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

April 6, 2026

SHANNONDELL INC

RE: THE MEADOWS AT SHANNONDELL
6000 SHANNONDELL DRIVE
THE MEADOWS & REHAB-FLOORS 1&4
AUDUBON, PA, 19403
LICENSE/COC#: 12837

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/17/2025 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: *THE MEADOWS AT SHANNONDELL* **License #**: *12837* **License Expiration**: *03/31/2026*

Address: *6000 SHANNONDELL DRIVE, THE MEADOWS & REHAB FLOORS 1&4, AUDUBON, PA 19403*

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *SHANNONDELL INC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/28/2005* **Issued By**: *CWOPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *206* **Waking Staff**: *155*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/17/2025*

Inspection Dates and Department Representative

09/17/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *171* **Residents Served**: *141*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Chatham C/ Avondale* **Capacity**: *34* **Residents Served**: *27*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *141*
Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *65* **Have Physical Disability**: *0*

Inspections / Reviews

09/17/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/08/2025*

11/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/07/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/20/2025*

Inspections / Reviews *(continued)*

11/21/2025 POC Submission

Submitted By: [redacted]
Date Submitted: *11/19/2025*
Reviewer: [redacted]
Follow Up Type: *Document Submission* **Follow Up Date**: *12/22/2025*

04/06/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *12/22/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On at 7:30 resident was found on floor of their bathroom in fetal position at base of toilet. pupils reactive but not equal, resident was admitted to the hospital with a to the head and . The home did not submit an incident report to the Department.

On at 7:43 PM resident was found unresponsive, had a blue pallor and was in distress. The resident was given the twice and 3 additional thrusts were made to the resident's chest, possibly dislodging food. Resident was sent to the hospital. The home did not submit an initial incident report to the Department. The home did not submit an initial incident report to the Department. The home did send a notice of reportable incident on , indicating that the resident was sent to the hospital on and expired on . No details regarding the reason for the transport to the hospital were provided in the incident report.

On at 10:41 AM resident was found on floor lying in front of wheelchair with the nightstand and lamp knocked over. The resident had a bruise on forehead and skin tear on right forearm. Vitals were taken and the resident had a temp of and . The resident's assessment and vitals were outside of normal baseline and was sent to the hospital for evaluation and treatment. The home did not submit an initial incident report to the Department. The home did send a notice of reportable incident on , indicating that the resident was sent to the hospital on and expired on . No details regarding the reason for the transport to the hospital were provided in the incident report.

Plan of Correction ***Accept - 11/21/2025)***

Any resident experiencing a "serious bodily injury or trauma requiring treatment at a hospital or medical facility", will be submitted in writing using the departments reportable incident and notification form. This will be completed timely within 24 hours.

Upon completion of the Reportable Incident Report, PCHA or designee will review report for content and details. Content of the report will include details as to the cause for the reportable.

Reporting forms will be submitted via email to the department upon completion.

Copies of reports will continue to be secured in individual resident file with additional copy maintained by the PCA and to be made available upon request by the department.

DHS sample Reportable Incident Report forms will be presented to PCHA and designee with education as to how to complete thoroughly and in detail, a sample of same will be made available to for review and reference. Inservice of PCHA and designee to be completed by 12/19/25.

Audits of the Reportable Incident Report will begin on 11/24/25, to be conducted weekly by the PCHA or designee. This audit will be conducted for 2 months or until compliance is achieved.

16c Written Incident Report (continued)

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] 04/06/2026)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] at 10:25 AM, resident assignment sheets which included information about showers and incontinence care, were unlocked, unattended, and accessible on a medication cart in the Chatham B hallway.

Plan of Correction ***Accept ([redacted] - 11/17/2025)***

Any resident record, regardless of nature of same, will be secured confidentially within nursing station or electronically.

Nursing staff will be in serviced by Administrator or designee, as to the proper handling of resident information. This will be completed by 11/30.

Top of the medication carts will be audited weekly for 2 months or until compliance has been achieved to ensure no confidential information is easily accessible to unauthorized persons.

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] 04/06/2026)

23a - Activities of Daily Living Assistance

3. 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 [redacted], for resident [redacted] indicates that the resident requires assistance with toileting needs and resident is unable to ambulate independently and has had several documented falls since their admission.

