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

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

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 **November 5, 2025** until **May 5, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **442841**

ISSUING OFFICER

Juliet Marsala
ACTING 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 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 5, 2025

[redacted]
WG South Hills SH LLC
5300 Clairton Boulevard
Pittsburgh, Pennsylvania 15236

RE: Celebration Villa of South Hills
License #: 442841

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) licensing inspections on June 5, 2025, July 1, 2025, July 3, 2025, August 15, 2025, and September 8, 2025, 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 REVOKES your certificate of compliance (442840) dated October 16, 2025 – October 16, 2026, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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 FIRST PROVISIONAL license is enclosed and is valid from NOVEMBER 5, 2025 to MAY 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)

Section:					
81(b)	II	86	$5	$430	5 calendar days from mailing date of this letter
185(a)	III	86	$3	$258	15 calendar days from mailing date of this letter
187(d)	II	86	$5	$430	5 calendar days from mailing date of this letter
63(a)	II	86	$5	$430	5 calendar days from mailing date of this letter
187(b)	III	86	$3	$258	15 calendar days from mailing date of this letter

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]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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
Fines Summary

cc: [redacted]

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:** *10/16/2025*

Address: *5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *WG SOUTH HILLS SH LLC*

[redacted]

Phone: [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:** *85* **Waking Staff:** *64*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *06/05/2025*

Inspection Dates and Department Representative

06/05/2025 - 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: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *80*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *5* **Have Physical Disability:** *0*

Inspections / Reviews

06/05/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/18/2025*

06/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/02/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/27/2025*

06/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/02/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/02/2025*

10/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/02/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At 9:25am, there was an unlocked and unattended binder labeled "med count cart 1" on top of the medication cart located in the 1st floor common living area near the kitchenette. The binder contained narcotic count logs for numerous residents, to include the following:

- *Resident #3's Tramadol HCL 500mg tablet-Take 1 tablet by mouth at bedtime*
- *Resident #4's Clonazepam 1mg tablet-Take 1 tablet by mouth every 8 hours as needed*
- *Resident #4's Buprenorphine 10mcg patch-Apply one patch to skin every 7 days*

Plan of Correction ***Accept [redacted] - 06/30/2025)***

Action: This was discovered by the Department Licensing Representative on 06/05/2025 and the Resident care Coordinator notified the medication technicians of this confidential issue immediately. The medication narcotic count logs for resident#3 and resident #4 as well as numerous other residents were locked and put away in the individual resident's medical record by the medication technician on 6/5/2025.
Training: On 6/9/25 – 6/16/25 medication technicians were trained on regulation 2600.17 record confidentiality by the Director of Nursing. Documentation on staff education will be kept. Starting on 6/27/2025-6/30/2025 staff education will be done and kept in accordance with regulation 2600.65i.
Ongoing: The Director of Nursing and/or Resident Care Coordinator will conduct daily audits starting on 6/9/2025, with the medication technicians, to ensure no records of confidentiality are left unattended. This area will be reviewed and monitored by the leadership team at monthly Quality Assurance meetings starting June 30, 2025. .

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 10/20/2025)

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

At 1:22pm, there was no cover present on resident #5's bed enabler, located at the top-right side resident #5's bed, which had an opening measuring approximately 12.5" wide by 7" high, which poses a limb entanglement risk to the resident.

At 1:26pm, there were no covers present on resident #6's bilateral bed enablers, located at the top on each side of resident #6's bed, which had openings measuring approximately 10.5" wide by 5" high, which poses a limb entanglement risk to the resident.

REPEAT VIOLATION: 4/22/2024, et. al.

81b - Resident Personal Equipment *(continued)*

Plan of Correction ***Accept [redacted] - 06/30/2025)***

Action: This was discovered by the Department Licensing Representative on 06/05/2025 and the Resident Care Coordinator immediately notified the caregivers and medication technicians of the hazardous condition of the bed enablers for resident #5 and resident #6. On 6/5/25, all resident rooms were checked, and pillowcases were placed over all bed enablers. The maintenance director removed all bed enablers that were not the PLC approved Halo bedside mobility devices . On 6/13/25 the Executive Director sent a letter to all residents' families informing them of the hazardous conditions of bed enablers and the PLC halo bed enabler policy.
Training: On 06/09/2025-6/16/2025 the Executive Director trained Medication Technicians on regulation 2600.81b. Documentation of training will be kept in accordance with regulation 2600.65i. Caregivers and housekeeping will also be educated on regulation 2600.81b on 6/12/25 by the Executive Director. Documentation of education will be kept in accordance with regulation 2600.65i.
Ongoing: Effective 6/19/25 the maintenance director or Resident Care Coordinator will check all resident beds weekly to ensure there are no hazardous bed enablers in place and documentation of this will be kept in the home's TELS maintenance platform system. This documentation will be reviewed and monitored by the leadership team at monthly Quality Assurance meetings starting June 30 2025..

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 10/20/2025)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 9:25am, the following medications were unlocked, unattended and accessible on top of the medication cart, located in the 1st floor common living area near the kitchenette:

- *A bottle of resident #1's Cefadroxil-500mg capsules*
- *A bottle of resident #2's Peg 3350 powder*

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept [redacted] - 06/30/2025)***

Action: This was discovered by the Department Licensing Representative during the complaint visit on June 5, 2025. The Director of Nursing was immediately notified and removed the medications from the top of the medication cart and locked them in the medication cart.
Training: Medication trained staff were trained on regulation 2600.183b on 6/6/25 and 6/7/25 by the Director of Nursing and Executive Director. Documentation of staff training will be kept in accordance with regulation 2600.65i.
Ongoing: The Director of Nursing, Resident Care Coordinator and/or designated medication technician will conduct daily rounds starting on 6/12/25 to ensure that no medications are left on the carts, all medications are stored properly, and the medication cart is locked. Documentation of daily rounds and any findings of the daily rounds will be kept in Executive Director office and reviewed and monitored by the leadership team at the monthly Quality Assurance meetings starting on June 30, 2025.
Regulation 2600.183b findings and plan to correct will be reviewed at June 30, 2025 Quality Assurance meeting

183b - Meds and Syringes Locked (continued)

and monthly thereafter.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 10/20/2025)

183d - Prescription Current

4. 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 /25, resident #7 was prescribed Ventolin HFA 90mcg-Inhale 2 puffs by mouth 3 times daily for 10 days; however, at the time of inspection, this medication was still present in the home's medication cart.

On 25, resident #7 was prescribed, "Chest Congestion Liquid 100/5ML-Take 2 teaspoons every 4 hours as needed for 10 days for cough/congestion; however, at the time of inspection, this medication was still present in the home's medication cart.

Plan of Correction ***Accept - 06/30/2025)***

Action: The expired medication was removed from the cart by the Director of Nursing and disposed of at the time of inspection on 06/05/2025. An audit of the medication cart was completed to be sure no further expired medication was in the cart at time of inspection on 6/5/25.
Training: All medication trained staff will be trained on regulation 2600.183d by the Director of Nursing and Executive Director. This training will be completed by 6/12/25. . Documentation of the training will be kept in the Executive Directors office and kept in accordance with regulation 2600.65i.
Ongoing: The Director of Nursing, the Executive Director and Resident Care Coordinator will conduct weekly MAR to Cart audits on 10 non-self-medicating residents
starting 6/12/25 . Audits will be kept in the Executive Directors office. Any expired, or order timed medication found will immediately be disposed of and the pharmacy will be notified to replace the expired medication. This area will be monitored by the Director of Nursing. and reviewed and monitored at the monthly Quality Assurance meetings starting June 30, 2025.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 10/20/2025)

185a - Implement Storage Procedures

5. 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 #7's glucometer is not set to the current date and time.

