



Pennsylvania
Department of Human Services

MAILING DATE: JUNE 22, 2026

[REDACTED]
WG South Hills SH LLC
5300 Clairton Boulevard
Priority Life Care
Pittsburgh, Pennsylvania 15236

RE: Celebration Villa of South Hills
License/COC #: 442841

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 30, 2025, December 16, 2026, December 17, 2026, of the above facility, we have determined that your submitted plan of correction is not implemented.

Correction of these violations in accordance with the specified plan of correction is required. Failure to correct these violations may result in further licensing enforcement action.

Sincerely,

[REDACTED]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *CELEBRATION VILLA OF SOUTH HILLS* License #: *44284* License Expiration: *05/05/2026*
Address: *5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *WG SOUTH HILLS SH LLC*

Address: [REDACTED]

Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *03/08/1999* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *110* Waking Staff: *83*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *12/17/2025*

Inspection Dates and Department Representative

10/30/2025 - On-Site: [REDACTED]

12/16/2025 - On-Site: [REDACTED]

12/17/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *139* Residents Served: *82*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *82*
Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *28* Have Physical Disability: *0*

Inspections / Reviews

10/30/2025 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/13/2026*

02/17/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *03/06/2026*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/24/2026*

02/23/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *03/06/2026*
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *03/02/2026*

04/10/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *03/06/2026*
 Reviewer: [REDACTED] Follow-Up Type: *Exception*

29a SOPa Hospice Care: Residents Receiving Hospice Service

1. Requirements

2600.

29.a.a. If a personal care home elects to provide assistance with IADLs or ADLs for a resident who receives hospice care and services in accordance with § 2600.29 (relating to hospice care and services), the home shall provide for the resident's personal care needs, as well as meet the needs directed by the hospice agency for the time period that hospice service staff are not physically present in the home, and in accordance with the resident's medical evaluation, assessment and support plan.

Description of Violation

Resident #1 was admitted to the home from [REDACTED] while receiving hospice care. However, during the residency, there were failures by the home to provide services related to eating, drinking, turning, positioning, call bell responses, medication administration, and wound care at times hospice service staff were not physically present in the home.

Plan of Correction

Accept [REDACTED] - 02/23/2026)

The home respectfully requests to withdraw this violation from the report. The home provided regular assistance to Resident #1 to eat and drink, but the resident regularly refused efforts. These refusals also happened with hospice staff, which are documented, and family members. There was one isolated call bell response noted that was listed as a concern, staff did respond and cleared the call bell within 35 minutes. This does not indicate a recurring issue and the call bell system is not supported by hospice and is irrelevant to their service. The home regularly repositioned and turned the resident. The home also contacted hospice for wound care support as instructed but when needed basic wound care could be completed by nurses on duty until the hospice nurse arrived it was done.

ACTION: Resident #1 no longer resides in the community.

TRAINING: On 2/6/26 the Director of Nursing was educated on regulation 2600. 29a, by the Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 12/1/25 the Director of Nursing/Assistant Director of Nursing will review weekly hospice notes to ensure all special health, dietary needs, and wound care is documented on the assessment and identify who the care needs will be managed by and how often. Results to be reviewed at monthly Quality Assurance meetings. By 2/28/26, all hospice partners have reviewed and signed the home's hospice protocols to ensure proper communication and expectation of the community are met. Effective 12/1/25 the Director of Nursing/Assistant Director of Nursing will review weekly home health, hospice, and therapy notes to ensure all special health or dietary needs for wound care are documented on the assessment and identify who the care needs will be managed by and how often. Effective 2/20/26 the Director of Nursing, Regional Director of Clinical Services and/or the Executive Director will conduct a weekly review on all current residents on hospice services to ensure their needs are met by the 3rd party provider and the community. If the residents' care needs exceed the level of care that the community can provide, the home will make a recommendation for the resident to be discharged to a higher level of care. The home's staff would assist with any of these transfers. Results of these review to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: 02/20/2026

Implemented [REDACTED] - 04/10/2026)

