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 12/18/2025 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**: *231* **Waking Staff**: *173*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *12/18/2025*

Inspection Dates and Department Representative

12/18/2025 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *171* **Residents Served**: *155*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Chatham C/Avondale* **Capacity**: *34* **Residents Served**: *33*

Hospice

Current Residents: *18*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *154*
Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *76* **Have Physical Disability**: *2*

Inspections / Reviews

12/18/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/24/2026*

01/26/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/22/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/31/2026*

Inspections / Reviews *(continued)*

02/03/2026 POC Submission

Submitted By: [redacted] **Date Submitted**: *01/28/2026*

Reviewer: [redacted] **Follow Up Type**: *Document Submission* **Follow Up Date**: *02/27/2026*

04/06/2026 Document Submission

Submitted By: [redacted] **Date Submitted**: *02/26/2026*

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 [redacted] Resident #[redacted] had a choking incident. Staff performed the Heimlich Maneuver 3 times. The resident was sent to the hospital on [redacted] due to an inability to swallow. The home did not report this incident to the department.

On [redacted] Resident #[redacted] sustained a fall with injury to the left side of [redacted] scalp and was sent to the hospital. The resident was treated in the hospital with 2 staples placed to the left scalp and returned to the home the same day. The home did not report this to the department until [redacted].

Plan of Correction ***Accept [redacted] 02/03/2026)***

After completing root cause, the internal processes resulting in this violation have been changed. The person responsible for submitting these reports prior this violation is no longer with the organization. The current process is that Incidents that require reporting to the department within 24 hours will be completed by the Administrator or designee within 24 hours.

The nursing staff will be in-serviced by the Administrator on this requirement. This will be completed by February 13, 2026

From 2/16/26 - 5/1/2026, the Administrator or designee will keep a log of incidents that require reporting and the date that they were reported for verification purposes. Any non-compliance will be immediately addressed.

Licensee's Proposed Overall Completion Date: *02/27/2026*

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 9:17 A.M., the electronic medication record and used medication cards with resident's names and prescription information were unlocked, unattended, and accessible on the 5000 building b wing medication cart.

On [redacted] at 9:35 A.M. and again at 11:29 A.M., the resident assessment and support plans and resident lab logs were unlocked, unattended, and accessible in the 5000 building 4th floor nursing office.

Plan of Correction ***Accept [redacted] 02/03/2026)***

Resident information on the 1st floor b wing medication cart was secured during the survey.

17 Record Confidentiality (continued)

After being observed open, the door to the 4th floor nursing office was closed during the survey

To ensure privacy, medication carts throughout the facility will be locked when not in use. Laptops, on the medication carts, will be "closed" appropriately when not in use.

The nursing staff will be in serviced by the ADON on this requirement. This will be completed by February 13, 2026

From 2/16/2026 5/1/2026, the ADON or designee will complete random audits throughout the facility, verifying that med carts and laptops are properly secured when not in use. At a minimum, each medication cart on each nursing unit will be audited on a weekly basis. Any non compliance will be addressed immediately.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented (- 04/06/2026)

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On at 10:31 A.M., Resident toilet was observed with feces smeared on the bottom of the toilet and an accumulation of dust and dirt at the corner of the shower.

Plan of Correction ***Accept 02/03/2026)***

At the time of the survey, Resident room had the flooring replaced in the entire unit. The Senior Administrator advised the representative from the Department of this. As a result, between the time that the floor installation was completed and the time that it took the housekeeping staff to complete cleaning the area, there was dust / debris (that is expected during this process) in the room.

The feces smear that was observed in Resident # s toilet was inside the toilet and was because of Resident recently using the toilet. The toilet was flushed, leaving a small smear in the toilet bowl.

Resident and all resident rooms receive regularly scheduled housekeeping services from representatives of our housekeeping staff

The nursing staff will be in serviced by the ADON on importance of monitoring environment to ensure sanitary conditions are maintained. This will be completed by 2/13/2026

From 2/16/2026 5/1/2026, the administrator or designee will complete rounds to verify sanitary conditions are being maintained.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented 03/10/2026)

88a - Surfaces

4. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

At 9:15 A.M. an active leak was observed in the walkway/hallway between the 5000 and 6000 personal care buildings. Water was visibly running down the wall; the ceiling and the carpeted floor was wet.

At 10:44 A.M. Chatham C's pantry kitchen was observed with a large brown stain above the kitchen and dining area.

