



Pennsylvania Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 24, 2026

[REDACTED]
WG South Hills SH LLC

[REDACTED]
Priority Life Care
[REDACTED]

RE: Celebration Villa of South Hills
License #: 442842

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on January 5, 2026, January 6, 2026, January 21, 2026, March 10, 2026, March 17, 2026, and April 7, 2026, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from MAY 5, 2026 to NOVEMBER 5, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
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Section:

187(b)	III	80	\$3	\$240	15 calendar days from mailing date of this letter
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A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED], Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Forum Place, 6th Floor
 PO Box 2675
 Harrisburg, PA 17105-2675
 PH: [REDACTED]

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: WG SOUTH HILLS SH LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP **Date:** 03/08/1999 **Issued By:** PA Dept L&I

Staffing Hours

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

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Incident **Exit Conference Date:** 01/21/2026

Inspection Dates and Department Representative

01/05/2026 - On-Site: [REDACTED]
01/06/2026 - On-Site: [REDACTED]
01/21/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 139 **Residents Served:** 86

Secured Dementia Care Unit

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

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 86
Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 24 **Have Physical Disability:** 0

Inspections / Reviews

01/05/2026 Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *03/05/2026*

03/06/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/21/2026*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *03/11/2026*

03/12/2026 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/21/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *03/21/2026*

04/10/2026 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *03/21/2026*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

25b Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident’s designated person if any, if the resident agrees.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. However, the resident-home contract completed [redacted] was not signed by the resident until [redacted].

Plan of Correction

Accept [redacted] - 03/12/2026)

ACTION: The Administrative Assistant, will complete an audit of all current residents contracts and will be completed by 3/20/26 to ensure all other contracts are in compliance with this regulation.

TRAINING: On March 3, 2026 the Executive Director and Sales Director were educated on regulation 2600.25b, by the Regional Director of Operations. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING: All new residents and their responsible parties will sign their contracts prior to or no later than the day of admission. A review of the contract audit and this regulation will be included in the home’s next Quality Assurance meeting in March 2026.

Licensee's Proposed Overall Completion Date: 03/20/2026

Implemented [redacted] - 04/10/2026)

60a Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

According to resident [redacted] assessment and support plan completed [redacted], the resident requires assist of two staff persons with transferring and toileting. Resident requires assist of 1 with propelling wheel chair and personal hygiene and turning and positioning in bed/chair. However, the home’s call bell records indicate the following:

- [redacted] at 9:08 p.m. – alert announced 30 times and as of 11:08 p.m., was never responded to.
- [redacted] at 5:20 p.m. – alert announced 30 times and as of 7:20 p.m., was never responded to
- [redacted] at 12:25 p.m. – alert announced 30 times and as of 2:25 p.m., was never responded to.
- [redacted] at 5:55 a.m. – alert announced 30 times and as of 7:55 a.m., was never responded to.
- [redacted] at 1:08 p.m. – alert announced 30 times, but as of 3:08 p.m., was never responded to.

According to Resident [redacted] assessment and support plan completed [redacted] the resident requires assistance of two staff for all transfers, toileting, personal hygiene and turning and positioning. The home’s call bell records indicate the following:

- [redacted] at 5:03 p.m. - alert announced 17 times and was not responded until 6:10 p.m. (67 minutes).
- [redacted] at 12:46 p.m. - alert announced 30 times. As of 2:46 p.m., the alert was never responded to.
- [redacted] at 8:14 a.m. – alert announced 17 times and was not responded to until 9:19 a.m. (69 minutes).

Repeat Violation [redacted] et al., [redacted]

60a Staff/Support Plan (continued)

Plan of Correction

Accepted [REDACTED] - 03/06/2026

ACTION: The Executive Director and Director of Nursing met with care staff and reviewed call logs the week of 1/5/26. It was confirmed that staff are regularly responding but failing to clear or reset call bells. 'How to' sheets on how to manage call bell equipment was made available to care staff, posted in the wellness office and reviewed with staff individually throughout January.

TRAINING: On 01/06/26 the Executive Director and Director of Nursing were educated on regulation 2600.60a, by the Regional Director of Operations. By 03/06/26 all direct care staff will be educated on regulation 2600.60a, the call bell system management expectations and on the call bell system equipment by the Director of Nursing or the Executive Director.

