



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **WG SOUTH HILLS SH LLC**

LEGAL ENTITY

To operate **CELEBRATION VILLA OF SOUTH HILLS**

NAME OF FACILITY OR AGENCY

Located at **5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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To provide **Personal Care Homes**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **139**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **October 16, 2026** until **October 16, 2027**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **442840**

[Signature]
ISSUING OFFICER

[Signature]
DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628 – 04/23



Pennsylvania Department of Human Services

Emailing Date: October 16, 2026

[REDACTED]
WG South Hills SH LLC

[REDACTED]
Priority Life Care
[REDACTED]

RE: Celebration Villa of South Hills
5300 Clairton Boulevard
Pittsburgh, Pennsylvania 15236
License #: 442840

[REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 29, 2026, July 30, 2026, and September 30, 2026, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
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:** 11/05/2026
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:** Labor and Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 78 **Waking Staff:** 59

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Provisional, Incident **Exit Conference Date:** 07/30/2026

Inspection Dates and Department Representative

07/29/2026 On Site: [REDACTED]
07/30/2026 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 139 **Residents Served:** 58

Secured Dementia Care Unit

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

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 58
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 20 **Have Physical Disability:** 0

Inspections / Reviews

07/29/2026 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 08/27/2026

08/26/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 09/01/2026

08/31/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 09/15/2026

10/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/03/2026

Reviewer: [REDACTED]

Follow Up Type: Exception

15c - Supervision**1. Requirements**

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [REDACTED] at approximately 12:30pm, resident #1 reported an allegation of abuse against direct care staff person A. Direct care staff person A was immediately suspended; however, returned to work and worked unsupervised during the 7:00am-3:00pm shift on [REDACTED].

Plan of Correction**Accepted [REDACTED] - 08/26/2026)**

ACTION: On 7/24/26, immediately upon receiving resident #1's complaint the home interviewed and immediately suspended direct care staff person A. After a thorough investigation it was determined that there was no validity to the claim. On 07/27/26 staff person A returned to work.

Though the results of the home's investigation and the investigation conducted by the BHSL showed that the report was unfounded, the employee returned to "paid-suspended leave" as we wait for the findings for the APS investigation. To date there has been no visit or update on their investigation despite weekly calls to APS.

TRAINING: On 08/21/2026, the Director of Nursing, Assistant Director of Nursing, Administrative Assistant, Maintenance Director, Dietary Director, Activities Director and Executive Director were educated on 2600.15.c, with focus on proper suspension procedures and return to work protocols for abuse allegations against an employee, by the Regional Director of Operations. Documentation will be kept in accordance with regulation 2600.65i in the Executive Director's office.

ONGOING: Effective 08/21/2026 the Executive Director will immediately escalate any investigations that could potentially warrant staff suspension to the Regional Director of Operations and Regional Director of Clinical Services to ensure that all proper steps are taken, which in some cases will include waiting on APS and BHSL to conduct their own investigations before a matter is closed and cleared.

Licensee's Proposed Overall Completion Date: 08/28/2026

Implemented [REDACTED] - 10/01/2026)**88a - Surfaces****2. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On [REDACTED] at 11:06am, there was no door handle present on the right door of the double set of doors next to bedroom [REDACTED]

Repeated Violation- [REDACTED]

88a Surfaces (continued)

Plan of Correction**Accept** [REDACTED] - 08/31/2026)

ACTION: On July 31, 2026 the door handle identified during inspection was replaced by the Maintenance Director. At the time of the installation, however, though the door handle and door was functioning as it should, the home ordered a new door handle for replacement through North Hills Lock. Due to the unique parts required for the door's age and style, the handle was not readily available, on August 21, 2026 the handle was delivered and installed by North Hills Lock, and the entire door and assembly tested and deemed to be functioning properly.

TRAINING: On 08/21/2026, the Executive Director educated the Maintenance Director and Maintenance Assistant on 2600.88.a, with specific focus on door hardware and functionality. Documentation will be kept in accordance with 2600.65i, in the Executive Director's office. All current staff will be educated by the Executive Director on Regulation 2600.88.a by 09/01/2026. Documentation will be kept in the Executive Director's office.

ONGOING: Starting on August 28, 2026, the Maintenance Director will inspect the entire home daily for 1 week then weekly thereafter to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Parts will be ordered immediately and repairs performed when needed. Documentation will be kept of these audits will be kept in the home's work order tracking system and a review of the audit will be conducted during the home's monthly QA Meetings, this will start on August 28, 2026. Documentation of QA Minutes will be kept in the Executive Director's office.

Proposed Overall Completion Date: 09/01/2026

Licensee's Proposed Overall Completion Date: 09/01/2026

Implemented [REDACTED] - 10/01/2026)

100a - Exterior - Free of Hazards

3. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On [REDACTED] at 10:40am, there were numerous sections of the aluminum fence, located in the lower level courtyard area of the home, which were bent and not secured to the other sections of the fencing.