Resident #7 is prescribed Lispro insulin 100u/ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale: below 70-call MD; 0-140=0 units; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4

185a - Implement Storage Procedures (continued)

units; 301-340=5 units; 341-400=6 units; if greater than 401, call MD. On the following dates/times, resident #7's blood glucose readings were incorrectly documented on resident #7's June 2025 medication administration record (MAR):

- *On 6/4/25 at bedtime, resident #7's glucometer indicated a blood glucose reading of 167; however was documented on resident #7's June 2025 MAR as 171*
- *On 6/4/25 at dinner, resident #7's glucometer indicated a blood glucose reading of 152; however was documented on resident #7's June 2025 MAR as 181*
- *On 6/3/25 at dinner, resident #7's glucometer indicated a blood glucose reading of 155; however was documented on resident #7's June 2025 MAR as 161*
- *On 6/2/25 at dinner, resident #7's glucometer indicated a blood glucose reading of 173; however was documented on resident #7's June 2025 MAR as 161*
- *On 6/1/25 at bedtime, resident #7's glucometer indicated a blood glucose reading of 176; however was documented on resident #7's June 2025 MAR as 201*

Resident #8 is prescribed Albuterol AER HFA-Inhale 2 puffs by mouth every 6 hours as needed for wheezing; however, this medication was not present in the home and available for administration.

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept [redacted] - 06/30/2025)***

Action: Resident's glucometer was replaced with a new one calibrated with the correct date and time on 6/06/2025 by Director of Nursing. Medication Technician contacted the pharmacy on for a medication refill for Resident #8 for Albuterol AER HFA on 6/5/25 . The medication was delivered 6/6/25 and available for PRN administration. A complete medication cart audit was done by the Director of Nursing and the Resident Care Coordinator on 6/5/25 to be sure that all prescribed medication was in the cart and available for administration ..
Training: All medication trained staff were trained on regulation 2600.185a by the Director of Nursing and Executive Director beginning 6/6/25 and completed on
6/12/2025_ . Training included the following : 1. Proper calibration of glucometers 2. How to obtain accurate blood sugar readings and document the correct reading in the MAR at the time blood sugar is obtained. 3. Following the prescribers orders and having all prescribed medication in the medication cart and available for administration. Training included that if medication is not available in the medication cart , med trained staff will alert the Director of Nursing and/or Resident Care Coordinator and contact the pharmacy for the medication to be refilled and delivered Documentation of staff education will be kept in accordance with regulation 2600.65i and will be kept in the Executive Directors office.
Ongoing: Beginning on 6/16/25 a complete MAR to medication in cart audit will be done for 10 residents weekly for the next 6 weeks along with daily glucometer checks and weekly calibration of glucometers. The audits will include a review of resident's blood sugar documented in the MAR compared to the glucometer reading to ensure accuracy. These audits will be completed and documented by the Director of Nursing and Resident Care Coordinator and audits will be kept in the Executive Directors office and reviewed and monitored at monthly Quality Assurance Meetings starting on June 30, 2025. Upon completion of the weekly audits, the Director of Nursing will conduct a random sampling audit of blood sugar readings in MAR vs glucometer to ensure accuracy once a month ongoing.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented ([redacted] - 10/20/2025)

187a - Medication Record

6. 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.
4. Strength.
6. Dose.
8. Frequency of administration.
10. Duration of therapy, if applicable.

Description of Violation

On 5/4/25, resident #7 was prescribed Chest Congestion Liquid 100/5ml-Take 2 teaspoons every 4 hours as needed for 10 days for cough/congestion; however, at the time of inspection, this medication was still present on resident #7's June 2025 MAR.

Plan of Correction ***Accept [redacted] 06/30/2025)***

Action: Resident#7 discontinued medication was immediately removed from the medication cart and disposed of at the time of inspection on 06/05/2025 by the Resident Care Coordinator. The pharmacy was made aware that the order was still showing on the medication administration record and it was removed by pharmacy personnel on 6/5 25. An audit of all the medication carts was done on 6/5/25 to ensure that all discontinued and expired were not present in the cart.
Training: All medication trained staff were educated on regulation 2600.187 starting on 6/6/25- _06/16/2025 by the Director of Nursing. This training included that all discontinued and specific time duration of medication must be removed from the medication cart immediately upon discovery. Documentation of this training will be kept in the Executive Directors office. Documentation of staff education will be kept in accordance with regulation 2600.65i. h
Ongoing: Beginning on 6/16/25 a complete review of the Medication Administration Records to order audit will be done for all residents weekly for the next 4 weeks to ensure that all discontinued and expired medications are removed from the cart, and that medication orders on the MARS are accurate. These audits will be completed by the Director of Nursing and Resident Care Coordinator. Long term monitoring will be achieved by completing weekly Medication Cart Audits . These audits will be completed by the Director of Nursing, Resident Care Coordinator and Executive Director. All audit documentation will be kept in the Executive Directors office. The Executive Director will monitor this area. These audits will be reviewed and monitored at monthly Quality Assurance Meetings beginning June 30, 2025

Licensee's Proposed Overall Completion Date: *06/30/2025*

Not Implemented [redacted] - 10/20/2025)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #7 is prescribed Lispro insulin 100u/ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale: below 70-call MD; 0-140=0 units; 141-180=1 unit; 181-220=2 units; 221-260=3 units; 261-300=4 units; 301-340=5 units; 341-400=6 units; if greater than 401, call MD. On numerous dates/times, to include the following, no blood glucose readings were present on resident #7 glucometer:

187d - Follow Prescriber's Orders (continued)

- On 6/4/25 at lunch, no blood glucose reading was present on resident #7's glucometer; however, a blood glucose reading of 130 was documented on resident #7's June 2025 on this day and time
- On 6/3/25 at lunch, no blood glucose reading was present on resident #7's glucometer; however, a blood glucose reading of 127 was documented on resident #7's June 2025 on this day and time
- On 6/3/25 at breakfast, no blood glucose reading was present on resident #7's glucometer; however, a blood glucose reading of 128 was documented on resident #7's June 2025 on this day and time
- On 6/1/25 at lunch, no blood glucose reading was present on resident #7's glucometer; however, a blood glucose reading of 141 was documented on resident #7's June 2025 on this day and time

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Directed [redacted] - 06/30/2025)***

Action: On 6/6/25 a complete MAR audit of all current residents with glucometers was completed by the Director of Nursing and Resident Care Coordinator to ensure all prescribers orders are being followed, and that each glucometer had the proper blood sugar readings for each resident and that the correct corresponding documentation was present on the MAR per the MD order. Audits will include reviewing blood sugar readings on resident's glucometers to ensure all blood sugar readings are completed in accordance with the prescriber's orders and cross referenced with the blood sugar reading documented in the MAR. These audits will be kept in the Executive Director's office. The root cause of this violation is that the weekly Medication Administration Record and Cart audits to ensure we are following Prescriber's orders are not being done. If discrepancies are found, further training and/or staff counseling will be done by the Director of Nursing and/or the Resident Care Coordinator and/or the Executive Director.
Training: On 6.9.2025 ED, RCC and DON was educated on regulation 2600 187d by Regional Director of Clinical Services. On 6.9.25-6.15.25 all med tech staff were trained on regulation 2600187d by Director of Nursing. Documentation of the staff education will be kept in accordance with 2600.65i and kept in the Executive Directors office.
Ongoing: Beginning on 6/12/25, the Director of Nursing and Resident Care Coordinator will review Medication Administration Records 3 times a week for 3 months, then weekly to ensure that the community is following prescriber's orders. (DIRECTED: All resident prescribed blood sugar checks shall be included in each of the audits to ensure compliance with 2600.187d. [redacted] 6/30/25). Audits will include reviewing blood sugar readings on resident's glucometers to ensure all blood sugar readings are completed in accordance with the prescriber's orders and cross referenced with the blood sugar reading documented in the MAR. These audits will be kept in the Executive Director's office. The root cause of this violation is that the weekly Medication Administration Record and Cart audits to ensure we are following Prescriber's orders are not being done. If discrepancies are found, further training and/or staff counseling will be done by the Director of Nursing and/or the Resident Care Coordinator and/or the Executive Director. The Executive Director is responsible for monitoring this . Documentation of the audit findings will be kept in the Executive Director's office and reviewed and monitored by leadership at the monthly Quality Assurance meetings beginning on June 30, 2025.