ONGOING: On a daily basis, the Executive Director and Director of Nursing receive call bell response logs to review. If/when there are call bells that have no response or have lengthy responses, the ED and DON will investigate and respond appropriately. On a weekly basis, the Executive Director also reviews the home's average call bell response time with the Regional Director of Operations. A review of the call bell response times, training efforts and this regulation will be included in the home's next Quality Assurance meeting in March 2026.

Licensee's Proposed Overall Completion Date: 03/05/2026

Not Implemented [REDACTED] - 04/10/2026

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person A, whose first day of work was [REDACTED], did not receive orientation in general fire safety and emergency preparedness that includes the following:

- (1) Evacuation procedures.*
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.*
- (3) The designated meeting place outside the building or within the fire safe area ...*
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.*
- (5) The location and use of fire extinguishers.*
- (6) Smoke detectors and fire alarms.*
- (7) Telephone use and notification of emergency services.*

Direct care staff person B, whose first day of work was [REDACTED], did not receive orientation in general fire safety and

65a FS Orientation 1st Day (continued)

emergency preparedness that includes the following until [REDACTED]

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within fire safe area ...
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

Plan of Correction

Directed [REDACTED] - 03/12/2026)

ACTION: An audit of all staff orientation training will be conducted by the Administrative Assistant and will be completed by 3/20/26. Any trainings identified as incomplete will be completed immediately.

TRAINING: By 3/6/26 the Executive Director will train the Administrative Assistant and Director of Nursing on 2600.65a. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING: At the completion of a staff member's first week of hire, the Administrative Assistant will review all trainings completed to ensure that the training has been done and documented appropriately. The Administrative Assistance will also have this information reviewed by the Executive Director prior to scheduling staff to start training on the floor. A review of this new process as well as a review of the audit conducted will be reviewed at the home's next Quality Assurance Meeting in March 2026.

Proposed Overall Completion Date: 03/20/2026

DIRECTED

Within 8 days of receipt of the plan of correction: The administrator shall have completed the training for direct care staff person A and B cited in the violation. [REDACTED] 3/12/26

Directed Completion Date: 03/20/2026

Not Implemented [REDACTED] 04/10/2026)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

- 1. Resident rights.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person A was hired [REDACTED] However, documentation of the following training topics was not dated when completed:

- (1) Resident rights.

65b - Rights/Abuse 40 Hours (continued)

- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act.
- (4) Reporting of reportable incidents and conditions.

Plan of Correction

Accept [REDACTED] - 03/12/2026)

ACTION: Staff member A hired on 10/11/25, completed their Orientation Training record which did not include the date, on 10/11/25_staff member A dated Orientation Training record and a tie back tool was added to the file on 01/06/26. Additionally, all staff orientation records were audited on 01/07/26 to confirm compliance with regulation 2600.65.b.

TRAINING: On 01/06/26 the Executive Director, Director of Nursing, Administrative Assistant were educated on regulation 2600.65b, by the Regional Director of Operations.

ONGOING: Effective immediately, the Administrative Assistant will ensure within 40 scheduled working hours, all direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the date when completed. The Executive Director will also review all training documentation with all new hires at the end of their 40 hours. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/11/2026

Implemented [REDACTED] - 04/10/2026)

85d - Trash Receptacles

5. Requirements

- 2600.
- 85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On [REDACTED] at 12:02 p.m., there was partially full uncovered trash can in the shower room across from room [REDACTED]

Plan of Correction

Accept [REDACTED] - 03/06/2026)

ACTION: On January 5, 2026, the uncovered trash can in the shower room across from room [REDACTED] was removed by the Executive Director and was replaced with a covered trash can on January 6, 2026.

TRAINING: On January 6, 2026 all staff were educated on regulation 2600.85d, by the Executive Director.

ONGOING: Effective March 3, 2026, rounds to be completed by the Director of Maintenance to ensure that trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents, weekly x 4 and then monthly x 4. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/05/2026

Implemented [REDACTED] 04/10/2026)

100b - Removal Snow/Obstructions

6. Requirements

100b - Removal Snow/Obstructions (continued)

2600.