42b - Abuse

2. 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

Resident #1 was admitted on [REDACTED]/25 while receiving hospice care with scarring from an old coccyx wound, measuring 0.5 cm wide and 0.3 cm long, being treated via protective cream. During the residency, there were failures by the home to provide services related to eating, drinking, turning, positioning, call bell responses, medication administration and wound care at times hospice service staff weren't physically present in the home, in accordance with 2600.29(a) SOP, culminating in the resident's discharge to [REDACTED] General Hospital on [REDACTED]/2025 for sacrum debridement surgery on the wound measuring 7.5 cm wide, 6.0 cm long, and 3.3 cm depth. Resident #1 was hospitalized from 10/08/25 to 10/28/25 and discharged to an acute care facility.

Some of the examples of the home's failure to provide adequate care to Resident #1 include:

9/7/25 – Resident #1 is on a mechanical soft diet and was provided a grilled cheese sandwich for lunch.

9/15/25 – Resident's coccyx wound advances to a stage 2 measuring 2 cm wide and 1 cm long. New wound care orders were faxed to the home.

9/23/25 – Hospice staff discovered that resident #1's wound care from [REDACTED] 20/25 to [REDACTED] 22/25 was improperly covered by the home's staff with a 4 x 4 border gauze which, according to hospice staff, provided a moist bacteria environment for the wound causing it to accelerate and increase in size to 5.2 cm wide and 5 cm long.

9/27/25 – Resident #1's assessment, dated [REDACTED]/25, indicated [REDACTED] was independent for eating and drinking; however, in the summary and determination section of the support plan it was handwritten by staff person A that the resident needs assistance with drinking and eating as [REDACTED] accepts. On 9/27/25, Resident #1's food was delivered to [REDACTED] room and placed on [REDACTED] table inside the apartment and left sitting there. No staff assisted or attempted to feed the resident.

9/29/25 – Resident #1 was prescribed Sulfamethoxazole Trimethoprim (Bactrim) DS 800-160mg tabs for 7 days with instructions for staff to crush the tablet and mix in applesauce. The medication was not received by the home until 10/03/25, and when the first dose was attempted to be administered, the medication administration record (MAR) indicates the resident spit it out. The home failed to administer the medication on the morning of [REDACTED] 05/25 because the resident was asleep. The antibiotic was only administered four days out of the seven-day prescription order. The MAR didn't indicate the medication was to be crushed and given to the resident in applesauce.

REPEATED VIOLATION: 7/1/2025 et al.

42b - Abuse (continued)

Plan of Correction

Accept [REDACTED] 02/23/2026)

The home respectfully requests to withdraw this violation from the report. An opportunity to review the specifics of the violation was not provided during the preliminary exit regardless of the request to review being made. Notes on each entry are as follows:

8/25/25- Resident was capable of eating by [REDACTED] but frequently required assistance, more so [REDACTED] needed encouragement. Facility staff were providing routine assistance with this. In many cases the resident was refusing, even with multiple attempts. Resident regularly refused hospice staff, which is documented, as well as family assistance. Resident was able to eat on [REDACTED] own but refused.

9/7/25- A grilled cheese is a mechanical soft food diet selection, the community made multiple attempts to provide a variety of options to encourage the resident to eat. If the family requested something different at the time of delivery, staff provided it. There was no harm to the resident, this was simply a preference that the staff would have easily been able to rectify once informed. This is a one-time food preference change, not abuse.

9/8/25- Staff Person B explained to the inspector that the home held a care meeting with hospice via phone on 9/30/25 to discuss several items, one was turning and repositioning. The home's staff asked for clarification on their recommendation, hospice initially suggested turning and repositioning every two hours. The home's staff explained that in their setting they typically didn't see orders for every 2 hours, instead they generally received orders for frequent turning and repositioning which would be 3x or more per shift. Hospice verbally agreed to this. Again on 10/7/25 the home's staff met with the resident's [REDACTED] in person and reviewed this, [REDACTED] was in agreement.

9/15/25- Per the hospice staff the resident was having a general decline in [REDACTED] overall condition. Changes in the wound cannot directly be tied to the home's actions.

