DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __--______________ B. WING: ________________	(X3) DATE SURVEY COMPLETED: 05/04/2026

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on May 4, 2026, it was determined that Rehab at Shannondell was not in compliance with the requirements of 42 CFR 483.73.	E 0000		
E 0006 SS=F	483.73(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E 0006	4.1. The facility will update the facility assessment to include the All Hazards Assessment annually. 4.2. The Director of Maintenance or designee Services will monitor bi-annually to meet compliance with E-006.	Completion Date: **06/30/2026** Status: **APPROVED** Date: **06/09/2026**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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	396101	A. BLDG: -- B. WING:	**05/04/2026**

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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E 0006 SS=F	Continued from page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	E 0006		

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E 0006 SS=F	Continued from page 2 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by:	E 0006		

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E 0006 SS=F	Continued from page 3 Based on documentation review and interview, it was determined the facility failed to ensure the Emergency Preparedness Plan was based on and included a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach and include strategies for addressing emergency events identified by the risk assessment. Findings include: Document review on May 4, 2026, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan did not include a documented community-based risk assessment, utilizing an all-hazards approach and the facility-based risk assessment was last updated in 2024. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmed the missing community-based HVA and the required annual update to the facility-based HVA.	E 0006		

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E 0013 SS=C	483.73(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of	E 0013	4.1. The facility will update the emergency preparedness to include the community based risk assessment 4.2. The Director of Maintenance or designee Services will monitor bi-annually to meet compliance with E-013.	Completion Date: **07/07/2026** Status: **APPROVED** Date: **06/09/2026**

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E 0013 SS=C	Continued from page 5 medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:	E 0013		

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E 0013 SS=C	Continued from page 6 Based on documentation review and interview, it was determined the facility failed to ensure emergency preparedness policies and procedures, based on the emergency plan, risk assessment, were updated at least annually, affecting the entire component. Findings include: Document review on May 4, 2026, at 8:30 a.m., revealed the facility could not provide an emergency preparedness plan community-based risk assessment which is one of the components required to update the emergency preparedness policies and procedures annually. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmedthe missing community-based HVA and the required annual update to the facility-based HVA.	E 0013		
E 0018 SS=C		E 0018		

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E 0018 SS=C	Continued from page 7 483.73(b)(2) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the	E 0018	4.1. The facility will update the emergency preparedness plan to include a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency; the specific name and location of the receiving facility or other location of on-duty staff and sheltered patients are relocated during an emergency. 4.2. The Director of Maintenance or designee will monitor bi-annually to meet compliance with E-0018.	Completion Date: **07/07/2026** Status: **APPROVED** Date: **06/09/2026**

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E 0018 SS=C	Continued from page 8 [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 0018		

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E 0018 SS=C	Continued from page 9 *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by:	E 0018		

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E 0018 SS=C	Continued from page 10 Based on documentation review and interview, it was determined the facility failed to develop Emergency Plan policies and procedures that included a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency; the specific name and location of the receiving facility or other location if on-duty staff and sheltered patients are relocated during an emergency, affecting the entire facility. Findings include: Document review on May 4, 2026, at 8:30 a.m., revealed the Facility's Emergency Preparedness Plan did not include a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency; the specific name and location of the receiving facility or other location if on-duty staff and sheltered patients are relocated during an emergency. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmedthe missing policies and procedures.	E 0018		
E 0025 SS=C		E 0025		

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E 0025 SS=C	Continued from page 11 483.73(b)(7) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the	E 0025	4.1. The facility will update the emergency preparedness plan to provide arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. 4.2. The Director of Maintenance or designee will monitor bi-annually to meet compliance with E-0025.	Completion Date: **07/07/2026** Status: **APPROVED** Date: **06/09/2026**

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E 0025 SS=C	Continued from page 12 continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, it was determined the facility failed to provide arrangements with other facilities, affecting the entire component. Findings include: 1. Document review on May 4, 2026, at 8:30 a.m., revealed the facility failed to provide arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmedthe missing transfer agreements.	E 0025		

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E 0035 SS=C	483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by:	E 0035	4.1. The facility will update the emergency communications plan to include a method of sharing information from the emergency plan with the residents and their families or representatives, affecting the entire facility. 4.2. The Director of Maintenance or designee will monitor bi-annually to meet compliance with E-0035.	Completion Date: **07/07/2026** Status: **APPROVED** Date: **06/09/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: -- B. WING:	(X3) DATE SURVEY COMPLETED: 05/04/2026

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0035 SS=C	Continued from page 14 Based on document review and interview, it was determined the facility failed to maintain and update an emergency preparedness communication plan that includes a method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families or representatives. Findings include: Document review and interview on May 4, 2026, at 8:30 a.m., revealed the emergency communications plan did not include a method of sharing information from the emergency plan with residents and their families or representatives, affecting the entire facility.Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmed the emergency communications plan did not include a method of sharing information from the emergency plan with residents and their families or representatives.	E 0035		

