

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

September 18, 2026

[REDACTED]
SHIRLEY HOME FOR THE AGED INC
[REDACTED]
[REDACTED]

RE: SHIRLEY HOME FOR THE AGED
17050 COUNTRY VIEW LANE
SHIRLEYSBURG, PA, 17260
LICENSE/COC#: 34397

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/28/2026 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,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: SHIRLEY HOME FOR THE AGED

License #: 34397

License Expiration: 12/12/2026

Address: 17050 COUNTRY VIEW LANE, SHIRLEYSBURG, PA 17260

County: HUNTINGDON

Region: CENTRAL

Administrator

Name: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Legal Entity

Name: SHIRLEY HOME FOR THE AGED INC

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP

Date: 04/02/2001

Issued By: Labor and Industry

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 26

Waking Staff: 20

Inspection Information

Type: Partial

Notice: Unannounced

BHA Docket #:

Reason: Complaint

Exit Conference Date: 05/28/2026

Inspection Dates and Department Representative

05/28/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 42

Residents Served: 26

Secured Dementia Care Unit

In Home: No

Area:

Capacity:

Residents Served:

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 13

Are 60 Years of Age or Older: 25

Diagnosed with Mental Illness: 10

Diagnosed with Intellectual Disability: 3

Have Mobility Need: 0

Have Physical Disability: 0

Inspections / Reviews

05/28/2026 Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/15/2026

06/24/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/16/2026

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 07/01/2026

Inspections / Reviews *(continued)*

09/18/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/16/2026

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

Resident [REDACTED] is prescribed [REDACTED] Inject 20 units at subcutaneously at bedtime. This medication was not administered on [REDACTED] because it wasn't available. This medication error was not reported to the Department.

Resident [REDACTED] is prescribed [REDACTED] subcutaneously weekly on Friday. This medication was not administered on [REDACTED] because it wasn't available. This medication error was not reported to the Department.

Plan of Correction

Accept [REDACTED] - 06/24/2026)

Reeducation of LPN/Med. Techs regarding not administered medications that these are medication errors and need report to the Physician, Administrator, and to the Department of Human Resources at a meeting on 6/11/2026.

New Administrator as of 6/1/26 will ensure that these errors are faxed according to regulation.

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented [REDACTED] - 09/18/2026)

185a Implement Storage Procedures**2. 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 [REDACTED] gets blood sugar tested three times daily. A comparison of blood sugar readings stored in the resident's glucometer was made against the blood sugar readings documented on the medication administration records (MARs) and the following discrepancies were observed:

- On [REDACTED] at 8:22 AM, a reading of [REDACTED] is stored in the meter but not documented on the MARs
- On [REDACTED] at 8:21 AM, a reading of [REDACTED] is stored in the meter but not documented on the MARs
- On [REDACTED] at 12:02 PM, a reading of [REDACTED] is stored in the meter but not documented on the MARs
- On [REDACTED] at 12:00 PM, a reading of [REDACTED] is documented on the MAR but not stored in the meter
- On [REDACTED] at 8:00 AM, a reading of [REDACTED] is documented on the MAR but not stored in the meter

Resident [REDACTED] gets blood sugar tested once daily. A comparison of blood sugar readings stored in the resident's glucometer was made against the blood sugar readings documented on the MARs and the following discrepancy was observed:

- On [REDACTED] at 5:25 AM, a reading of [REDACTED] is documented on the MAR but is not stored in the meter

Resident [REDACTED] gets blood sugar tested once daily. A comparison of blood sugar readings stored in the resident's

185a Implement Storage Procedures (continued)

glucometer was made against the blood sugar readings documented on the MARs and the following discrepancy was observed:

On [REDACTED] at 9:02 AM, a reading of [REDACTED] was stored in the resident's meter, however, was not documented on the MARs

Plan of Correction**Accept [REDACTED] 06/24/2026)**

Reeducated LPN/Med. Techs regarding the need to chart all information at a staff meeting on 6/11/26. It was explained the importance of charting of these blood sugars. All stated understanding.

Administrator will do a chart audit weekly to ensure that blood sugar readings are recorded and counsel staff as needed for missing information.