9/23/25- Hospice was responsible for dressing changes and for providing dressing supplies. On one occasion, due to resident incontinence, a nurse did provide a dressing change with the supplies provided by hospice, before a hospice nurse arrived. The home does not stock wound care supplies and only would have used what was provided by hospice.

9/27/25- There is no evidence that the food in the apartment was not offered to the resident. There are numerous notes in from staff that the resident was regularly refusing food, this was also documented on hospice paperwork by their staff and noted by the family. The most likely scenario is that the resident refused food again, and the staff had not yet picked up the tray.

9/29/25- Per the doctor's order, medications for this resident 'may be' crushed in applesauce but they are not required to be administered that way. This is generally not an order that is on the MAR, in the event it's required or not permitted to be crushed it would be on the MAR. This is common practice for hospice in the event that a resident declines to the point that they need a medication crushed.

The order for an antibiotic was submitted by the physician late afternoon on 9/29/25, it was then sent to the pharmacy early in the morning on 9/30/25. Additionally, the resident had several days [REDACTED] refused medication, which is [REDACTED] right, [REDACTED] spit it out on one occasion, and the occasion where [REDACTED] was asleep was also a refusal after several attempts to wake [REDACTED] and ask [REDACTED] to take medications. Resident was admitted to the hospital per family choice on 10/7/25 and was unable to finish the prescribed antibiotic.

10/6/25- This was one call bell alert that had a longer response time. Staff did in fact respond, which is why the call bell alert was cleared. Generally, staff clear call bells when they enter a room but in some occasions they start care directly and once completed they clear it. This was the only occasion cited where there was a longer response but staff did respond; this does not indicate a repeat concern or abuse.

42b - Abuse (continued)

ACTION: Resident #1 no longer resides in the community.

TRAINING: On 2/6/26 the Director of Nursing, were educated on regulation 2600. 42b, by the Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Director of Nursing will review community protocols and expectations with all current and future hospice providers, this will be completed by 2/27/26. These protocols include expectations on communication, managing orders and expressing concerns. Any third party home care or hospice provider working in the home will be expected to review and sign the protocols with the Director of Nursing and/or Executive Director every six months.

Documentation of these signed protocol reviews will be kept in the administrator's office. Effective 2/6/25 the Director of Nursing/Assistant Director of Nursing will review weekly hospice notes to ensure all special health, dietary needs, and wound care is documented on the assessment and identify any areas of concern that need to be address by the facility and/or the hospice.

Effective 2/20/26 the Director of Nursing, Regional Director of Clinical Services and/or the Executive Director will conduct a weekly review on all current residents on hospice services to ensure their needs are met by the 3rd party provider and the community. If the residents' care needs exceed the level of care that the community can provide, the home will make a recommendation for the resident to be discharged to a higher level of care. The home's staff would assist with any of these transfers. Results of these review to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: 02/20/2026

Not Implemented [REDACTED] - 04/10/2026)

187a - Medication Record

3. Requirements

2600.

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

- 5. Dosage form.
- 8. Frequency of administration.
- 11. Special precautions, if applicable.

Description of Violation

Resident #1 was prescribed Calmoseptine ointment to be applied 2x daily to buttocks with brief changes. On 9/15/25 there was a change order to Calmoseptine ointment to be applied 3x daily to buttocks with brief changes. The resident's MAR was not updated to include increased frequency.

Resident #1 was prescribed Sulfamethoxazole Trimethoprim (Bactrim) DS 800-160mg tabs were ordered to be crushed and given to the resident in applesauce. The residents MAR did not include these instructions. Repeat Violation 6/5/25

Plan of Correction

Accept [REDACTED] 02/17/2026)

The home respectfully requests to withdraw this violation from the report. Based on the orders received at the community and at the pharmacy, the home was following the orders correctly and the MAR reflected that.

Action: Resident #1 no longer resides in the community.

Calmoseptine ointment was prescribed three times daily till 8/30/25, then was changed on 8/31/25 to twice daily which the MAR reflects, the pharmacy nor the community received any additional orders after that date.