Proposed Overall Completion Date: 06/30/2025

Directed Completion Date: *06/30/2025*

187d - Follow Prescriber's Orders *(continued)*

Not Implemented [redacted] - 10/20/2025)

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**: *10/16/2025*

Address: *5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *WG SOUTH HILLS SH LLC*

Address: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *07/08/2025*

Inspection Dates and Department Representative

07/01/2025 - On-Site: [redacted]

07/03/2025 - 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: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

07/01/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/02/2025*

08/04/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/08/2025*

08/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/27/2025*

10/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/28/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #5's most recent support plan, dated [redacted]/24, indicates resident #5 requires the physical assistance of 2 staff persons with transferring and toileting; however, according to numerous interviews, only 1 staff person regularly assists resident #5 with toileting.

Plan of Correction ***Accept ([redacted] - 08/04/2025)***

Action: Effective 7/4/2025 two staff members will be assigned to assist Resident #5 with all transferring and toileting needs, as outlined in the support plan
Training: Direct care staff will be trained on Regulation 2600.23a by the Director of Nursing by 8/9/2025. A full audit of resident assessments and support plans will be completed by the Director of Nursing and/or Resident Care Coordinator updated by 8-20-25. Documentation of the audit will be kept. All resident assessments and support plans of residents requiring assistance with activities of daily living will be reviewed with the documentation of the reviews kept. Training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: Director or Nursing and/or the Resident Care Coordinator will observe Resident #5's care weekly for the next 8 weeks to verify proper assistance is being provided. Observations will be documented and kept. A shift checklist will be implemented on 7/14/2025 to ensure all staff are aware of residents requiring two-person assistance, and that it is communicated to the direct care staff. This area will be monitored by the Executive Director and reviewed at the monthly Quality Assurance meetings beginning on 8/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

25a - Written Contract and Review

2. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2 was admitted to the home on [redacted]/25; however, resident #2's resident-home contract was not completed until 4/9/25.

Plan of Correction ***Accept ([redacted] - 08/11/2025)***

ACTION: The Regional Director of Operations discussed this noncompliant area with the Executive Director on 7/28/2025. Documentation of this discussion will be kept.
Training: The Regional Director of Clinical Services educated the Executive Director in Regulation 2600.25a. On 7/29/2025 and 7/30/2025 the Operations Specialist audited all of the current resident home-contracts for

25a - Written Contract and Review (continued)

completion and to ensure compliance. Training records will be kept in accordance with Regulation 2600.65i.
ONGOING: The Executive Director is responsible for maintaining compliance with Regulation 2600.25a. The Regional Director of Operations will monitor that each new written contract is reviewed within the required time for 4 weeks starting on 8/1/2025. Written contract review dates and signatures will be discussed at monthly Quality Assurance meetings starting on 8/25/2025. Documentation of Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

42b - Abuse

3. 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

From approximately 5/1/25 through 6/23/25, there were numerous unauthorized monetary transfers totaling approximately $2,696 from resident #10's personal bank account to PayPal and CashApp accounts belonging to staff person A. Additionally, from approximately 5/30/25 through 6/23/25, there were numerous unauthorized monetary transfers totaling approximately $5,235 from resident #10's personal bank account to PayPal and CashApp accounts belonging to staff person A's significant other. Prior to the unauthorized charges, resident #10 indicated that staff person A asked resident #10 to borrow $40 for an Uber. Resident #10 complied and gave staff person A [redacted] debit card.

On the evening of 6/25/25, staff persons E and F were attempting to retrieve a cup of ice from resident #6, during which time staff person E forcibly grabbed both of resident #6's arms and instructed staff person F to remove the cup of ice from resident #6's hand.

REPEAT VIOLATION: 7/11/2024

Plan of Correction ***Accept [redacted] - 08/04/2025)***

Action: Upon investigation on 6/26/2025 Staff member E was immediately suspended. The Executive Director filed an Act 70 report and informed Adult Protected Services and the Department of the alleged incident. On 7/1/2025 The home was informed by the Department during their site visit that there were unauthorized monetary transfers totaling approximately $2,696 from resident #10's personal bank account to PayPal and CashApp accounts belonging to Staff person A. After the investigation was complete for the two incidents, Staff member A and E were terminated by the Executive Director. Staff E was terminated on [redacted]/2025 and Staff A was terminated on [redacted]025. Staff person F was trained in resident rights and reporting abuse on 7/8/2025 by the Executive Director.
TRAINING: Executive Director trained Staff person F on 7/8/2025 on Resident rights and reporting abuse. ERxecutive Director will retain all staff on regulation 42b and reporting requirements by 8-8-25 Training documentation will be kept in accordance with Regulation 65i.
ONGOING: Starting on 7/14/2025. Three resident interviews will be conducted weekly for 4 weeks, then monthly for six months. The Executive Director will be responsible for any issues identified and will address them immediately. The Executive Director is responsible for monitoring this area. Documentation of the interviews will be kept. This area and findings will be discussed at the monthly Quality Assurance meetings starting on 8/25/2025. Quality Assurance meeting minutes will be documented

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, hired on [redacted]/24, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted]/04/2025)***

ACTION: Direct care staff person A was immediately removed from the schedule by the Director of Nursing on 7/1/2025 upon findings by Department. Staff person A was terminated on [redacted]/2025by the Executive Director in response to the investigation that was conducted between 7/1/25-7/3/24. HR and Administrative Assistant have been tasked with ensuring that all new hires have their Diploma, GED or active registry status completed before their start date starting 7/28/2025. The Executive Director implemented a checklist that includes Regulation 2600.54a compliance. The checklist was started on 7/7/2025. An audit of all current direct care staff files was completed by the administrative assistance on 7-31-25 to ensure all have high school diploma or the equivalent per regulation 54a.
Training: The Executive Director trained caregivers on Regulation 2600.54a and trained Administrative Assistant on using the pre-employment checklist on 7/30/2025.Training records will be kept in accordance with Regulation 2600.65i.
ONGOING: The Administrate Assistant and/or the Executive Director will conduct monthly audits to ensure compliance with this regulation. Audits will be documented. The audits will be reviewed by the Executive Director at monthly Quality Assurance meetings starting on 7/31/2025. Meeting minutes will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

60a - Staff/Support Plan

5. 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

The home currently serves 80 residents. Of the 80 residents served, 18 of the residents are residents with mobility needs, and 5 of the residents require physical assistance from 2 staff persons to transfer in/out bed/chair. According to documentation from the fire safety expert, dated 9/24/24, the maximum evacuation time to the home's fire-safe areas is 8 minutes. The home routinely schedules 3 staff persons during the 11:00pm through 7:00am shift, which is not adequate to evacuate all residents in an emergency. Additionally, the home conducted a fire drill using only 3 staff

60a - Staff/Support Plan (continued)

persons on 2/4/25 at 4:00am; however, the evacuation time for that fire drill was completed in 8 minutes, 15 seconds, which exceeds the current maximum evacuation time.