At an unknown time during the 11p 7am shift starting on [redacted], resident [redacted] had an unwitnessed fall, sustaining a skin tear to their arm and was laying on the floor of their bathroom for an unidentified length of time. The resident laid on the floor long enough for blood from the skin tear to pool and dry on the floor. The resident lay in wet briefs and when found around 7am on the morning of [redacted], resident [redacted]s incontinence brief was saturated and the resident's clothing was wet. Resident [redacted] temperature was 93.2 degrees Fahrenheit. Staff of the home report that they receive training that they are to check on residents every two hours at least, and if the resident is a 'frequent faller' they are to check on

23a Activities of Daily Living Assistance (continued)

the resident more often. There is no indication staff checked on the resident every two hours during the night shift, as required by the homes initial care training. On [redacted] and [redacted], Resident [redacted] did not receive assistance with care as required.

Plan of Correction ***Accept[redacted] 11/21/2025)***

Resident [redacted] would attempt to ambulate/transfer without assistance.

Re education will be conducted with DCS related to the need for and importance of checking on residents routinely to aid in their safety and wellbeing, to be completed by 12/19. Documentation of re education to be maintained and available to the department upon request.

Weekly interviews will be conducted with random residents to discuss their care needs and the effectiveness of which they are met. These interviews will be conducted by the PCHA or designee beginning 12/1/25. Documentation of interviews will be maintained and made available upon Department request. These interviews will be conducted for 2 months.

Licensee's Proposed Overall Completion Date: *12/01/2025*

Implemented [redacted] - 04/06/2026)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

According to Resident [redacted] Resident Assessment and Support Plan dated [redacted] Resident [redacted] requires assistance with toileting needs, bowel and bladder management, personal hygiene and is noted to be unable to ambulate independently unless they are using their electric wheelchair. At some unknown time during the overnight shift beginning on [redacted] until approximately 7am On [redacted], resident [redacted] had an unwitnessed fall. On [redacted], the day shift staff found resident [redacted] laying on the floor of their private bathroom, for an unknown period of time, with a visible skin tear on their arm, dried blood on both the resident's shirt and in a trail along the floor, and resident was found to be wearing an overly saturated incontinence brief having soaked through to their clothing. The home has no documentation verifying that resident [redacted] was checked on at any time during the overnight shift, despite the home training staff to check on resident every two hours or more from residents with a history of falls. When staff found the resident on the morning of [redacted] around 7:00 AM, the resident's temperature was [redacted] Fahrenheit, resident was confused and not at their baseline.

Additionally, on [redacted] the resident's physician ordered a urine culture and sensitivity lab test after resident exhibited increased confusion. The staff never obtained a urine sample to send to the lab to check for infection.

Following the unwitnessed fall, the resident was admitted to the hospital on [redacted]. The resident's hospital records indicate the resident was admitted with a temperature of 86 degrees. Fahrenheit. Laboratory studies and imaging conducted on [redacted] and [redacted] at the hospital were concerning for [redacted] with both [redacted] and [redacted] sources as indicated by the treating physicians. Resident [redacted] expired at the hospital on [redacted] of as a result of [redacted]

42b Abuse (continued)

, and

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Plan of Correction ***Accept (11/21/2025)***

Upon discovery of resident, immediately intervention took place. Based on findings of assessment conducted by nurse, emergency responders were contacted with resident transported to hospital for intervention.

Abuse training to be conducted to licensed nurses and DCS by administrator or designee to include verbal discussion and handouts. Retraining of licensed nurses and DCS will take place on 12/2/25, 12/4/25, and 12/10/25. Training will include, but not limited to, neglect of care, intimidation, physical or verbal abuse, mistreatment, subject to corporal punishment, or disciplined in any way. Training to be completed by 12/17/25 by the PCHA or designee. Verification of training by signature to be made available to the department upon request.

Weekly audits conducted of resident interviews to include feedback related to care received.

Failure to follow prescribers orders addressed in 187d.

Licensee's Proposed Overall Completion Date: *12/17/2025*

Implemented - 04/06/2026)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On at 10:16 AM, resident room had a strong odor of old urine. The windows were open, and the source of the odor could not be located. On the wall behind the trash can there was a brown stain of a dried substance measuring about 1 foot in length along the baseboard trim. In the bathroom of the resident's room there was a splatter of dried blood on the floor.

Plan of Correction ***Accept - 11/21/2025)***

Brown "substance" stain was caused by resident continuously running electric wheelchair against the base board trim.