Plan of Correction**Accept** [REDACTED] 08/31/2026)

ACTION: On 07/29/2026, a metal bracket was installed on the damaged portion of the fence to further secure it, by the Executive Director. This fence was damaged by a storm, where a large tree fell on top of it. The repair has become part of an insurance claim. Maxim General Contracting was contacted on 07/29/2026 to replace the damaged section of the fence. The repair is going through an insurance claim with a scheduled call for 08/25/2026 to try to match & repair the fence. An additional fencing vendor was contacted and is scheduled to assess the fence and offer a quote on 08/28/2026.

TRAINING: The Executive Director trained the Maintenance Director and Maintenance Assistant on regulation 2600.100.a on 08/21/2026. A record of training will be maintained in/ accordance with 2600.65i and kept in the Executive Director's office.

100a - Exterior - Free of Hazards (continued)

ONGOING: Monthly preventative maintenance, starting on August 21, 2026, will be completed by the Maintenance Director who will inspect the entirety of the home's exterior. Any areas of concern will be addressed through the on-site maintenance team and/or an approved outside vendor when needed. Documentation of these audits will be kept in the home's work order tracking system and a review of the audit will be conducted during the home's monthly QA Meetings, this will start on 08/28/2026. Documentation of QA Minutes will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: 09/01/2026

Implemented [REDACTED] - 10/01/2026)

103g - Storing Food**4. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On [REDACTED] at approximately 10:30am, there was an opened and unsealed 30 pound box of bacon, which was approximately 3/4 full, present in the walk-in cooler.

Plan of Correction

Accept [REDACTED] - 08/26/2026)

ACTION: On 07/29/2026, at the time of inspection, the product, which was just opened for preparation at breakfast, was sealed, dated and secured, by the Dietary Director.

TRAINING: On 07/29/2026, the Dietary Director was reeducated on regulation 2600.103g, by the Executive Director. On 08/21/2026 all dietary staff were reeducated on regulation 2600.103g, by the Dietary Director. A record of training will be maintained in accordance with 2600.65i and documentation will be kept in the Executive Director's office.

ONGOING: Effective 08/21/2026 the Dietary Director and/or Cook will monitor frozen and refrigerated items weekly x 4, and then monthly x 4 to ensure items are stored in closed or sealed containers. Documentation of these audits will be kept in the Executive Director's office and reviewed during monthly QA Meetings starting on 08/28/2026. QA Minutes will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: 08/28/2026

Implemented [REDACTED] - 10/01/2026)

130g - Smoke Detector Repair**5. Requirements**

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On [REDACTED] at approximately 8:30am, the home's fire system became inoperative; however, at the time of inspection, the fire system was still inoperative. On [REDACTED] the home's fire panel indicated "fire trouble".

130g - Smoke Detector Repair (continued)

Plan of Correction**Directed () - 08/31/2026)**

The home respectfully requests to withdraw this citation. At the time of inspection the home's administrator explained and showed evidence from the fire alarm monitoring company stating that the fire system and panel were operating appropriately. The alarm sounded and the 'trouble signal' started on 7/21/26 after a leak in the home. Immediately after the leak was cleaned up, the home started fire watch and the company was called in for inspection. The responding company confirmed the alarm was working but recommended continuing fire watch in a certain area as a preventative measure in the event water was still settling. From 7/21/26 until the time of inspection the fire alarm system did not stop working, the fire watch and message on the panel was only a preventative to monitor for any additional concerns. This was all listed in an email from the vendor and provided to the home's inspector at the time of inspection.

ACTION: On 07/21/2026, a resident flooded their bathroom which leaked to the floor, damaging two smoke detectors. Grunau Fire Services were immediately contacted and came out to inspect and replace the smoke detectors. Grunau replaced the smoke detectors from the home's own stock. Though the system was functional, Grunau recommended that the community conduct fire watch only a small section of rooms where the leak occurred, to include the laundry area. Grunau suggested that the home remain on fire watch until further notice due to water that might be present on electrical wires connecting the smoke detectors; this was only a preventative measure. Having given the wiring ample time to dry, on 08/13/2026, an electrician scheduled by the Fire Protection Company, replaced wiring for the smoke detectors effecting Apt 212 & 214. The fire system was tested and is fully operational. There is no trouble signal on the fire panel. The home discontinued fire watch at that time. The home reported both the start and end of the fire watch measures to the regional incident reporting email address.

TRAINING: On 08/21/2026, Executive Director and Maintenance Director were retrained as to regulation 2600.130.g by the Regional Director of Operations. Documentation will be maintained in accordance with 2600.65i and kept in the Executive Director's office

DIRECTED: By 9/15/26: The home shall obtain written documentation from a qualified professional indicating the home's entire fire system is operable. Documentation shall be kept in the home. () 8/31/26

ONGOING: Whenever a smoke detector is found to be damaged, the home will continue to have the device replaced within a 48-hour time period. Documentation of immediate contact with the Fire Safety Company, repairs made and recommendations will be kept. A review of any concerns or repairs conducted will be reviewed during the home's monthly QA meetings starting on 08/28/2026. A record of QA minutes will be kept in the Executive Director's office.

Proposed Overall Completion Date: 08/28/2026

Directed Completion Date: 09/15/2026

Implemented () - 10/01/2026)

132g - Fire Drills Days/Times

6. Requirements

2600.