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept (- 08/11/2025)***

Action: On 7/24/2025 the Executive Director increased overnight staff as a directive from the Department from 3 to 4 staff to ensure adequate coverage for emergency evacuations. Staffing schedules will be reviewed and adjusted every two weeks by the Executive Director to maintain compliance beginning 7/24/2025.
Training: Fire safety and evacuation training by Fire Safe Solution for the Executive Director was held on 7/31/2025. Documentation of training will be kept in accordance with Regulation 2600.65i.
Ongoing: An unannounced fire drill was completed on 7/31/2025 by the Executive Director at 11:30pm with 4 staff persons. The Executive Director and/or Maintenance person will conduct an unannounced fire drill within the next 30 calendar days scheduled on 8/21/2025 at 1:00am using 4 staff persons. The Director of Maintenance or the Executive Director will conduct unannounced monthly fire drills to ensure residents can be safely evacuated in emergency situations. Documentation of fire drill findings will be reviewed at monthly Quality Assurance meetings beginning 7/31/2025 by the Director of Maintenance or the Executive Director. Quality Assurance meeting minutes will be kept.

Licensee's Proposed Overall Completion Date: *08/21/2025*

Not Implemented - 10/20/2025)

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On numerous occasions, to include the following dates/times, there were no staff persons present in the home who are currently trained in first aid and certified in obstructed airway techniques and CPR:

- *On 6/14/25 from approximately 11:00pm through 6/15/25 at approximately 7:00am*
- *On 6/16/25 from approximately 11:00pm through 6/17/25 at approximately 7:00am*
- *On 6/20/25 from approximately 11:00pm through 6/21/25 at approximately7:00am*
- *On 6/25/25 from approximately 11:00pm through 6/26/25 at approximately 7:00am*
- *On 6/26/25 from approximately 11:00pm through 6/27/25 at approximately 7:00am*

REPEAT VIOLATION: 4/22/2024, et. al.

Plan of Correction ***Accept - 08/11/2025)***

ACTION: On 7/30/2025 A review of all staff CPR training was conducted by the Administrative Assistance and the Director of Nursing to identify which staff persons need first aid, certification in obstructed airway techniques and CPR. CPR classes were scheduled by the Regional Director of Clinical Services, who is a certified CPR trainer for training on 7/30/2025. Another CPR class is scheduled for 8/27/2025.
TRAINING: A CPR training was held on 7/30/25 by the Regional Director of Clinical Services a certified CPR/first aid instructor for and direct care staff that did not have a current CPR card. Leadership staff will be trained on regulation 63a by regional Clinical director by 8-8-25 with documentation kept. A copy of the required training and certification cards will be kept. Documentation of training will be kept in accordance with Regulation 2600.65i. On 7/24/2025

63a - First Aid/CPR Training (continued)

The Director of Nursing was trained by the Executive Director on reviewing the schedule to ensure that there is one staff person trained for every 50 residents in the home at all times. Documentation of training will be kept in accordance with Regulation 2600.65i.
ONGOING: Starting 7/31/2025 a review of trained staff on First Aid/CPR by the Director of Nursing and/or the Resident Care Coordinator will be done monthly to ensure compliance with this regulation. The Director of Nursing and/or the Resident Care Coordinator and/or the Executive Director will monitor and ensure that First Aid/CPR staff persons are scheduled for resident safety and compliance with Regulation 2600.63. The Executive Director and/or the Administrative Assistant will conduct a monthly review of the new tracking system which will include all current staff persons certified in CPR/first aid along with their current expiration dates. Tracking record will be documented. This area will be discussed at the monthly Quality Assurance meetings starting on 8/25/2025. Quality Assurance meeting minutes will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

64a - Admin Training

7. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person B, the home's administrator, has not successfully completed the Department-approved competency-based training test.

Plan of Correction ***Accept [redacted]/04/2025)***

ACTION: Staff person B, the Executive Director completed the Department-approved competency-based training test on 3/26/2025. The Executive Director located the required training test on 7/7/2025 and made a copy of the training record for the personnel file.
TRAINING: On 7/8/2025 the Regional Director of Operations discussed the importance of having the required training readily available in the personnel file and on Regulation 2600.64a. This discussion was documented on 7/8/2025 by the Regional Director of Operations.
ONGOING: Regulation 2600.64a finding will be discussed at the Quality Assurance meeting on 7/31/2025. Documentation of the Quality Assurance meeting will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
6. Safe management techniques.

65f - Training Topics *(continued)*

Description of Violation

Direct care staff person C, hired on [redacted]19, did not receive training on safe management techniques during the 2024 training year.

Direct care staff person D, hired on [redacted]/23, did not receive training on the following topics during the 2024 training year:

- *Safe management techniques*
- *Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration*

Plan of Correction ***Accept [redacted] - 08/04/2025)***

ACTION: Staff person C and D were trained on 7/8/2025 by the Administrative Assistant on the missed required annual training. Training documentation will be kept in accordance with Regulation2600.65i.
TRAINING: Between 7/7/2025 and 7/22/2025 all Direct Care Staff training records will be audited by the Executive Director and Administrative Assistant to ensure that the required training is completed. Audits will be documented by the Executive Director and kept. Direct Care staff, Director of Nursing and Resident Care Coordinator will be trained on Regulation 2600.65f by the Executive Director by 8/30/2025. Training will be documented and kept in accordance with Regulation 2600.65i.
ONGOING: The Executive Director will monitor and ensure that the training plan is being followed starting on 7/24/2025. Monthly scheduled training plan will be checked by the Executive Director or the Administrative Assistant and schedule the required training to ensure training compliance. The direct care staff persons will be reminded of the scheduled trainings by the Executive Director and/or the Director of Nursing and/or the Resident Care Coordinator and ensure attendance. This area will be discussed monthly at Quality Assurance meetings starting 7/31/2025. The Executive Director will monitor this area. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented ([redacted] - 10/20/2025)

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Description of Violation

Direct care staff person C, hired on [redacted]/19, did not receive training on emergency preparedness procedures and recognition and response to crises and emergency situations during the 2024 training year.

Direct care staff person D, hired on [redacted]/23, did not receive training on emergency preparedness procedures and recognition and response to crises and emergency situations during the 2024 training year.

