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

April 9, 2026

NHA
OIL CITY PC OPCO, LLC

RE: OIL CITY PERSONAL CARE COMMUNITY
1293 GRANVIEW ROAD
OIL CITY, PA, 16301
LICENSE/COC#: 45585

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/06/2026 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: *OIL CITY PERSONAL CARE COMMUNITY* **License #**: *45585* **License Expiration**: *10/29/2026*

Address: *1293 GRANVIEW ROAD, OIL CITY, PA 16301*

County: *VENANGO* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *OIL CITY PC OPCO, LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/17/1998* **Issued By**: *Department of Health*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/06/2026*

Inspection Dates and Department Representative

02/06/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *22* **Residents Served**: *20*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *17*
Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*
Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

02/06/2026 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2026*

03/17/2026 - POC Submission

Submitted By: **Date Submitted**: *04/03/2026*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/03/2026*

Inspections / Reviews *(continued)*

04/09/2026 - Document Submission

Submitted By: [redacted]
Date Submitted: *04/03/2026*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A, hired [redacted] did not receive training in Care for residents with mental illness or [redacted] [redacted] during the January 2025 to December 2025 training year.

Plan of Correction ***Accept ([redacted] - 03/17/2026)***

The Administrator reviewed all current resident diagnoses to confirm weather individuals with mental illness/Intellectual disabilities are currently residing in the home.
All direct care staff were identified and scheduled for required training.
Training will be completed by all staff by 3/31/2026
Training will be provided to all new hires during orientation before independent assignment.
The administrator will maintain a training log with staff signatures and completed dates.
Personnel files will be audited quarterly to ensure compliance.
Annual refresher training will be required to stay in compliance.
The homes orientation checklist has been updated to include mandatory training specific to serving residents with mental illness and/or intellectual disabilities to ensure compliance with Regulation 65.f
The facility will achieve full compliance by March 31st 2026
The administrator will be responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented ([redacted] - 04/09/2026)

89b - Hot Water Temperature

2. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At approximately 10:30 a.m., the water temperature at the sink in the shared bathroom in bedroom 110 measured 128.6 degrees Fahrenheit. At 1:06 p.m., measured 135.5 degrees Fahrenheit.

At approximately 10:38 a.m., the water temperature at the sink in the private bathroom in bedroom 116 measured 125.4 degrees Fahrenheit. At 1:13 p.m., measured 127.2 degrees Fahrenheit.

At approximately 10:44 a.m., the water temperature at the sink in the private bathroom in bedroom 101 measured 125.8 degrees Fahrenheit. At 1:10 p.m., measured 129.4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 03/17/2026)***

2/6/2026 maintenance adjusted the hot water heater thermostat to reduce water temperature.
Same- day temperature checks(2-6-26) were conducted after adjustment to ensure water temperature were with in compliant range.
A licensed professional plumber was contacted for further evaluation of the system.
The plumber submitted a bid on 2/27/26 for necessary repairs.

89b - Hot Water Temperature (continued)

The bid has been forwarded to corporate office for approval on 2/27/26
*Upon corporate approval plumbing corrections will be completed by the licensed plumber to ensure consistent compliance with <120*f requirements.*
Water Temperature monitoring log:
Weekly hot water temperature monitoring log has been implemented.
Temperatures will be taken and documented in all resident sinks and showers.
*Any reading above 120*F will require immediate corrective action and documentation.*
The maintenance director will conduct quarterly inspections of the hot water system and mixing valves
Staff have been re-educated on regulatory temperature limits and instructed to report immediately if water feels excessively hot.
Immediate temperature adjustment completed when temps are out of compliance.
Plumbing repair pending corporate approval estimated to be by March 31st 2026
Maintenance Director will be responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *03/31/2026*

Implemented (- 04/09/2026)

132c - Fire Drill Records

3. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

Ther home’s fire drill log did not record the duration and time of fire drills in minutes and seconds on the drills conducted on:
**1/8/26 at 8:45 p.m. – 3 minutes*
**10/29/25 at 7 p.m. – 2 minutes 45 seconds*
**4/17/25 at 6 p.m. – 2 minutes*