132g - Fire Drills Days/Times (continued)

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 4 staff persons during 11:00pm-7:00am shift; however, the home has not conducted a fire drill with only 4 staff persons since [REDACTED] at 1:03am.

Plan of Correction**Accept [REDACTED] - 08/31/2026)**

ACTION: The facilitator of monthly fire drills will not sign participation sheets when conducting/observing/monitoring fire drills, instead only those participating in evacuating residents will sign and be counted on the drills. The home conducted a 3rd shift/sleeping hours drill on 8/8/2026 in which the minimum amount of staff (4) participated. The home's updated fire drill record will be kept in the Executive Director's office.

TRAINING: The Executive Director and Maintenance Director will be retrained as to regulation 2600.132.g by the Regional Director of Clinical Services on 8/24/26. Documentation will be maintained in accordance with 2600.65i and kept in the Executive Director's office

ONGOING: For future third shift fire drills the Maintenance Director, who is facilitating all fire drills, will ensure that the minimum amount of staff are participating in 3rd shift drills, no more than minimum. The Executive Director shall review fire drill records monthly starting on 8/28/26 to ensure compliance with 2600.132g. . The fire drill logs will be reviewed at monthly QA meetings that are scheduled to start on 08/28/2026, documentation of the meeting minutes will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: 08/28/2026

Implemented [REDACTED] - 10/01/2026)**141b1 - Annual Medical Evaluation****7. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on [REDACTED]; however, resident #2's previous medical evaluation was completed on [REDACTED]

Repeated Violation- [REDACTED]

Plan of Correction**Accept [REDACTED] - 08/26/2026)**

The home is respectfully requesting that this violation be withdrawn. Resident #2's annual medical evaluation was not completed timely by previous Director of Nursing; this individual is no longer employed by the home. On 7/23/2025 an audit of all residents Medical Evaluations was completed by the Regional Director of Clinical

141b1 - Annual Medical Evaluation (continued)

Services; documentation of this audit was kept. A tracking system was created to ensure timely completion/scheduling of annual medical evaluations. Beginning on 10/10/25 the director of nursing/designee has reviewed and updated the tracking system monthly to ensure timely medical evaluations are completed in accordance with 2600.141b. This is a previous plan of correction that was approved, and the community has been working. Documentation of the tracking system shall be kept.

ACTION: On 7/23/25 an audit was conducted on all charts to identify any missing or late medical evaluations. Resident #2's late evaluation was identified, on 7/30/25 a new evaluation was completed when identified by the Director of Nursing. By 8/25/2025 all current residents had a Medical Evaluation which is in compliance with Regulation 2600.141b1.

On 08/11/2026 an audit of DME's was completed on all current residents, by the Director of Nursing, to ensure an annual medical evaluation has been completed. Documentation of this audit will be kept in the Executive Director's office.

TRAINING: On 08/21/2026 the Executive Director, Director of Nursing and Assistant Director of Nursing were reeducated on regulation 2600.141.b, by the Regional Director of Clinical Services. Documentation will be maintained in accordance with 2600.65i and kept in the Executive Director's office.

ONGOING: Effective August 8/25/25 the Director of Nursing continue to review tickler file monthly to ensure all current residents have an annual medical evaluation. The tickler file is to be reviewed a month prior to due date, by Director of Nursing or Assistant Director of Nursing. Effective 08/28/25 the results will be reviewed at the monthly Quality Assurance meeting. Documentation will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: 08/28/2026

Implemented [REDACTED] - 10/01/2026)

183d - Prescription Current**8. Requirements**

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [REDACTED] resident #1's [REDACTED] was present in the home's medication cart; however, the medication was discontinued on [REDACTED].

Plan of Correction

Accept [REDACTED] - 08/31/2026)

ACTION: On 07/30/2026, during the time of inspection the [REDACTED] was removed by the Director of Nursing. The original order was only for 14 days but it was identified that the resident still needed it. On 07/30/2026 a new order was obtained for resident #1's [REDACTED], by the Director of Nursing. This new order was presented to the inspector on 7/30/26.

183d - Prescription Current (continued)

On 07/30/2026 a complete med cart audit of all current residents was completed by the DON & ADON, to ensure only current prescriptions, OTC, sample and CAM medications were in the cart.

TRAINING: On 08/21/2026 the Director of Nursing and Assistant Director of Nursing was educated on regulation 2600. 183d, by the Regional Director of Nursing. By 08/27/2026 all medication trained staff were re-educated on regulation 2600.183d by the Director of Nursing. Documentation will be maintained in accordance with 2600.65i and kept in the Executive Director's office

ONGOING: Effective 08/21/2026, all discontinued orders to be reviewed by the Director of Nursing or Assistant Director of Nursing, along with medication being removed from medication cart by the Director of Nursing or Assistant Director of Nursing. Audits will be reviewed at monthly QA meetings that are scheduled to start on 08/28/2026, documentation of the meeting minutes will be kept in the Executive Director's office.

Licensee's Proposed Overall Completion Date: 08/28/2026

Implemented [REDACTED] - 10/01/2026)