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

Description of Violation

On [redacted] at 12:25 p.m., there was approximately 1-2" of snow and icy slush covering the walkway outside of the exit near the main laundry at the bottom of stairwell #2.

Plan of Correction

Accept [redacted] 03/06/2026)

ACTION: On 1/5/26 the Director of Maintenance removed the snow and icy slush covering the walkway outside of the exit near the main laundry at the bottom of stairwell #2.

TRAINING: On January 6, 2026 the Executive Director and the Director of Maintenance were educated on regulation 2600.100b by the Regional Director of Operations.

ONGOING: As part of daily rounds, starting March 3, 2026, the Director of Maintenance or Manager on Duty, will check all exits, ramps and walkways upon arriving at the community. If the snowfall happens quickly in the future and the Maintenance team members are not available to actively clear walkways the members of maintenance will communicate need for further support from other staff persons to assist in shoveling and salting said areas. Additionally, the maintenance staff will monitor all exits and sidewalks during inclement weather. In the event neither are on site the manager on duty will take on this responsibility. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/05/2026

Implemented [redacted] - 04/10/2026)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On [redacted] at 11:10 a.m., the temperature in the top freezer section of the white refrigerator-freezer in the main level country kitchen near the dining room measured 20 degrees Fahrenheit. At 2:42 p.m., the temperature measured 14 degrees Fahrenheit.

Plan of Correction

Accept [redacted] 03/06/2026)

ACTION: On January 5, 2026 a new thermometer was replaced in the top freezer section of the white refrigerator-freezer in the main level country kitchen near the dining room by the Executive Director.

TRAINING: By 3/6/26, all dietary staff and management staff, which included the Dietary Director, Activities Director, Sales Director, Administrative Assistant, Maintenance Director, and Director of Nursing, were educated on regulation 2600.103f by Executive Director.

ONGOING: Effective March 3, 2026 the dietary department will review temperatures daily to ensure food requiring refrigeration shall be stored at or below 40°F, and frozen food shall be kept at or below 0°F, the white refrigerator-freezer in the main level country kitchen near the dining room. Documentation to be reviewed at the next monthly

103f - Refrigerator/Freezer Temps (continued)

Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/06/2026

Implemented [REDACTED] - 04/10/2026)

132c - Fire Drill Records

8. 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

The fire drill record for the drill conducted on [REDACTED] 6:18-6:28 a.m. which originally indicated 8 minutes, 13 seconds was crossed out and changed to 7 minutes, 57 seconds.

The fire drill record for the drill conducted on [REDACTED] 3:40-3:48 p.m. indicated 478 sec in the "time" column . It was not written in "minutes and seconds."

REPEATED VIOLATION: [REDACTED] et al.

Plan of Correction

Accept [REDACTED] - 03/06/2026)

ACTION: The fire drill record for the drill conducted on 12/31/25 3:40-3:48 fire drill was documented in seconds . On 01/05/26_ the fire drill record was corrected to reflect time in minutes and seconds by the Maintenance Director.

TRAINING: On 01/06/26 the Executive Director and the Maintenance Director were trained by the Regional Director of Operations on regulation 132.c to ensure time is documented in "minutes and seconds" in the "time" column. Documentation of the training shall be kept in accordance with regulation 2600.65.i.

ONGOING: Effective immediately, the Executive Director will review fire drill documentation monthly for 6 months; the review will be initialed by each to document the review. Documentation to be reviewed at monthly QA.

Licensee's Proposed Overall Completion Date: 03/05/2026

Implemented [REDACTED] - 04/10/2026)

183e - Storing Medications

9. Requirements

2600.

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

Description of Violation

On [REDACTED] at 1:55 p.m. there was a [REDACTED] with pharmacy label for resident [REDACTED] in the 3-Long medication cart that was not dated when opened.

On [REDACTED] at 2:24 p.m., there was a [REDACTED] injection pen with pharmacy label for resident [REDACTED] in the 3-Short medication cart that was not dated when opened.

183e - Storing Medications (continued)

Plan of Correction

Accepted [redacted] - 03/06/2026

ACTION: On 2/25/26 unable to verify resident [redacted] & [redacted] insulin pens from 1/6/26. On 2/25/26 resident [redacted] & [redacted] insulin pens were verified to include open date and expiration date, by the Director of Nursing.