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented [REDACTED] - 09/18/2026)**187c - Refusal of Medication****3. 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

Resident [REDACTED] is prescribed [REDACTED], inject units subcutaneously three times daily with meals based upon a sliding scale if blood sugar is:

[REDACTED]

Resident [REDACTED] refused to take scheduled doses of insulin on [REDACTED] at 4pm; [REDACTED] at 4pm; [REDACTED] at 4pm; and [REDACTED] at 12pm, however, these refusals were not reported to the prescriber.

Plan of Correction**Accept [REDACTED] - 06/24/2026)**

New orders were obtained to clarify.

Reeducation was given at a LPN/Med. Tech meeting on 6/11/26 regarding refusal of medications that all refusals need to be reported to the prescriber.

A log will be used to record refusals and sent to the prescriber. LPN/Med. Tech will track to see if there is a consistent trend to work with the resident and provider regarding the medication.

Licensee's Proposed Overall Completion Date: 06/15/2026

187c - Refusal of Medication (continued)

Implemented [REDACTED] - 09/18/2026)

187d - Follow Prescriber's Orders

4. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] [REDACTED] at subcutaneously at bedtime. This medication was not administered on [REDACTED] because it wasn't available.

Resident [REDACTED] is prescribed [REDACTED] subcutaneously weekly on Friday. This medication was not administered on [REDACTED] because it wasn't available.

Plan of Correction

Accepted [REDACTED] - 06/24/2026)

Reeducation on preventing missing medications was done at the meeting of 6/11/2026. Educated that for insulin products that if you open the last pen/vial you need to reorder it at that time to ensure there is enough time to receive it from the pharmacy.

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented [REDACTED] 09/18/2026)

188b - Medication Error Reporting

5. Requirements

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] [REDACTED] at subcutaneously at bedtime. This medication was not administered on [REDACTED] because it wasn't available. This medication error was not reported to the prescriber.

Resident [REDACTED] is prescribed [REDACTED] subcutaneously weekly on Friday. This medication was not administered on 5/15/26 because it wasn't available. This medication error was not reported to the prescriber.

Plan of Correction

Accepted [REDACTED] - 06/24/2026)

Reeducation on preventing missing medications was done at the meeting of 6/11/2026. Educated that for insulin products that if you open the last pen/vial you need to reorder it at that time to ensure there is enough time to receive it from the pharmacy.

Responsibility will be all LPN/Med. Tech

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented [REDACTED] - 09/18/2026)

190a - Completion Medication Course

6. Requirements

2600.

190.a. A staff person who has successfully completed a Department approved medications administration course that includes the passing of the Department's performance based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

- On [REDACTED] at 8:00 PM, [REDACTED] tablets to Resident [REDACTED]
- On [REDACTED] at 8:00 PM, [REDACTED] tablets to Resident [REDACTED]
- On [REDACTED] at 8:00 PM, [REDACTED] tablets to Resident [REDACTED]

Staff person B, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

- On [REDACTED] at 8:00 PM, [REDACTED] units/ML to Resident [REDACTED]
- On [REDACTED] at 8:00 PM, [REDACTED] units/ML to Resident [REDACTED]
- On [REDACTED] at 8:00 PM, [REDACTED] units/ML to Resident [REDACTED]

Staff person C, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

- On [REDACTED] at 8:00 AM, [REDACTED] to Resident [REDACTED]
- On [REDACTED] at 8:00 AM, [REDACTED] to Resident [REDACTED]

Plan of Correction**Accept ([REDACTED] - 06/24/2026)**

Please see attached certifications regarding each staff person. All have completed the training that is required to be a Med. Tech.

The New Administrator as of 6/1/26 is applying for a Med. Tech Trainer the Trainer Waiver in order to take the class. Presently waiting to hear. FYI The present Administrator was a Med. Tech Trainer the Trainer in the past but needs to be recertified.

Present records are being reviewed to see what was done in the past by the past Administrator/Train the Trainer that was left go 5/8/26.

Contact was made with another Trainer The Trainer to cover in the meantime. Coverage will be scheduled with current Med Techs for their observations.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented [REDACTED] 09/18/2026)