified by surveyors on 2/24/2026". Documentation shall be kept.

On 4/8/2026, Health Care Director educated on 2600.234a by Director of Compliance and Survey Management. Documentation shall be kept.

By 4/15/2026, the Health Care Director will audit current SDCU residents support plans to verify compliance with 2600.234.a. Assessments out of compliance shall have "Non-compliance identified during Resident Record audit completed on XX/XX/XXXX by who as part of a plan of correction for survey on 2/24/2026" written on the bottom of the support plan. Documentation shall be kept.

234a - Admission Support Plan (continued)

Starting 4/10/2026 the Health Care Director shall bring new SDCU resident support plans to stand up, for the Residence Director to review and validate compliance. This will continue for the next 1 months. Documentation shall be kept.

To ensure consistent adherence to Regulation 2600.234a, on 4/22/2026, the above audit findings will be reviewed during the community's next routine Quality Management Performance Improvement Meeting (QMPI) to validate compliance. Additional recommendations shall be implemented. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (█ - 05/18/2026)