TRAINING: On 03/03/26, the Director of Nursing was educated on regulation 2600.183e by the Executive Director, by March 4, 2026 all Certified Med Techs educated on regulation 2600.183e by the Director of Nursing. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING: Effective March 5, 2026, during weekly glucometer audits all insulin pens will be verified to include open and expiration dates, by the Director of Nursing or appointed Certified Med Tech. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/05/2026

Implemented [redacted] - 04/10/2026

184a - Resident's Meds Labeled

10. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident [redacted] is ordered [redacted] oral tablet – Take 2 tablets by mouth every 6 hours as needed for pain, mild (1-3). However, the label for this medication indicated [redacted] – take 2 tablets = 650mg by mouth every 6 hours as needed for pain/mild (1-3).

Resident [redacted] is ordered [redacted] - Apply 1 patch topically every day, on 12 hours and off 12 hours to right hip** as needed. However, on [redacted] at 11:42 a.m., the pharmacy label on this medication indicated Apply 1 patch topically every day, on 12 hours and off 12 hours to right hip ** on at bedtime, off in morning.**

Repeat Violation [redacted] et al.

Plan of Correction

Accepted [redacted] - 03/06/2026

ACTION: On 1/7/26 resident [redacted] Tylenol new order received, by the Director of Nursing, order sent to the pharmacy to profile and send medication to indicate [redacted] take 2 tablets to= 1000mg. On 1/21/26 a change of direction sticker was put in place on resident [redacted] lidocaine PA PAD by the Director of Nursing.

TRAINING: On 03/03/26, the Director of Nursing was educated by the Regional Director of Clinical Services. All med trained staff to be educated on regulation 2600.184a, by the Director of Nursing on March 4, 2026. Documentation of the staff training shall be kept in accordance with 2600.65i.

184a Resident's Meds Labeled (continued)

ONGOING: Effective immediately, the Director of Nursing/designee and med trained staff that approves orders, will ensure the following for each resident for whom medications are administered, name of the medication and dose to be reviewed prior to approving orders on the MAR, weekly x4, then monthly x4. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/05/2026

Implemented [REDACTED] - 04/10/2026)

185a - Implement Storage Procedures

11. 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] is ordered blood glucose checks with sliding scale coverage four times a day. The following blood glucose values which were entered on the resident's January 2025 medication administration record (MAR) were not measured with the resident's glucometer:

- [REDACTED]

Repeat Violation [REDACTED] et al., [REDACTED]

Plan of Correction

Directed [REDACTED] 03/12/2026)

ACTION: On January 6, 2026 DHS incident report was filed by the community after identifying during weekly glucometer audit that a resident's glucometer had been shared with another resident, by the Director of Nursing.

TRAINING: On March 3, 2026 the Director of Nursing was educated on regulation 2600. 185a, by the Executive Director. By 3/4/26 all med trained staff were educated on regulation 2600. 185a, by the Director of Nursing. Documentation of the staff training shall be kept in accordance with 2600.65i.

ONGOING: Effective March 5, 2026, the Director of Nursing, or certified med tech will audit the MAR and glucometer to ensure they match, twice weekly x4, weekly x4, monthly x 4. Documentation of these audits will be kept and reviewed at the home's next Quality Assurance Meeting in March 2026.

Proposed Overall Completion Date: 03/11/2026

DIRECTED

Within one day of receipt of the plan of correction: The administrator shall notify the residents and designated persons cited in the violation of the glucometer sharing. [REDACTED] 3/12/26

Within one day of receipt of the plan of correction: The administrator shall purchase new glucometers for all residents who receive blood glucose testing who were involved in the glucometer sharing at no cost to the residents. [REDACTED] 3/12/26

Within one day of receipt of the plan of correction: The administrator shall review all of the glucometers to assure that each glucometer is labeled to identify the specific resident it is to be used upon. [REDACTED] 3/12/26

185a - Implement Storage Procedures (continued)

Within one day of receipt of the plan of correction: The administrator shall notify each resident's physician (for those that receive blood sugar testing) of the possibility of shared glucometer use and all recommendations made by the physician (i.e. testing for blood borne pathogen) should be followed. Documentation of the notification to the physician, the recommendations of the physician, and the home's follow-up based on the recommendations shall be maintained by the home for Department review. [REDACTED] 3/12/26