Resident #1 was prescribed Sulfamethoxazole Trimethoprim (Bactrim) DS 800-160mg tabs, the order states "may"

187a - Medication Record (continued)

crush, this is generally not an order that is on the MAR, in the event it's required or not permitted to be crushed it would be on the MAR.

Training: On 2/6/26 the Director of Nursing was educated on regulation 187a, by the Regional Director of Clinical Services. On 2/6/26 all med trained staff that approves orders were educated on regulation 187a, by the Director of Nursing. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Effective 2/6/26 the Director of Nursing and med trained staff that approves orders, will ensure the following for each resident for whom medications are administered, frequency of the administration, and special precautions, prior to approving orders, weekly x4, then monthly x4. Results to be reviewed at the next monthly Quality Assurance meeting.

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

Not Implemented ([REDACTED] - 04/10/2026)

187b - Date/Time of Medication Admin.

4. 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 is prescribed Acetaminophen 325mg tab, take 2 tablets = 650mg by mouth every 6 hours. On 10/7/25 according to multiple progress notes the medication was not available in the home and not administered. However, on 10/6/25 and 10/7/25 at 11:30 a.m. staff initialed the medication administration record as administering the medication. REPEATED VIOLATION: 9/8/2025; 8/15/2025; 7/1/2025 et al.; 3/25/2025

Plan of Correction

Accept [REDACTED] 02/17/2026)

Action: Resident #1 no longer resides in the community.

Training: On 2/6/26 the Director of Nursing was educated on regulation 187b, by Regional Director of Clinical Services. On 2/6/26 all med trained staff were educated on regulation 187b by the Director of Nursing. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Effective 2/6/26 the Director of Nursing will review all current resident MARS to ensure the medication has been administered and includes the date, time, name, and initials of the staff administering the medications, weekly x4, then monthly x4. Results to be reviewed at the next monthly Quality Assurance meeting.

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

Not Implemented ([REDACTED] - 04/10/2026)

187d - Follow Prescriber's Orders

5. Requirements

2600.

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

Description of Violation

187d - Follow Prescriber's Orders (continued)

Resident #1 was prescribed Calmoseptine ointment with a start date of 9/15/25 and an end date of 9/23/25 apply 3x daily to buttocks with brief changes, however, the ointment was only applied to the buttocks area with brief changes twice a day during that period.

Resident #1 was prescribed Sulfamethoxazole Trimethoprim (Bactrim) DS 800-160mg tabs with a start date of 9/29/25 to 10/08/25 take 1 tablet by mouth twice daily for 7 days for the coccyx wound infection. The physician's orders instructed staff to crush the tablets and mix in applesauce and then administer to the resident. The antibiotic was not received by the home until 10/03/25, when the first dose was attempted to be administered on 10/03/25 the resident spit the medication out as was noted on the medication administration record (MAR). Then on 10/05/25 the dose at 09:00 a.m. was not administered because the resident was asleep and then on 10/08/25 the 09:00 a.m. dose was refused.

REPEATED VIOLATION: 9/8/2025; 8/15/2025; 6/5/2025; 3/25/2025

Plan of Correction

Accept [redacted] - 02/17/2026

9/21/25- Resident #1 was never ordered ciprofloxacin, home believes this information was pulled in error by the inspector from another resident chart, pharmacy also confirmed this order was never on file for this resident.

Action: Resident #1 no longer resides in the community.

Resident # 1 Calmoseptine ointment was prescribed three times daily till 8/30/25, then was changed on 8/31/25 to twice daily which the MAR reflects, the pharmacy nor the community received any additional orders after that date. Resident #1 was prescribed on 9/29/25 Sulfamethoxazole Trimethoprim (Bactrim) DS 800-160mg tabs, was delivered from the pharmacy on 10/2/25 and was administered on 10/3/25, resident did not receive 7 days of antibiotic due to spitting out, sleeping, and refusing.