The residents room failed to be cleaned and returned to good repair after resident went to hospital. The resident was very destructive of living space.

Licensed nurses and DCS to be educated on the importance of immediately reporting area of a resident room in need of attention to maintenance and in good sanitary condition. This training will be completed by 12/19/25.

Any area noted to be in need of maintenance repair or housekeeping attention, will be addressed in a timely fashion.

Rounds to be completed routinely by the PCA or designee of all living personal care areas; with any area requiring

85a - Sanitary Conditions (continued)

attention, a work order will be placed. This will begin on 11/24/25.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented [redacted] - 03/10/2026)

101o - Walls, Floors, Ceilings

6. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The walls in resident [redacted] room were in extreme disrepair. There was a large gash/hole in the dry wall under the windows, and another gash/hole under the towel rack in the connected bathroom. The edges of the walls near the closet had no paint or drywall left on them and metal corners were visible from floor to ceiling.

Plan of Correction ***Accept ([redacted] - 11/21/2025)***

Resident was very destructive to [redacted] living space, unintentionally. [redacted] frequently bumped into walls, baseboard trim, and doorways while using electric wheelchair.

Resident had been seen by physical therapy related to safe use of wheelchair on several occasions.

Nursing staff will be educated on the need to have timely reporting of any area in resident living space in need of repair. This will be completed by 12/19/25.

Routine rounds to include inspection of random resident rooms with focus on areas of disrepair. This will begin on 11/24/25.

Work order to be submitted for any needed repairs to maintenance department.

Documentation to be maintained of identifiable areas in need of repair and outcome by PCA or designee. This documentation to be maintained by Administration and made available to department upon request.

Licensee's Proposed Overall Completion Date: *12/19/2025*

Implemented ([redacted] - 03/10/2026)

187c - Refusal of Medication

7. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

From [redacted] resident [redacted] refused their [redacted] for nebulization 4 times daily. The home did not report the refusal to the resident's doctor as required.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

187c - Refusal of Medication (continued)

The provider will be notified within 24 hours of all resident medication refusals.

The ADON or designee will review the home's medication administration and documentation procedures with all licensed nurses. Staff will be in serviced on the requirement that: All medication refusals must be documented on both the MAR and in the resident's record. This reeducation will be completed by 11/30.

The ADON or designee will randomly audit MARs weekly for 2 months to ensure refusals are properly documented and prescribers are notified within 24 hours. This will begin 12/01.

Licensee's Proposed Overall Completion Date: *02/03/2026*

Implemented [redacted] 03/10/2026)

187d - Follow Prescriber's Orders

8. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On [redacted] Resident [redacted] was prescribed an order to obtain a [redacted] with culture and sensitivity screening. However, a specimen was not obtained and sent for this order.

Resident [redacted] is prescribed [redacted] give 1 tablet by oral route once daily. However, this medication was not administered to resident [redacted] on [redacted] because the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 11/17/2025)***

On 9/3/2025, Resident [redacted] was prescribed an order to obtain a urinalysis with culture and sensitivity screening. However, a specimen was not obtained and sent for this order. Resident [redacted] is prescribed [redacted] 1 tablet by mouth daily. However, this medication was not administered on 9/2/2025 because it was not available in the home.

For Resident [redacted] the urinalysis with culture and sensitivity was not obtained on 9/3. Resident was made aware on 9/3 that a specimen needed to be collected and the instructions to do same. The nurse went to collect the specimen the morning of 9/3 however the resident discarded of the specimen.

For Resident [redacted], [redacted] was obtained and administration was resumed on 9/3. The resident did not experience any adverse effects due to the missed dose. The Medication Administration Record (MAR) was reviewed and updated to accurately reflect administration status and documentation.

All licensed staff responsible for medication administration and coordination of medical orders will be in-serviced on regulation 187d and the homes medication administration policy, following Prescriber's Orders, emphasizing timely fulfillment of lab orders and ensuring medication availability. This will be completed by 11/30. All orders will be reviewed during routine clinical meetings.

The ADON or designee will conduct a weekly audit for 2 months by reviewing a sample of physician orders and corresponding documentation to ensure compliance. Any discrepancies will be addressed immediately. This will begin 12/1.

187d Follow Prescriber's Orders (continued)

Licensee's Proposed Overall Completion Date: *01/26/2026*

Implemented [redacted] - 03/10/2026)