Within one day of receipt of the plan of correction: The administrator, Director of Wellness, Certified Medication Administration Trainer, Certified Medication Administration Observer, designated staff person shall observe each staff responsible for medication administration completing blood glucose checks and administration of insulin medication. Each staff will be observed once per week for a period of (three) months. After which, each staff will be observed once per month for a period of (three) months, Including the start date of the observations. Documentation of the observations shall be maintained by the home for Department review. [REDACTED] 3/12/26

Within five days of receipt of the plan of correction: The administrator shall review and amend the home's policies regarding 2600.185a, specifically addressing the safe storage, access, distribution, and use of glucometers and testing equipment. A copy of the updated policy will be provided to and reviewed with all medication administration staff. [REDACTED] 3/12/26]

Directed Completion Date: 03/16/2026

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

187a - Medication Record

12. Requirements

2600.

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

- 3. Name of medication.
- 6. Dose.

Description of Violation

Resident [REDACTED] is ordered [REDACTED] oral tablet – Take 2 tablets by mouth every 6 hours as needed for pain, mild (1-3). However, the entry on the resident's January 2026 medication administration record (MAR) indicated [REDACTED] – Take 2 tablets = 650mg by mouth every 6 hours as needed for pain/mild (1-3).

On [REDACTED] at 1:55 p.m., there was a [REDACTED] with pharmacy label for resident [REDACTED]. However, the entry on the resident's January 2026 MAR indicates [REDACTED]

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 03/06/2026)

ACTION: On 1/7/26 resident [REDACTED] Tylenol new order recieved, by the Director of Nursing, order sent to the pharmacy to profile and send medication to indicate [REDACTED] take 2 tablets to= 1000mg. On 01/07/2026 resident [REDACTED] was corrected on the MAR to indicate [REDACTED], by the pharmacy. On 1/7/26 all current residents receiving insulin were audited to ensure that the insulin name on pen matched insulin name on the MAR, by the Director of Nursing.

187a - Medication Record (continued)

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 03/05/26 the Director of Nursing/designee and med trained staff that approves orders, will ensure the following for each resident for whom medications are administered, name of the medication and dose match the medication and dose on the MAR this will be reviewed prior to approving orders on the MAR, weekly x4, then monthly x 4. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/06/2026

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

187b - Date/Time of Medication Admin.

13. 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

On [REDACTED] resident [REDACTED] was ordered [REDACTED] tablet – Take 4 tablets (40mg total) by mouth daily for 3 days, THEN 3 tablets (30mg total) daily for 3 days, THEN 2 tablets (20mg total) daily for 3 days, THEN 1 tablet (10mg total) daily for 3 days. On [REDACTED] at 3:36 p.m., resident [REDACTED] s January 2026 MAR was documented that a blister of 3 tablets was administered on this date at 8:00 a.m. However, all of the blisters of 3 tablets were intact in the medication card for this medication.

Repeat Violation [REDACTED] et al. [REDACTED]

Plan of Correction

Accept [REDACTED] - 03/06/2026)

Action: Resident was to receive a tapered dose of prednisone. The resident was to receive 10mg: 4 tablets on 1/3/26, 1/4/26, and 1/5/26, On 1/6/26 [REDACTED] was to receive 3 tablets. A drop shipment was received from CVS pharmacy on 1/2/26 to start and receive 1st dose on 1/3/26. Attached are pictures of bottle. Remaining bubble pack received from Synchrony Pharmacy on 1/3/26 to administer remaining doses , at that point 2 doses of the 4 tablets was administered, at this point resident would have received 3 tablets on 1/6/26, the bubble pack contained 4 tablets, med tech administered 3 tablets, destroyed 1 per policy, see attached statement and destruction log.

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 are recorded at the time of the

Licensee's Proposed Overall Completion Date: 03/06/2026

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

190a - Completion Medication Course

14. Requirements

2600.