Training: On 2/6/26 the Director of Nursing was educated on regulation 187d, by the Regional Director of Clinical Services. On 2/6/26 all med trained staff were educated on regulation 187d by the Director of Nursing. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Effective 2/6/26 the Director of Nursing will review all current resident MARS to ensure the medication has been administered and includes the date, time, name, and initials of the staff administering the medications, weekly x4, then monthly x4. Results to be reviewed at the next monthly Quality Assurance meeting.

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

Not Implemented [redacted] 04/10/2026

225c - Additional Assessment

6. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's assessment, dated [redacted]/25, indicated the resident was independent with eating and drinking; however,

225c - Additional Assessment (continued)

the support plan summary indicates that staff are to assist the resident with drinking and eating as [REDACTED] accepts. The assessment indicated the resident was independent with turning and positioning. However, the resident required total physical assistance with turning and positioning.

Plan of Correction**Accept [REDACTED] 02/17/2026)**

The home respectfully requests to withdraw this violation from the report. The home provided regular assistance to Resident #1 to eat and drink, but the resident regularly refused efforts. These refusals also happened with hospice staff, which are documented, as well as with family members. Resident #1 was independent with eating and drinking but the staff assisted as needed. Resident #1 was independent with turning and positioning, as she often moved in bed on [REDACTED] own, regardless staff provided assistance as indicated on the RASP.

Action: Resident #1 no longer resides in the community. Resident #1 assessment dated [REDACTED] 25, was updated to reflect that staff are to assist the resident with drinking and eating as [REDACTED] accepts. The resident was independent with eating and drinking, also. Resident #1 assessment dated [REDACTED] 25, was updated to include that resident does need staff assist of 2 at times. Resident was also independent with turning and repositioning.

Training: On 12/1/25 the director of nursing was educated on regulation 225c by the Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing : Effective 12/1/25 the Director of Nursing/Assistant Director of Nursing will review weekly home health, hospice, and therapy notes to ensure all special health or dietary needs for wound care are documented on the assessment and identify who the care needs will be managed by and how often, or if a significant change needs to be completed prior to the annual. Results to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: 02/13/2026

Not Implemented [REDACTED] 4/10/2026)

227c - Support Plan Revision**7. Requirements**

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1's assessment and support plan, dated [REDACTED] 25, indicated that the resident was independent with turning and positioning in bed and chair. However, the plan to meet the service needs of the resident indicated that the resident was to be repositioned frequently without indicating a specific frequency or a responsible party. The resident had a physician's order dated 9/8/25 "to reposition patient with cushion from right to left every 2 hours to relieve pressure to coccyx". The support plan was not updated to include this information.

Plan of Correction**Accept [REDACTED] 02/17/2026)**

The home respectfully requests to withdraw this violation from the report. On 12/1/25 this regulation was cited. As part of the home's approved Plan of Correction, audits were being conducted to identify issues or noncompliance. The home was actively working their plan to address any outstanding concerns, this chart was not included in the review because resident had been discharged from the home. While this inspection started on 10/30/25, it was not completed until after the 12/1/25 inspection and that inspection's POC was approved.

Action: Resident #1 no longer resides in the community.

The hospice sent the order directly to the pharmacy and not to the facility, the facility was unaware of the order.

227c - Support Plan Revision (continued)

This regulation was cited on 12/1/25 and the plan of correction was accepted. On 12/1/25, the Assistant Director of Nursing completed an audit of all current residents, to identify formal support and identify the assessed care needs to be managed. All current residents with wounds were identified to ensure all special health or dietary needs for wound care were documented on the assessment and identify who the care needs will be managed by.

Training: On 12/1/25 the Director of Nursing, Assistant Director of Nursing, and Resident Care Coordinator were educated on regulation 2600. 225c, by the Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Effective 12/1/25 the Director of Nursing/Assistant Director of Nursing will review weekly home health, hospice, and therapy notes to ensure all special health or dietary needs for wound care are documented on the assessment and identify who the care needs will be managed by and how often. Results to be reviewed at the next monthly Quality Assurance meeting.

Licensee's Proposed Overall Completion Date: 02/13/2026

Not Implemented [REDACTED] 04/10/2026)