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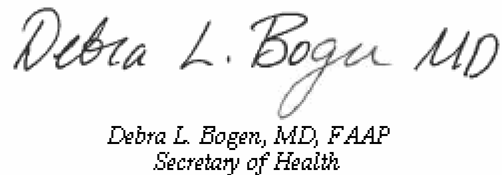
REHAB AT SHANNONDELL

STATE LICENSE NUMBER: 17580201

SURVEY EXIT DATE: 05/04/2026

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 02 B. WING:	(X3) DATE SURVEY COMPLETED: 05/04/2026

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

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K 0000	INITIAL COMMENT Facility ID #17580201 Component 02 Meadows II Based on a Medicare/Medicaid Recertification Survey completed on May 4, 2026, it was determined that Rehab at Shannondell was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a four-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0225 SS=E		K 0225		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **396101**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 02 B. WING:	(X3) DATE SURVEY COMPLETED: **05/04/2026**

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0225 SS=E	Continued from page 1 NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	4.1. The chairs were permanently removed from the third floor C-wing, stair # 2, the third floor B-wing, stair # 3, and the third floor A-wing, stair # 4 on Tuesday, May 5th, 2026. 4.2. The maintenance staff will be in-serviced on importance of verifying that stairwells are cleared Stairways and smokeproof enclosures used 4.3. The maintenance staff will perform monthly audits to confirm that stairwells are cleared. Audits will be completed for 6 months. 4.4. The maintenance director will monitor to meet the compliance	Completion Date: **06/30/2026** Status: **APPROVED** Date: **06/09/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **396101**	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 02 B. WING:	(X3) DATE SURVEY COMPLETED: **05/04/2026**

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K 0225 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to maintain stair towers, affecting one of five levels. Findings include: 1. Observations on May 4, 2026, revealed chairs were stored on landings in the following locations: a. 11:30 a.m.- on the third floor C-wing, stair #2. b. 11:40 a.m.- on the third floor B-wing, stair #3 c. 11:50 a.m.- on the third floor A-wing stair #4. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmed the storage within the stair towers.	K 0225		
K 0321 SS=E		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 02 B. WING:	(X3) DATE SURVEY COMPLETED: 05/04/2026

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

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K 0321 SS=E	Continued from page 3 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	4.1. On the second floor, the common area soiled utility room door latch was repaired on May 4th, 2026. 4.2. The maintenance staff will be in-serviced to meet compliance requirements of K-0321; NFPA 101 Hazardous areas – enclosures. 4.3. The maintenance staff will perform monthly audits to meet compliance requirements of K-0321 to November 30th, 2026. 4.4. The maintenance director will monitor to meet the compliance requirements of K-0225.	Completion Date: **06/30/2026** Status: **APPROVED** Date: **06/09/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396101	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 02 B. WING:	(X3) DATE SURVEY COMPLETED: 05/04/2026

NAME OF PROVIDER OR SUPPLIER: **REHAB AT SHANNONDELL** STATE LICENSE NUMBER: **17580201**	STREET ADDRESS, CITY, STATE, ZIP CODE: **5000 SHANNONDELL DRIVE AUDUBON, PA 19403**

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous areas in sprinklered locations, affecting one of five levels. Findings Include: 1. Observation on May 4, 2026, at 12:15 p.m., revealed, on the second floor, the common area soiled linen room door failed to positively latch when tested. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmed the door deficiency.	K 0321		
K 0923 SS=E		K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396101	A. BLDG: 02 B. WING:	**05/04/2026**

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
REHAB AT SHANNONDELL STATE LICENSE NUMBER: **17580201**	**5000 SHANNONDELL DRIVE** **AUDUBON, PA 19403**

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K 0923 SS=E	Continued from page 5 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	4.1. The empty freestanding oxygen cylinder on the 3rd floor rom 5352 was removed & placed into the proper oxygen storage room on May 4th, 2026. The corridor malfunction identified on the c hall oxygen storage door will be repaired to ensure proper closure. 4.2. The maintenance staff will be in-serviced to meet compliance requirements of K-0923; NFPA 101 Gas equipment – Cylinder & container storage. 4.3. The maintenance staff will perform monthly audits to meet compliance requirements of K-0923 to November 30th, 2026. 4.4. The maintenance director will monitor to meet the compliance requirements of K-0923.	Completion Date: **06/30/2026** Status: **APPROVED** Date: **06/09/2026**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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K 0923 SS=E	Continued from page 6 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain oxygen storage requirements, affecting one of five levels. Findings include: 1. Observation on May 4, 2026, revealed the following oxygen storage deficiencies: a. 11:30 a.m., 1-freestanding oxygen cylinder, on the third floor room 5352. b. 11:40 a.m., C-Hall oxygen storage room door failed to close and latch due to coordinator malfunction. Exit interview with the Maintenance Director on May 4, 2026, at 1:30 p.m., confirmed the oxygen storage deficiencies.	K 0923		

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REHAB AT SHANNONDELL

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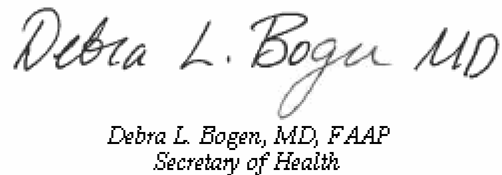

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