190a - Completion Medication Course (continued)

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

Direct care staff person A's initial medication administration training was passed on [redacted] No annual practicums have been completed since then. However, staff person A administered medications to residents to include:

- Resident [redacted] - carvedilol on [redacted] at 6:00 p.m., [redacted] on [redacted] at 5:00 p.m.; nystatin powder on [redacted] at 6:00 p.m.; [redacted] sod DR on [redacted] at 4:00 p.m., [redacted] on [redacted] at 9:00 p.m.
- Resident [redacted] - [redacted] & [redacted] tab on [redacted] at 8:00 p.m., [redacted] on [redacted] and [redacted] at 8:00 p.m.; [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] and [redacted] at 8:00 p.m.; [redacted] on [redacted] and [redacted] at 9:00 p.m., [redacted] on [redacted] and [redacted] at 8:00 p.m.
- Resident [redacted] - [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m., [redacted] on [redacted] at 8:00 p.m.

REPEATED VIOLATION: [redacted] et al.

Plan of Correction

Accept [redacted] - 03/06/2026)

Action: On 01/05/26 staff member A was removed from med cart, by the Director of Nursing. On 01/11/26 staff member A completed medication administration training.

Training: On 01/06/2026 Director of Nursing was educated on regulation 2600.190a by the Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

Ongoing: Effective 03/05/26, the Director of Nursing will monitor all medication technician required paperwork quarterly to ensure annual practicums are completed timely. Documentation of this quarterly audit will be kept and reviewed with the Executive Director. Documentation to be reviewed at the next monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: 03/05/2026

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

225a - Assessment 15 Days

15. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. However, the resident's initial assessment was not completed until [redacted]. REPEATED VIOLATION: [redacted] et al.

Plan of Correction

Accept [redacted] - 03/06/2026)

ACTION: On 7/23/25 an audit on current residents' RASP was completed by the Regional Director of Clinical Services. It was identified that the RASP was not completed within 15 days of admission. As of 01/07/2026 all new residents have had a written initial assessment within 15 days of admission, completed by the Director of Nursing or designee. Audit documentation will be kept.

TRAINING: On 01/06/2026 the Director of Nursing was educated on regulation 2600. 225a by the Executive Director. Documentation of the staff training shall be kept in accordance with 2600.65i.

225a Assessment 15 Days (continued)

ONGOING: Effective immediately, all new residents were added to an audit tool by the Director of Nursing to ensure a written initial assessment has been completed with 15 days of admission and is reviewed by the Regional Director of Clinical Services weekly x4 weeks. Results of this audit to be reviewed at the next monthly Quality Assurance meeting in March 2026.

Licensee's Proposed Overall Completion Date: 03/05/2026

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

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] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: WG SOUTH HILLS SH LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 87 **Waking Staff:** 65

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 04/07/2026

Inspection Dates and Department Representative

03/10/2026 On Site: [REDACTED]
03/17/2026 On Site: [REDACTED]
04/07/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 139 **Residents Served:** 80

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:** 80
Diagnosed with Mental Illness: 4 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 25 **Have Physical Disability:** 0

Inspections / Reviews

03/10/2026 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 04/20/2026

04/20/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/25/2026

04/29/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/24/2026

Reviewer: [REDACTED]

Follow Up Type: Exception

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] Staff person A, the homes administrator, submitted incident report [redacted] to the incorrect email address of [redacted] headquarters instead of the regional office email address of [redacted] despite being provided technical assistance on this issue several times previously.

Plan of Correction

Accept [redacted] - 04/20/2026)

Action: At the time of inspection, the Executive Director submitted the incident report to the regional office by email address. The initial incident report was submitted in a timely manner but to the wrong email address on 03/01/26 and forwarded to the correct address on 03/06/26 when notified of the error.

Training: A training was completed with the Executive Director and Director of Nursing on 03/11/26 to review regulation 2600.16c by the Regional Director of Operations. Training records will be kept?in?accordance with? Regulation 2600.65i.?

Ongoing: Future state incident reports will be sent to the appropriate regional email address and the Regional Director of Clinical Services as well as the Regional Director of Operations will be copied on all reports to ensure they were sent to the appropriate address.

Licensee's Proposed Overall Completion Date: 04/17/2026

Implemented ([redacted] 04/29/2026)

65a - FS Orientation 1st Day

2. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person B, substitute agency LPN hired on or before [redacted], did not receive general orientation in general fire safety and emergency preparedness that included the following:

(1) Evacuation procedures.