Plan of Correction ***Accept [redacted] - 08/04/2025)***

ACTION: On 7/4/2025 direct care staff person C and D were made aware by the Director of Nursing of their

65g - Annual Training Content (continued)

missed training that needs to be done. The training schedule will be reviewed by the Administrative Assistant. All staff training records will be audited by the Executive Director by 8/25/2025 to ensure compliance with Regulation 2600.65g.
TRAINING: On 7/8/2025, direct care staff person C and direct care staff person D were trained on emergency preparedness and emergency situations, and on Regulation 2600.65g by the Administrative Assistant. Documentation of the training will be kept in accordance with Regulation 2600.65i.
ONGOING: The Executive Director will monitor and ensure that the training plan is being followed starting on 7/24/2025. The monthly scheduled training plan will be reviewed by the Executive Director or the Administrative Assistant to ensure training compliance. The direct care staff persons will be reminded of the scheduled training courses by the Executive Director and/or the Director of Nursing and/or the Resident Care Coordinator and ensure attendance. This area will be discussed monthly at Quality Assurance meetings starting 8/25/2025. The Executive Director will monitor this area. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

66b - Training Plan Content

10. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's 2025 staff training plan does not include the following:
- *The name, position and duties of each direct care staff person*
- *The dates, times and locations of the scheduled training for each staff person for the year*

Plan of Correction ***Accept [redacted] - 08/04/2025)***

Action: As of 7/24/2025 the home's 2025 training plan has been revised to include:
A complete list of all current direct care staff, including:
Full name
Job title/position
Description of job duties and responsibilities
A detailed training calendar for the 2025 calendar year that outlines:
The required training courses per staff member
The scheduled dates and times of each training session
The location where each training will be conducted
Training: The Regional Director of Operation trained the Executive Director on Regulation 66b on 7/30/2025. Training documentation will be kept in accordance with Regulation 2600.65i. The Executive Director and Resident care Coordinator will be responsible for maintaining and updating the training plan in compliance with Regulation 2600.66(b).
Ongoing: The training plan will be reviewed quarterly by executive Director, Resident care Coordinator and

66b - Training Plan Content (continued)

Administrative assistant to ensure accuracy and completeness. This will start on 7/30/2025.
A staff training tracker will be implemented to monitor compliance with training schedules and documentation requirements.
Any changes in direct care staff (new hires, resignations, position changes or training dates will be reflected in the plan.
An annual review of the training plan will be completed in December of each year to prepare for the upcoming year. This area will be monitored by the Executive Director and reviewed with the leadership team at the monthly Quality Assurance meetings starting 7/31/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/1/25 at 10:40am, there were 2 large uncovered garbage cans, both containing trash, outside the exit door of the "2 long hallway".

REPEAT VIOLATION: 7/11/2024

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/1/2025 upon findings the caregivers immediately took the trash to the dumpster and closed the lid.
Training: To ensure a clean and pest-free environment for everyone, the Executive Director is reminding all staff regarding the proper disposal of waste. The Executive Director trained all staff in Regulation 2600.85e on 7/7/2024-7/14/2025. Training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: Starting 7/7/2025 the home's leadership team will monitor this area when doing daily walking rounds. The Executive Director and/or the Manager on Duty will document their findings after their daily walk through. The findings will be reviewed at the monthly Quality Assurance meetings starting on 7/31/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

103d - Storing Food Off Floor

12. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 7/3/25 at 9:29am, numerous cases of water were stored on the floor in the 2nd floor emergency food and water storage closet.

103d - Storing Food Off Floor *(continued)*

Plan of Correction ***Accept [redacted] - 08/04/2025)***

ACTION: On 7/1/2025 the Dining Director immediately placed the water on the pallets in the storage closet to ensure the proper storage of emergency water supplies.
Training: The Dining Director was trained in Regulation 2600.103d by the Executive Director on 7/8/2025. The training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: At the home's monthly Quality Assurance meetings starting on 7/31/2025 a review will be done on Regulation 2600.103d. A weekly checklist to ensure that water is stored off the floor will be completed by the Dining Director starting 7/25/2025. A documented checklist will be kept. This area will be monitored by the Dining Director.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

132c - Fire Drill Records

13. 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 records for the following fire drills do not include the evacuation time in minutes and seconds:

- *6/24/25 at 9:30pm-evacuation time of 7 minutes*
- *9/24/24 at 2:05pm-evacuation time of 7 minutes*
- *8/27/24 at 6:07am-evacuation time of 8 minutes*
- *7/26/24 at 8:46am-evacuation time of 8 minutes*
- *6/24/24 at 9:18pm-evacuation time of 8 minutes*
- *5/21/24 at 1:31pm-evacuation time of 8 minutes*

The fire drill records for the following fire drills do not indicate the exit routes:

- *2/4/25 at 4:00am*
- *1/28/25 at 1:01pm*

The fire drill record for the fire drill conducted on 12/17/24 at 3:20pm does not indicate the number of residents that were present in the home at the time of the fire drill. The fire drill record just indicates 92 residents participated.

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/24/2025 the Executive Director replaced the old fire drill forms with the fire drill records from the DHS website ensures compliance with Regulation 2600.132c. On 7/31/2025 Fire & Life Safety Solutions completed the annual walkthrough. During this visit, they reviewed Pennsylvania fire drill regulations and help ensure our procedures are aligned with PA 2600.
Training: On 8/13/2025 the Director of Maintenace will be educated on Regulation 2600.132c, by Fire & life safety Solutions person. Documentation of training will be kept in accordance with Regulation 2600. 65i.The fire safety

132c - Fire Drill Records (continued)

expert will walk through the home and after the walkthrough, they will provide a formal letter summarizing their visit. On 7/31/2025 an overnight fire drill was completed with 4 direct care staff members and the Department's fire drill record was completed by the Executive Director.
Ongoing: Starting 7/31/2025 the Administrative Assistance will review the fire drill records monthly to ensure compliance. Fire drill record will be kept. The monthly review of the fire drill record will be discussed at the monthly Quality Assurance meetings beginning 8/25/2025. Documentation of the Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

132d - Evacuation

14. Requirements

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

Description of Violation

According to documentation from the fire safety expert, dated 9/24/24, the maximum evacuation time to the home's fire-safe areas is 8 minutes. According to the home's fire drill records, the evacuation time for the following fire drills exceeded 8 minutes:

- *2/4/25 at 4:00am-evacuation time was 8 minutes, 15 seconds*
- *1/28/25 at 1:01pm-evacuation time was 8 minutes, 10 seconds*

Plan of Correction ***Accept ([redacted] - 08/11/2025)***

ACTION: An additional staff person was added to the overnight shift effective 7/24/2025 as a directive from the Department. On 7/31/2025 a fire drill was completed with 4 staff members and evacuation time was 7 minutes and 16 seconds, with 79 residents in the home. The fire drill record was completed.
TRAINING: The staff will be trained in Regulation 2600.132d by the Director of Maintenace or the Executive Director by 8/13/2025. Documentation of training will be kept in accordance with Regulation 2600.65i. Fire safety and evacuation will be reviewed by the Executive Director at the resident council meeting on 7/31/2024. Resident council meeting minutes will be kept.
ONGOING: The Director of Maintenance and/or the Executive Director will monitor the time it takes to evacuate the home according to Regulation 2600.132d and will ensure it is completed within the designated time the Fire Safet Expert determined and has documented in the required letter. Starting 7/31/2025 the Administrative Assistant will be monitoring all fire drill documentation monthly to ensure compliance with regulation 2600.132d. This area will be discussed by the Administrator at the monthly Quality Assurance meetings starting on 7/31/2025. Documentation of Quality Assurance meetings will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

141a 1-10 Medical Evaluation Information

15. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's medical evaluation, dated [redacted]25, does not include resident #3's special health or dietary needs, immunization history, ability to self-administer medications and body positioning/movement. These sections of resident #3's medical evaluation are blank. Additionally, the medication section of resident #3's medical evaluation indicates "see attached"; however, nothing is attached.

REPEAT VIOLATION: 2/10/2025

Plan of Correction ***Directed [redacted] 08/11/2025)***

Action: Immediate reassignment on resident #3 will be re-evaluated by a licensed healthcare provider no later than 8/9/2025. All missing sections will be completed thoroughly and reviewed for accuracy. The Operations Specialist is responsible for conducting the audit to be done by 8/8/2025. All other resident records will be reviewed by the Director of Nursing/ Resident Care Coordinator to ensure they have a medical evaluation completed in its entirety, present in their chart by 8/25/2025.