Plan of Correction ***Accept (- 03/17/2026)***

The fire drill documentation form has be revised to require recording of the exact evacuation time in both minutes and seconds for every drill conducted. For drills conducted on 1/8/26 and 4/17/25 where seconds were not recorded, documentation was updated to reflect that the exact seconds were not documented at the time of the drill.
Effective 2/9/26 , The Fire Drill log form has been updated to include total evacuation time including seconds, and will not allow the drill to be complete unless minutes and seconds are documented.
The maintenance director and Administrator have been re-educated on the requirements of 2600.132c, specifically that evacuation time must be recorded in minutes and seconds, even if the seconds are zero. A digital stop watch will be used during each drill to ensure accurate timing.
The Administrator or designee will review each fire drill log immediately following the drill to ensure minutes and seconds are properly documented.
Fire drill logs will be audited monthly for a period of three months to ensure continued compliance. Ongoing quarterly audits will occur there after.

132c - Fire Drill Records (continued)

The Administrator is responsible for ensuring compliance with fire drill documentation requirements. We will be in compliance as of 2/9/2026 with minutes and seconds of all fire drill documentation.

.

Licensee's Proposed Overall Completion Date: *03/08/2026*

Implemented (█ - 04/09/2026)

132d - Evacuation

4. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's safe evacuation time is 3 minutes 2 seconds. However, the home exceeded the safe evacuation time during drills conducted on the following dates:
**12/16/25 at 11:00 a.m. – 3 minutes 15 seconds*
**11/7/25 at 11:00 p.m. – 3 minutes 28 seconds*
**8/22/25 at 5:00 a.m. – 3 minutes 22 seconds*
**7/22/25 at 3:30 p.m. – 3 minutes 10 seconds*

Plan of Correction ***Accept (█ - 03/17/2026)***

Fire drill procedures were reviewed with all staff on 2/10/2026.
Additional fire drill training was conducted focusing on:
Staff positioning
Assigned resident assistance
Use of evacuation routes
A full review of resident mobility levels was conducted on 2/10/26.
The Administrator began contacting qualified fire safety professionals to reassess and establish a safe evacuation time based on building construction layout, and resident population as required by regulation.
All staff received re-education on evacuation procedures and their assigned responsibilities on 2/10/26. Training emphasized immediate response , door control and resident grouping techniques.
The Administrator and Maintenance Director are actively seeking a qualified fire safety professional to evaluate:
Building construction type
travel distance
resident acuity and mobility
Documentation of outreach efforts will be maintained.
Once established the updated safe evacuation time will be implemented and submitted to DHS as appropriate.
Monthly fire drills will continue as required.
Drill times will be reviewed by the Administrator
Efforts to obtain professional reassessment are on going and expected to be completed by March 31st 2026

Licensee's Proposed Overall Completion Date: *02/28/2026*

Implemented (█ - 04/09/2026)

184a - Resident's Meds Labeled

5. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed Basaglar Kwik pen 100U/ml – inject 8 units subcutaneously at bedtime. However, the resident's medication label indicates Basaglar Kwikpen 100U/ml – inject 12 units subcutaneously every night at bedtime.

Resident #2 is prescribed Lantus Solostar 100U/ml – inject 32 units subcutaneously at bedtime. However, the resident's medication label indicates Lantus Solostar 100U/ml – inject 28 units subcutaneously at bedtime.
Repeat Violation: 2/5/25