65a - FS Orientation 1st Day (continued)

- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

Direct care staff person C, substitute agency LPN hired on or before 2/10/26, did not receive general orientation in general fire safety and emergency preparedness that included the following:

- (1) Evacuation procedures.
- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

Plan of Correction

Accept [redacted] 04/20/2026)

Action: All agency staff have a required training packet to review and acknowledge prior to working in the home. The packet included the information outlined in 2600.65a. At the time of inspection, the Executive Director updated the packet and acknowledgement to more specifically review the training requirements

Training: On 3/18/26 the Executive Director and the Director of Nursing were educated on regulation 2600.65a by the Regional Director of Operations. Training records will be kept in accordance with Regulation 2600.65i.?

Ongoing: All agency records including their training acknowledgements are kept digitally within the agency's portal. Starting 4/1/26 an audit was started to review all current agency staff records to ensure their appropriate training documentation was completed. This audit will be completed by 4/24/26. Documentation of these audits will be kept and reviewed at the home's next Quality Assurance Meeting in March 2026. Effective 4/24/26, the Director of Nursing will keep a list of agency staff who have fully completed their training in accordance with regulation 2600.65a prior to picking up shifts. If new agency staff accept shifts at the home, the Director of Nursing will confirm this has been completed prior to working in the home.

Licensee's Proposed Overall Completion Date: 04/24/2026

Not Implemented [redacted] - 04/29/2026)

85b - Infestation

3. Requirements

- 2600.
- 85.b. There may be no evidence of infestation of insects or rodents in the home.

85b Infestation (continued)

Description of Violation

On [redacted] at approximately 3:25 p.m., resident's room [redacted] belonging to resident [redacted] had numerous flying insects in [redacted] room along with a dead cockroach lying on the television stand, and a live cockroach crawling up the wall behind the television.

Plan of Correction

Accept [redacted] - 04/20/2026)

ACTION: Resident moved from a hoarding situation prior to residing in the community. On different occasions staff reported seeing bugs in the unit. Each time the onsite Maintenance Director or Executive Director responded, and pest control was called. There were several treatments done in the unit, but it was determined that items being brought in from outside of the facility were the source of the issue. With approval from the POA and resident infested items were removed. On 3/20/26 the resident was relocated to a new unit with new furniture. On 03/20/26 a new treatment was completed by Orkin Pest Control in unit [redacted]. On 03/24/26 the pest control contract confirmed that the situation had been resolved.

TRAINING: On 3/18/26 the Executive Director, Maintenance Director, Director of Nursing and Sales Director were educated on regulation 2600.85b. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective immediately, the Executive Director will review how the home manages any pest control concerns with any new residents and their responsible parties during their contract signing which will include inspecting any furniture being brought into the community. The Executive Director will also review how to report any pest control concerns with residents at the next three monthly resident council meetings. Documentation of this review will be kept in the Resident Council minutes.

Licensee's Proposed Overall Completion Date: 04/17/2026

Implemented [redacted] - 04/29/2026)



187b - Date/Time of Medication Admin.

5. 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 [redacted] is prescribed [redacted] take one tablet by mouth three times daily for [redacted] however, on [redacted] and [redacted] while family members were in the room visiting the resident never received [redacted] 2:00 p.m. doses as scheduled. However, the electronic medication administration record was initialed by staff persons D and E recording that they did administer the drug to resident [redacted] An audit was done and it was determined that a total of three doses were not administered to resident [redacted] The third dose's date and time were never determined.

REPEAT VIOLATION - [redacted], et al., [redacted]

Plan of Correction

Accept [redacted] - 04/20/2026)

Action: On 2/3/26 the Director of Nursing filed DHS report; family and PCP were also notified. On 2/3/26 the Director of Nursing reviewed all current residents' MARS to ensure the time the medication administer was recorded. On 2/6/26 staff member D was removed from med carts by the Director of Nursing, discipline action taken. On 2/13/26 agency staff nurse/staff person E was DNR'd from the community by the Director of Nursing.

?

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 are recorded at the time of the administration, weekly x4, then monthly x4. Results to be reviewed at the next monthly

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

Quality Assurance meeting.?