Training: Initial audit completed on 7/23/2025 by the Regional Clinical Specialist to ensure they have medical evaluation, completed in its entirety present in the chart. On 7/28/2025 the Regional Clinical Director trained the Director of Nursing on Regulation 2600.141a 1-10. Training documentation will be kept in accordance with Regulation 2600.65i.

Ongoing: When a Medical Evaluation is received, the Director of Nursing and/or the Resident Care Coordinator will review it to ensure that the Provider filled out the form completely. (DIRECTED: Beginning on 8/15/25: The Director of Nursing or Resident Care Coordinator shall review all newly-completed medical evaluations within 72 hours of completion to ensure compliance with 2600.141a. LM 8/11/25). If it is incomplete the Provider will be notified to complete blank areas. The Director of Nursing and/or the Resident Care Coordinator are responsible for ensuring that the Medical Evaluation is complete and that all attachments are kept with it as documented on the Medical Evaluation. The Executive Director and/or the Administrative Assistant is responsible for monitoring this area and will review each Medical Evaluation to ensure compliance with Regulation 2600.141a 1-10 before filing it in the resident's medical record. This area will be discussed at the monthly Quality Assurance meetings beginning 8/25/2025. Quality Assurance meeting documentation will be kept.

141a 1-10 Medical Evaluation Information (continued)

Proposed Overall Completion Date: 08/25/2025

Directed Completion Date: *08/25/2025*

Not Implemented (- 10/20/2025)

141b1 - Annual Medical Evaluation

16. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #6's most recent medical evaluation was completed on /24; however, resident #6's previous medical evaluation was completed on /23.

REPEAT VIOLATION: 4/22/2024, et. al.

Plan of Correction ***Directed - 08/11/2025)***

Action: Immediate reassessment was done on resident #6 and will have a Medical Evaluation completed by 025. On 7/23/2025 an audit of all residents Medical Evaluations was completed by the Regional Director of Clinical Services with documentation kept. A tracking system was created to ensure timely completion/scheduling of annual medical evaluations. All residents that need a new Medical Evaluation to be in compliance will have it done by 8/25/2025. The Executive Director and Director of Nursing will ensure compliance with Regulation 2600.141b1 by reviewing each Medical Evaluation received prior to securing it in the resident's medical record.
Training: On 7/28/2025 Executive Director and Director of nursing were trained on Regulation 141 b1, by the Regional Director of Clinical Services. Training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: By 8/25/2025 all residents will have a Medical Evaluation which is in compliance with Regulation 2600.141b1. Medical evaluation schedule will be reviewed monthly to ensure the resident's Medical Evaluation is completed by their next annual due date. (DIRECTED: Beginning on 8/25/25: The Director of Nursing or Resident Care Coordinator shall review the tracking system monthly to ensure each resident has a timely medical evaluation completed in accordance with 2600.141b. 8/11/25).

This area will be reviewed at the monthly Quality Assurance meeting beginning on 8/25/2025. Quality Assurance meeting documentation will be kept.

141b1 - Annual Medical Evaluation (continued)

Proposed Overall Completion Date: 08/25/2025

Directed Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

184a - Resident's Meds Labeled

17. Requirements

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

Description of Violation

Resident #9 is prescribed "Bisacodyl 10mg suppositories-Insert 1 suppository rectally every 24 hours as needed for constipation for up to 24 days"; however, resident #9's pharmacy label indicates "Bisacodyl 10mg suppositories-Iinsert rectally every 4th day as needed for constipation".

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/4/2025 The physician was contacted immediately for clarification, by Director of Nursing. The pharmacy was notified of the discrepancy, and a corrected label was replaced on 7/4/2025 to reflect the accurate frequency. The Director of Nursing and Medication Technicians were instructed to follow the physician's order as written. The medication label error was due to a miscommunication between the prescribing physician and the pharmacy during transmittal of order. On 7/4/2025 a new correct pharmacy label was created by the Regional Director of Clinical Services. The label was placed on the medication bottle on 7/4/2025 by the Regional Director of Clinical Services.
Training: On 7/14/2025 the Director of nursing trained the Medication Technicians on Regulation 2600.184a and training documentation will be kept in accordance with Regulation 2600.65i. The Medication Technicians will also be retrained on the five rights of medication administration by the Director of Nursing by 8/8/2025. The Director of Nursing and/or the Resident Care Coordinator will observe each Medication Technician administering medications and following the five rights on administering medications to two residents by 8/25/2025. Observations will be

184a - Resident's Meds Labeled (continued)

documented and kept.
Ongoing: Starting on 8/1/2025 weekly audits of all residents to compare medication orders to pharmacy labels will be conducted by Director of Nursing and/or the Resident Care Coordinator. Any discrepancies seen by the Medication Technicians during their medication pass will be reported to the Director of Nursing or Resident Care Coordinator immediately and the plan to correct will be initiated. The Director of Nursing and the Resident Care Coordinator will oversee this area to ensure compliance with Regulation 2600.184a.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

185a - Implement Storage Procedures

18. 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 #9 is prescribed Lispro insulin 100u/ml-Inject subcutaneously before meals in accordance with sliding scale: 0-140=0 units; 141-180=1 unit; 181-220=2 units; 221-280=3 units; 281-300=4 units; 301-340=5 units; 341-400=6 units; >400, call MD. On the following dates/times, resident #9's blood glucose readings were incorrectly documented on resident #9's June 2025 medication administration record (MAR):

- *On 6/26/25 at the 6:30am, resident #9's glucometer indicated a blood glucose reading of 127; however was documented on resident #9's June 2025 MAR as 121*
- *On 6/23/25 at the 6:30am, resident #9's glucometer indicated a blood glucose reading of 224; however was documented on resident #9's June 2025 MAR as "NA" and "DR" indicating drug refused*

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept ([redacted] - 08/11/2025)***

Action: Medication Technicians who documented the readings incorrectly on Resident #9s Medication Administration Record were informed of this finding and noncompliance with Regulation 2600.185a. by the Director of Nursing on 7/7/2025.
Training: By 8/8/2025 Medication Technicians will be re-educated by the Director of Nursing on accurate documentation and the importance of aligning glucometer readings with Medication Administration Record documented entries and on Regulation 2600.185a. Resident #9's Medication Administration Record entries were reviewed and corrected for June 2025, with notations added to clarify discrepancies. Training by the Director of Nursing will be done by 8/8/2025 on accurate documentation of blood sugar readings with Medication Technicians by 8/8/2025 by the Director of Nursing. Training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: Starting on 8/6/2025 weekly audits of blood sugar documentation and glucometer readings will be completed for all residents who have blood sugar check orders by the Director of Nursing. Documentation will be kept. This area will be reviewed at the monthly Quality Assurance meeting beginning on 8/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

187b - Date/Time of Medication Admin.