Plan of Correction ***Accept (- 02/03/2026)***

The Senior Administrator was present with the representative from the Department of Human Services when the area in the hallway between the 5000 and 6000 buildings was observed. At no time, was water visibly "running down the walls". The area in question is not under the Personal Care licensure as it is in an administrative hallway. This was explained to the representative at the time of the visit.

The ceiling tiles in the hallway between the 5000 and 6000 building that were stained were replaced.

The hallway between the 5000 and 6000 building will be inspected to verify that there are no leak concerns. This will be completed by the maintenance department before 1/30/2026. If any remediation is identified, it will be completed by 2/6/2026.

The ceiling tile above the Chatham C Wing kitchen was replaced.

The nursing staff and maintenance department will be in-serviced by the ADON or designee on the importance of observing all areas and reporting anything that needs attention appropriately. This will be completed by February 13, 2026.

From 2/16/2026 - 5/1/2026, the Maintenance Director or designee will conduct rounds through various areas of the facility to ensure that there is no condition in need of attention. The location of these areas will rotate each week. Any area identified to be in need of attention will be addressed immediately.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented - 03/10/2026)

100b - Removal Snow/Obstructions

5. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

At 10:07 A.M., an approximate 1 inch accumulation of snow was observed on the path to the Avondale courtyard exit.

At 10:23 A.M. an approximate 2 inch accumulation of snow and ice was observed on the patio used for egress from exit door near the salon area.

100b - Removal Snow/Obstructions *(continued)*

Plan of Correction ***Accept - 02/03/2026)***

The Avondale courtyard exit is the exterior secured area for one of our memory care units. At the time of the survey, the area had not yet been shoveled by a member of our snow removal team. Upon being pointed out, our team altered their schedule and reported to the area to complete shoveling. During winter conditions, this area is not used by our residents.

The patio used for egress from the exit door near the salon area is an exterior area used for visitors and our activities staff. During winter conditions, this area is not used. Upon being notified, our snow removal team altered their schedule and reported to the area to clear the snow from this area.

The Shannondell at Valley Forge community has a snow removal team of between 30 and 40 individuals. Ultimately, all areas on the campus are attended to, with priorities given to roadways, sidewalks and areas used by residents.

The Administrator or designee will monitor snow removal to ensure that these 2 areas, as well as any other exterior area, is managed by our snow removal team timely. The Administrator or designee will stay in contact with the snow removal supervisor throughout any storm resulting in accumulations throughout the duration of the storm to verify that all areas in need of shoveling, are properly addressed. The snow in the courtyards will be removed within 48 hours of the completion of any storm.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented - 03/10/2026)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On at 9:55 A.M., the home's Berwyck B exit door was not able to be easily opened without using a significant amount of force.

Plan of Correction ***Accept (- 02/03/2026)***

The Berwyck B Wing exit door is at the lowest level of our emergency stairwell and is only used in the event of an emergency. This stairwell is not accessible unless there is an emergency. The senior administrator was present with the representative from the Department and confirmed that the door needs extra force to open.

All emergency stairwell doors have the standard "push bar" on them that require full compression to open. An alternate employee, from our maintenance department, was nearby during this observation and was able to open the door by pressing the emergency push bar. The door worked as it was supposed to work.

The maintenance department will be in-serviced by the Director of Maintenance on the importance of emergency stairwell doors operating correctly. This will be completed by 2/13/2026

The Maintenance Director or designee, maintenance will complete an inspection of all emergency stairwell exit

121a Unobstructed Egress (continued)

doors to ensure that they work as they are intended to. This will be completed by 2/13/2026

From 2/16/2026 5/1/2026, the maintenance department will inspect the Berwyck B Wing exit door and other doors in emergency stairwells to verify that they are operating correctly. These inspections will be completed weekly. f any area is identified as being in need of attention, it will be addressed immediately.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented - 03/10/2026)

127a - Portable Space Heaters

7. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On at 10:23 A.M., a "heat surge" portable space heater was observed on the desk in the salon area.

Plan of Correction ***Accept - 02/03/2026)***

The “heat surge” portable space heater observed on the desk in the salon area was removed.

The salon staff will be in serviced on this issue. This will be completed by 2/13/2026.

From 2/16/26 5/1/26, the Director of Maintenance or designee will complete rounds in both salon areas to ensure that no “heat surge” portable space heaters are present. These rounds will be completed weekly.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented - 03/10/2026)

183b - Meds and Syringes Locked

8. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident’s room.

Description of Violation

On at 9:17 A.M., the medication cart was unlocked, unattended, and accessible in 1st floor 5000 building b wing.