Plan of Correction ***Accept (- 03/17/2026)***

Upon discovery, the incorrectly labeled insulin pens were immediately removed from use on 2/6/26.
The pharmacy and physician office was contacted to verify the correct prescribed dosage and administration instructions.
Correctly labeled insulin pens were obtained and verified against physician orders.
A medication audit was conducted for all residents on insulin to ensure proper labeling on 2/6/2026.
Resident 1 and Resident 2 were receiving the correct dosage of insulin the label was incorrect, the Mar was accurate.
The medication receiving process has been revised. All new medications are wrote down on shift change sheet. All incoming medications must be checked with the MAR prior to putting them into the med cart. All med techs have been retrained on:
Regulation 2600.184(a)
Proper medication label verification.
Insulin administration and dosage verification
Procedures for addressing pharmacy labeling errors
Training was completed on February 18th 2026
All new hires will receive this training during orientation prior to administering medications.
The administrator /Designee will conduct weekly medication audits for 30 days.
Monthly medication audits will occur thereafter.
Results will be documented and corrective action taken immediately if discrepancies are identified.
Compliance will be reviewed quarterly during Quality Assurance meetings.
The facility will be in full compliance by March 1st 2026
The administrator or designee will be responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *02/18/2026*

Implemented (- 04/09/2026)

185a - Implement Storage Procedures

6. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #1 is prescribed Mucinex 12 hour 600mg – give two tabs by mouth twice daily. However, this medication was not available in the home

Plan of Correction ***Accept (█ - 03/17/2026)***

During the inspection the medication Mucinex 12 hr 600mg was located in the overflow drawer on 2/6/2026.
The medication was immediately 2/6/2026 removed from the overflow storage and placed in Resident #1's properly labeled medication bin in the medication cart.
The MAR and physician order were reviewed to ensure accuracy on 2/6/26.
A full medication Cart and overflow drawer audit was conducted to verify that no other resident medication were improperly stored on 2/6/2026.
No additional discrepancies were identified.
The facility has implemented the following corrective measures:
Routine and active resident medications will not be stored in the over flow drawer.
Over flow will only be used for back-up stock or newly delivered medications awaiting verification. Medications will be transferred to the resident designated bin upon arrival.
Upon delivery from pharmacy medications will be:
Verified against the physician order and MAR.
Logged on a medication delivery verification log.
Immediately placed in the residents assigned bin'/ cart
The staff member completing the process will sign and date the log.
The Administrator or designee will conduct weekly inspections for four weeks starting Feb 9th then monthly inspections for three months starting March 9th 2026. The Administrator or designee will be responsible for this plan of correction.
Finding will be documented and maintained for quality insurance review.
All medication staff were reeducated on :
2600.185a storage requirements
immediate placement of medications into correct residents storage areas.
Staff competency validation will be completed and documented.
Immediate corrective action was completed on:2/6/26

Licensee's Proposed Overall Completion Date: *02/28/2026*

Implemented (█ - 04/09/2026)

187a - Medication Record

7. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #1's February 2026 medication administration record (MAR) does not record the following medications in the home's medication cart:
**Milk of Magnesia 1200/15ml*
**Mylanta Suspension*

187a - Medication Record (continued)

**Anti-Diarrhea tabs 2mg*

Plan of Correction ***Accept (- 03/17/2026)***

Immediately on 2/6/26 upon discovery:
The medication administration record (MAR) for Resident #1 was reviewed.
Physician orders were verified for Milk of Mag, Mylanta, and Anti- Diarrhea tablets.
All current medications present in the medication cart were reconciled against the physician orders.
The MAR was updated to accurately reflect all medications currently in the home and available in the medication cart.
A full medication cart audit was completed to ensure no additional discrepancies existed.
The facility has implemented the following:
A 100% audit of all resident MARS was completed to ensure every medication present in the medication carts match physician orders and is documented on the MAR.
A new medication Cart audit checklist has been implemented to be completed.
Weekly by the administrator or designee for 4 weeks starting on 2/9/26 then
Monthly as part of quality assurance review.
Staff responsible for medication administration received re-education on:
2600.187(a) requirements
Proper MAR documentation.
Requirement that all medications present in the home must have a corresponding physician order and MAR entry.
A newly received medication will now be:
Verified against the physician order.
Immediately added to the MAR
A double check system has been implemented when new medications are delivered by the pharmacy.
All Correct Actions were completed on : 2-09-26 and we will continue to monitor weekly for 4 weeks and monthly for 3months there after. The administrator or designee is responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented (- 04/09/2026)

187b - Date/Time of Medication Admin.

8. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1's February 2026 medication administration record, (MAR) indicates the resident's Mucinex 12 hour 600mg – give two tabs by mouth twice daily was administered at 8:00 a.m. However, this medication was not available in the home

Plan of Correction ***Accept (- 03/17/2026)***

Upon discovery the Administrator immediately on 2/6/26 conducted a full reconciliation of Resident#1 medications.
The medication was located in the over flow drawer.
The MAR was corrected to accurately reflect the the medication was not administered at the scheduled time.
The resident was assessed for any adverse effects related to the missed dose of medication. No adverse out comes

187b - Date/Time of Medication Admin. (continued)

were noted. The physician was notified of the missed medication.
Staff involved received immediate re-education regarding accurate documentation and verification of medication prior to signing the MAR.
The facility has implemented the following corrective actions:
All medications are stored in there designated resident bins.
No routine medications remain in the overflow storage.
All medications documented on the MAR are physically present and accessible.
Over flow drawer procedures were revised.
Routine and active medications will not be stored in the over flow.
Overflow will be clearly labeled for back up stock only.
Weekly inspection of over flow drawer will be conducted by the administrator or designee..
All medication Staff were re-educated on:
Verifying medication availability prior to admission.
The prohibition of signing the MAR before the medication is physically administered. Proper documentation of missed or unavailable doses.
All corrective actions actions were completed on February 15th 2026
The administrator or designee is responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *02/28/2026*

Implemented (- 04/09/2026)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident #1 is prescribed Mucinex 12 hour 600mg – give two tabs by mouth twice daily. However, this medication was not available in the home. However, according to staff interview this medication was not administered on 2/6/25 at 8:00 a.m.

Plan of Correction ***Accept (- 03/17/2026)***

Upon discovery on 2/6/2026, the Administrator immediately reviewed Resident #1's medication orders and MAR
The med tech found the medication in the over flow drawer.
The physician was notified of the missed dose and further instructions
were obtained and documented.
The staff member involved was immediately counseled on 2/6/26 regarding proper medication administration and documentation procedures.
A full audit of all current residents medications was conducted to ensure:
All prescribed medications are available in the home.
MAR document accurately reflects administration.
All prescriber orders are followed as written.
Immediate notification to pharmacy when medications are running low.
Medication Techs have been educated that:
any unavailable medication must be reported to the Administrator or designee immediately.
Never to document administration of medication that was not physically administered.

187d - Follow Prescriber's Orders (continued)

Must follow prescriber orders exactly as written
Accurate MAR documentation
Proper procedures for handling unavailable medications
training completed on Feb 10th 2026
All new hires will receive this education during orientation prior to medication administration.
The administrator or designee will be responsible for this plan of correction.:
Conduct monthly medication cart and supply audits monthly.
All discrepancies will result in immediate corrective action and re-education.
The facility will achieve full compliance by: March 1st 2026

Licensee's Proposed Overall Completion Date: *03/01/2026*

Implemented (- 04/09/2026)

224a - Preadmission Screen Form

10. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's pre-admission screening, dated is incomplete: Part III: Determination is blank

Plan of Correction ***Accept (- 03/17/2026)***

The Administrator reviewed Resident #3 pre- admission screening on 2/6/26.
Part III determination was completed confirming that the resident's needs can be met by the personal care services provided by the home.
The completed form was signed and dated appropriately.
An audit of all current resident records will be conducted to ensure:
Pre- admission screenings were completed within 30 days prior to admission.
All sections of the departments pre-admission screening form will be reviewed.
Any incomplete documentation identified was corrected immediately.
A Pre-Admission Documentation Checklist has been implemented to ensure:
All sections of screening are completed prior to admission.
The determination statement is documented, signed, and dated.
The Administrator will review and approve all pre-admission screenings prior to finalizing admission.
The administrator is new at the facility and will completed an audit on all pre-admission screenings no later than 3/15/2026. The Administrator will be responsible for this plan of correction.

Licensee's Proposed Overall Completion Date: *03/16/2026*

Implemented (- 04/09/2026)