19. 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 #9's June 2025 and July 2025 MAR's do not include the initials of the staff person who administered the following medications to resident #9:

- *Skin Prep Mis Wipes-Cleanse bilateral heals and elbows with soap and water twice daily pat dry and apply topically skin prep, which was not documented as administered on 7/1/25 at 9:00pm*
- *Sensi-Care Protective Bar-Apply topically to coccyx twice daily, which was not documented as administered on 7/1/25 at 9:00pm*
- *Lantus 100u/ml-Inject 10 units subcutaneously at bedtime, which was not documented as administered on 7/1/25 at 9:00pm*
- *Lispro 100/ml-Inject subcutaneously before meals per sliding scale, which was not documented as administered on 6/22/25 at 4:00pm*

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/25/2025 an audit of July 2025 Medication Administration Records was completed for all residents by the Director of Nursing to ensure all medications are recorded by the Director of Nursing.
Training: On 7/24/2025 the Executive Director and Director of Nursing were educated on Regulation 2600.187b, by Regional Director of Clinical Services. By 8/15/2025 all Medication Technicians will be educated on Regulation 2600.187b, by the Director of Nursing. Training documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: Starting 7/24/2025 the Director of Nursing and/or Resident Care Coordinator will review 18 Medication Administration Records weekly to ensure all medication is administered and recorded. Documentation of findings will be kept. Documentation of findings will be reviewed at monthly Quality Assurance meetings beginning 8/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

190a - Completion Medication Course

20. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff person C has not successfully completed the Department-approved medication administration annual practicum since [redacted]/22; however, has administered medications to numerous residents on numerous dates/times, to include the following medications to resident #6:

- *Acetaminophen-325mg tablets on 6/1/25, 6/7/25, 6/8/25, 6/11/25, 6/15/25 and 6/30/25 at 6:00pm*
- *Atorvastatin-40mg tablets on 6/7/25, 6/8/25, 6/11/25, 6/15/25 and 6/30/25 at 9:00pm*

190a - Completion Medication Course (continued)

- *Mirabegron-50mg tablets on 6/2/25, 6/12/25 and 6/27/25 at 9:00am*

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/1/2025 immediately upon discovery staff person C was removed from passing medication by Director of Nursing. On 7/15/2025 staff person C successfully completed and passed the Department-approved medication administration course. Record documentation is kept. Staff person C completed the diabetic patient education program on 6/27/2025 with documentation kept.
An audit of all current Medication Technicians will be done by clinical leadership to ensure all Medication Technicians are properly trained per regulation 190a by 8/5/2025.
Training: Executive Director and Director of Nursing will educate on Regulation 2600.190a by the Regional Nurse by 8/5/25 with documentation kept per regulation 2600.65i
Ongoing: The Executive Director and/or the Resident Care Coordinator and/or the Director of Nursing will conduct monthly audits of all Medication Technician records and will review all new Medication Technician certifications to ensure they are valid and current. This will be done beginning 7/15/2025 - 8/8/2025 with documentation kept. This area will be reviewed at monthly Quality Assurance meetings beginning 8/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

190b - Insulin Injections

21. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Direct care staff person C has not successfully completed the Department-approved medication administration annual practicum since [redacted]/22; however, administered Lispro insulin to resident #9 on the following dates and times:

- *6/29/25 at 11:30am*
- *6/28/25 at 11:30am*
- *6/26/25 at 11:30am*

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/1/2025 immediately upon discovery Staff person C was removed from passing medication by Director of Nursing. In accordance with the department-approved medication course direct care staff, staff person C successfully passed the Department-approved medication administration course on 7/15/2025 and diabetic patient education program on 6/27/2025 by a certified diabetic educator in accordance with regulation 2600.190b. The Director of Nursing verified that no adverse effects occurred from the administrations on 6/26/2025, 6/28/2025, and 6/29/2025 of resident #9 by staff person C on 7/1/2025. An audit of all current medication technicians' certifications will be done by clinical leadership to ensure all medication technicians are properly trained per Regulation 2600.190b by 8/5/2025.
Training: Executive Director and Director of nursing will be educated on regulation 190a by the Regional Nurse by 8/8/2025 with documentation kept per Regulation 2600.65i.
Ongoing: Starting 7/15/25 through the go happy platform messaging app and/or verbally all Medication

190b - Insulin Injections (continued)

Technicians will receive reminders about when their diabetic patient education is due to be completed by a certified diabetic educator. The education will be scheduled by the Director of Nursing before the Medication Technician's diabetic certification expires. The Director of Nursing will contact the certified diabetic patient educator and provide the number of Medication Technicians who will need education in the next quarter. The new tracking system will be used to notify the Medication Technicians in the quarter prior to certified diabetic expiration dates. The tracking system record will be kept by the Executive Director and reviewed quarterly starting on 7/15/2025. The tracking record will be reviewed at monthly Quality Assurance meetings starting 8/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

224a - Preadmission Screen Form

22. Requirements

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

Description of Violation

Resident #3's preadmission screening form, dated [redacted]/25, is not signed by the person who completed the screening. Additionally, resident #3's preadmission screening does not include a determination that the home can meet resident #3's needs. This section of resident #3's preadmission screening form is blank.

Plan of Correction ***Accept [redacted] - 08/04/2025)***

Action: The facility has immediately implemented a policy to ensure that all preadmission screening forms are completed and documented within the required 30-day period prior to any resident's admission. The Executive Director is responsible for verifying the completion of these forms before admission. Resident #3 prescreen form dated 5/27/25 was updated to include signature, and determination that the home can meet the resident's needs on 7/7/2025 by Executive Director. On 7/30/25 an audit of all current residents prescreens was initiated and to be completed on 8/6/25 to ensure signature of the person who completed the screening, and that the needs of the resident can be met by the services provided by the home by Regional Operations Specialist.
Training: To prevent recurrence, the facility has revised its admission protocol to include a mandatory checklist that requires the completion of the preadmission screening form. The checklist will be reviewed and signed off by the executive director or Director of nursing. On 7/28/2025 the Executive Director and Director of Nursing was educated on Regulation 2600.224a by the Regional Director of Clinical Services. Training record documentation will be kept in accordance with Regulation2600.65i.
Ongoing; Effective 7/28/2025, the Director of Nursing will be responsible for keeping an audit sheet for all new residents prescreening form to be reviewed prior moving in to ensure compliance with Regulation 2600.224a, by the Director of Nursing and Executive Director prior to placing on resident medical record. Documentation to be reviewed at monthly Quality assurance meeting starting 7/31/2025. Quality Assurance meetings documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented [redacted] - 10/20/2025)

225a - Assessment 15 Days

23. 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 #2 was admitted to the home on [redacted]/25; however, resident #2's assessment was not completed until [redacted]/25. Additionally, resident #2's assessment, [redacted]/25, does not include the diagnoses of Hypothyroidism, Hypertension, and Tachycardia as indicated on resident #2's medical evaluation, dated "3/6/25-4/4/25".

Resident #3 was admitted to the home on [redacted]25; however, no assessment was completed for resident #3.

Resident #8's medical evaluation, dated [redacted]/25, includes diagnoses of Polyneuropathy, Hyperlipidemia, muscle weakness and frequent falls; however, these diagnoses are not indicated on resident #8's assessment, dated [redacted]25.

Resident #8's assessment, dated [redacted]/25, indicates resident #8 has no supervision needs; however, on [redacted]/25, resident #8 wandered from the home and was found by police at a nearby gas station.