On at 10:31 A.M., ammonium lactate lotion was unlocked, unattended, and accessible in resident bedroom

On at 12:38 P.M. saline nasal spray and was present in Resident bedroom unlocked and accessible. Resident # has not been assessed to self administer their medications.

Repeat Violation:

183b Meds and Syringes Locked (continued)

Plan of Correction ***Accept - 02/03/2026)***

The unlocked, unattended medication cart on 1st floor 5000 building was also mentioned in 17 above. This cart was secured during the survey
The lotion in room was removed.

Resident had OTC Nasal Spray in their room without the facility's knowledge.
The facility is not able to identify Resident We do not have a resident by this name.

The ADON or designee will complete an in service with the nursing staff on the facility policy for medication storage. This will be completed by 2/13/2026

From 2/16/26 5/1/26, the ADON or designee will complete random audits verifying that medications are not stored in inappropriate locations. These audits will include resident rooms and common areas and will rotate throughout the facility locations each week. If any medications are found to be inappropriately stored, immediate corrective action will take place.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented (03/10/2026)

183e - Storing Medications

9. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Loose pills were observed in the following medication carts listed below:

-
-
-
-

Resident # was observed with a puncture to the foil in the blister pack at numbers: 1, 9, 10, and 12.

Resident # was observed with a puncture to the foil in the blister pack number 5.

Plan of Correction ***Accept 02/03/2026)***

The Administrator is evaluating options for alternative medication storage carts to verify that the current arrangement continues to be most effective. Alternative solutions to be considered to address the loose pill and puncture to the foil issue.

183e - Storing Medications (continued)

The loose pills identified during the survey were discarded appropriately

The ADON or designee will complete in-servicing with the licensed nursing staff on propre medication handling, using caution when moving throughout the med cart to reduce the frequency that pills may become loose. This will be completed by 2/13/2026

From 2/16/26 - 5/1/26, the ADON or designee will complete audits of medication carts to verify that meds are stored properly, there are no loose pills and that there is no punctured foil. These will be completed weekly and the audits will include all med carts in the facility.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented 03/10/2026)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident # is prescribed and as needed.
On these medication(s) were not available in the home.

Repeated Violation: et al.

Plan of Correction ***Accept - 02/03/2026)***

The physician approved Resident s order for as needed to be discontinued because resident #6 does not take this medication.

The ADON or designee will complete an audit to ensure that active physician orders are only for medications that our residents are taking or that they need to have as part of their personal medication regimen.

The ADON or designee will complete an in-service for licensed nursing staff reminding them to monitor for medication availability and to follow re-order procedures when needed. This will be completed by 2/13/2026

From 2/16/26 - 5/1/26, The ADON will conduct audits of facility medication carts, as is being completed for 183e, to ensure that physician ordered medications are available. These audits will be completed weekly and include all med carts in facility.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented (- 03/10/2026)

187d - Follow Prescriber's Orders

11. Requirements

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident [redacted] is prescribed [redacted] tablet daily. However, this medication was not administered on [redacted] and [redacted] because the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 02/03/2026)***

This medication is a specialized medication, ordered by the resident's oncologist and it is not available from the facility pharmacy. As a result, the resident's family assists with managing the supply and ensuring delivery is made appropriately.

On 12/16, our nurse contacted the pharmacy (Biologics) to check on the status of the delivery date because the supply was going to run out. The pharmacy, biologics informed our nurse that the delivery would arrive on 12/18

Our nurse updated our medical team and they approved "holding" the medication until it arrived. The original order was not changed as there was no change to any part of the instructions. The only change was that the medication could not be administered on 12/17 and 12/18 as it had not arrived from the pharmacy. The resident was aware of this. The family was aware of this. The doctor was aware and had no concerns, and, provided instructions to hold the medication until it arrived.

The Administrator discussed the ordering / delivery process with the family of the resident on 1/27/2026. The primary issue is that before sending an additional supply of medications, the outside pharmacy has to obtain information from the resident every time. They will not take the information from the family. The ADON is working with the resident, family and pharmacy with the hope of simplifying this process.

The licensed nursing staff will be in-serviced on the importance of monitoring this inventory and having proactive communication with the family so that delivery is made timely. This will be completed by 2/13/2026

From 2/16/26 - 5/1/26, the ADON or designee will audit this medication to ensure all elements of this process are completed correctly. This audit will be completed monthly.

Licensee's Proposed Overall Completion Date: *02/27/2026*

Implemented [redacted] 04/06/2026)