Licensee's Proposed Overall Completion Date: 04/17/2026

Not Implemented [redacted] - 04/29/2026)

187d - Follow Prescriber's Orders

6. Requirements

2600.

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

Description of Violation

Resident [redacted] is prescribed [redacted] take one tablet by mouth twice daily to treat opioid dependence, however, on [redacted] at approximately 7:18 p.m., resident [redacted] requested [redacted] second dose [redacted] tablet and was informed by staff person C that the [redacted] was not on the cart. After an extensive search of the home and audits performed on all medication carts, the remaining 61 tablets of [redacted] were never located and considered missing.

Resident [redacted] is prescribed [redacted] take one tablet by mouth three times daily for [redacted] however, on [redacted] and [redacted] while family members were in the room visiting the resident never received [redacted] 2:00 p.m. doses as scheduled.

REPEAT VIOLATION [redacted], et al., [redacted]

Plan of Correction

Accept [redacted] - 04/20/2026)

Action: On 2/3/26 the Director of Nursing filed DHS report; family and PCP were also notified. On 2/3/26 the Director of Nursing reviewed all current residents' MARS to ensure the time the medication administer was recorded. On 2/6/26 staff member D was removed from med carts by the Director of Nursing, discipline action taken. On 2/13/26 agency staff nurse was DNR'd from the community by the Director of Nursing.

Training: On 3/17/26 the Director of Nursing was educated on regulation 187d, by the Regional Director of Clinical Services. On 3/17/26 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: 04/17/2026

Not Implemented [redacted] - 04/29/2026)

225a - Assessment 15 Days

7. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident [redacted] was admitted to the home on [redacted]. [redacted] had two assessments and support plans, both dated

225a - Assessment 15 Days (continued)

██████████. One assessment and support plan indicated that the resident's admission date was ██████████ and was signed and dated by the resident on ██████████. The second assessment and support plan indicated that the resident's admission date was ██████████ however, this was never signed by the resident.

REPEAT VIOLATION - ██████████, et al., ██████████

Plan of Correction

Accept ██████████ - 04/20/2026)

Action: At the time of inspection there were two copies of resident ██████████ initial assessment in their chart. On 3/10/26, resident ██████████ assessment was updated to reflect the correct admission date and was signed and dated by the resident. On 3/20/26 an audit was completed by the administrative assistant to ensure all current residents shall have a written initial assessment that is documented on the départements assessment form within 15 days of admission and is signed by the resident.

Training: On 3/18/26 the Director of Nursing and Executive Director were educated on regulation 2600.225a, by the Regional Director of Clinical Servies. Training records will be kept?in accordance with?Regulation 2600.65i.??

Ongoing: Effective 3/18/26 all initial assessments will be completed by ADON/DON and reviewed by the Director of Nursing prior to being filed in residents' chart to ensure the admission date is correct and that the resident has signed the assessment within 15 days admission. Documentation of these audits, this regulation and the training completed will be kept and reviewed at the home's next Quality Assurance Meeting in March 2026.??

Licensee's Proposed Overall Completion Date: 04/17/2026

Not Implemented ██████████ - 04/29/2026)

226a - Mobility Assessment

8. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident ██████████ medical evaluation completed on ██████████ indicates the residents use a wheelchair, however the resident's assessment indicated that the resident ambulates independently with a wheeled walker.

Plan of Correction

Accept ██████████ - 04/20/2026)

Action: On 3/10/26, at the time of inspection, residents' assessment was updated to reflect that residents use of a wheelchair for further distances and a walker for short distances, by the Director of Nursing. On 3/20/26 an audit of all current residents' mobility needs was completed by Administrative Assistant and ADON to ensure the mobility needs on the medical evaluation are reflected on the assessment.

Training: On 3/18/26 the Director of Nursing and Executive Director was educated on regulation 2600.26a by, the Regional Director of Clinical Services. Training records will be kept?in accordance with?Regulation 2600.65i.??

Ongoing: Effective 3/20/26 all residents mobility needs indicated on the medical evaluation will be placed on the resident's assessment by ADON/DON and will be reviewed by DON prior to placing on the residents' chart, to ensure the assessment reflects the mobility needs.

Licensee's Proposed Overall Completion Date: 04/17/2026

Implemented ██████████ - 04/29/2026)