REPEAT VIOLATION: 7/11/2024

Plan of Correction ***Accept [redacted] - 08/11/2025)***

Action: On 7/7/2025 Resident Reassessment will be done on each affected resident #2, #3, #8 and will have a full reassessment done by the Executive Director and/or Director of Nursing and/or the Resident Care Coordinator within 15 days of admission. Diagnoses listed in the medical evaluations will be verified and incorporated into updated care plans. A comprehensive audit of all current residents' assessments vs. medical evaluations will be completed by 8/8/2025. Any discrepancies will be corrected immediately and documented including direct comparison against medical evaluations. Supervision needs will be reassessed and verified during initial assessment, annually and within 5 days of a significant change.
On 7/7/2025 resident #2 RASP dated [redacted]/25 was updated by the Executive Director to include diagnosis from medical evaluation dated 3/6/25-4/4/25. Resident #3 admitted to the community on [redacted]/25 RASP was completed on 7/7/2025 by Executive Director. On 7/7/2025 resident #8 RASP was updated to include from medial evaluation dated [redacted]25 and supervision needs by Director of Nursing. On 7/23/25 an audit on current residents RASP was completed by the Regional Director of Clinical Services. All current residents will have completed RASP by 8/15/2025. Audit documentation will be kept.
Training: Mandatory in-service training on assessment procedures and documentation accuracy will be provided to all clinical staff by 8/9/2025.Training will include elopement risk identification and prevention. On 7/28/2025 the Executive Director and Director of Nursing was educated on regulation 2600.225a by Regional Director of Clinical. On 8/7/2025 all staff will be educated on regulation 2600.225a by the Director of Nursing and Executive Director. Training record documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: Starting 8/1/2025 the Director of Nursing and/or the Resident Care Coordinator will monitor completion and accuracy of assessments by reviewing 10 assessments a week for the next 90 days. Starting 10/1/2025 a quarterly review of 20 assessments will be implemented to ensure long-term compliance. Starting 8/1/2025 all residents shall have a written initial assessment that is documented on the department's assessment form within 15 days of the admission, by the Director of Nursing or the Resident Care Coordinator or the Executive Director. All admissions will be reviewed within 15 days to ensure written assessment is completed by the Director of Nursing for 3 months. Documentation to be kept and reviewed at monthly Quality Assurance meetings beginning 8/25/2025.

225a - Assessment 15 Days (continued)

Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented [redacted] - 10/20/2025)

225c - Additional Assessment

24. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #5's most recent assessment is dated as completed on [redacted]/24.

Resident #6's most recent assessment was completed on [redacted]4; however, resident #6's previous assessment was completed on [redacted]/23. Additionally, resident #6's current assessment, dated [redacted]/24, indicates resident #6 is prescribed a pureed diet; however, on [redacted]/25, resident #6 was prescribed a mechanical soft diet with nectar thickened liquids.

On 3/26/25, resident #7 was prescribed a pureed diet with nectar thick liquids; however, resident #7's most recent assessment, dated 7/2/24, indicates a regular diet.

REPEAT VIOLATION: 2/10/2025

Plan of Correction ***Accept[redacted] - 08/11/2025)***

Action: A comprehensive review and completion of the missing assessments for residents # 5,6,7 was done on 7/11/2025. The Director of Nursing is responsible for ensuring the assessments are updated accurately and completely. On 7/14/2025 resident # 5 RASP dated [redacted]/24 was completed assessment dates by Director of Nursing on 7/14/2025 Resident #6 RASP was updated to reflect current diet on 7/14/2025 by Director of Nursing. 7/14/2025 Resident #7 RASP was updated to reflect current diet 7/14/2025 by Director of Nursing. On 7/23/25 an audit of all current residents RASP was completed by the Regional Director of Clinical Services. On 7/31/2025 an audit of all residents' diets was completed by the Regional Operations Specialist. All current residents to have completed RASP by 8/30/2025. Documentation of audits will be kept.
Training: To prevent recurrence, we have revised our assessment process to include a mandatory checklist that ensures all sections are completed. The Regional Director of Clinical Services held a training for Director of Nursing and Executive Director on 7/14/2025 on the importance of thorough assessments and on Regulation 2600.225c. Documentation of training will be kept in accordance with regulation 2600.65i. Documentation of monitoring will be maintained by the Executive Director.
Ongoing: Beginning 8/1/2025 the Director of Nursing will monitor compliance by conducting 40 audits a month of residents' assessments to ensure all sections are completed. On 8/1/2025 a new tracking system was implemented by the Director of Nursing and Resident Care Coordinator to ensure timely completion of annual assessments. The Executive Director will monitor compliance by conducting 20 audits monthly of resident assessments to ensure all sections are completed. These audits will be documented and reviewed during the monthly Quality Assurance meeting held on 7/30/2025. Any audit discrepancies will be addressed immediately. The results of the audits will

225c - Additional Assessment (continued)

be evaluated quarterly to ensure compliance. Effective 8/25/2025 all current RASP's will be updated with any resident changes and to be completed annually or if the condition of the resident significantly changes prior to the annual assessment, by the Director of Nursing or Resident Care Coordinator or the Executive Director. Documentation to be kept and reviewed at monthly Quality Assurance meetings beginning 8/25/2025.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented - 10/20/2025)

227a - Support Plan 30 Days

25. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #2 was admitted to the home on 25; however, resident #2's support plan was not completed until /25.

Resident #3 was admitted to the home on /25; however, no support plan was completed for resident #3.

Plan of Correction ***Accept - 08/04/2025)***

Action: The support plan for Resident #2 was completed on /2025. While this was past the 30-day requirement, it is now in place and addresses the resident needs. T Resident #3 admitted on /25 Support Plan was completed by Executive Director on 7/7/2025. On 7/23/25 a complete audit of all current residents Support Plans was completed by the Regional Director of Clinical Services. All current residents will have a completed Support Plan by 8/30/2025.
Training: On 7/28/2025 the Executive Director and Director of Nursing was educated on Regulation 2600.227a by the Regional Director of Clinical Services. On 7/31/2025 all staff were trained on Regulation 2600.227a by the Executive Director. Training record documentation will be kept in accordance with Regulation 2600.65i.
Ongoing: The Executive Director will conduct weekly audits starting 8/1/2025 of newly admitted residents to confirm that support plans are being initiated and completed within the regulatory timeframes. The Executive Director and/or the Director of Nursing will review the audits and address any identified deficiencies. The audits will be documented and maintained for review. Effective 8/1/2025 all residents requiring personal care services will have a written support plan developed and implemented within 30 days of admission to the home. The support plan will be documented on the Departments support plan by the Director of Nursing and/or the Resident Care Coordinator and/or the Executive Director. Regulation 2600.227a findings will be discussed at monthly Quality Assurance meetings starting 8/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Not Implemented - 10/20/2025)

227g -Support Plan Signatures

26. Requirements

227g -Support Plan Signatures *(continued)*

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5's most recent support plan, dated [redacted]/24, is not signed or dated by the assessor.

Resident #8's support plan, dated [redacted]/25, is not signed by the assessor.

REPEAT VIOLATION: 7/11/2024; 4/22/2024, et. al.

Plan of Correction ***Accept ([redacted] - 08/04/2025)***

Action: The assessors reviewed all signed plans immediately on 7/7/2025. On 7/7/2025 resident #5 support plan dated [redacted]/24 was signed and dated by the assessor. On 7/7/2025 Resident #8 support plan dated [redacted]/25 was signed by the assessor. On 7/23/2025 a complete audit of all current residents Support Plan signatures was completed by the Regional Director of Clinical Services. All current residents will have a completed Support Plan dated and signed by the assessor by 8/30/2025.
Training: On 7/28/2025 the Regional Director of Clinical Services trained the Executive Director, Director of Nursing on Regulation 2600.227g. Training records will be kept in accordance with Regulation 2600.65i. The Director of Nursing and Resident Care Coordinator will monitor compliance by conducting monthly audits of completed support plans to ensure they are signed and dated according to Regulation 2600.227g. The audits will be documented and reviewed by the Executive Director and any discrepancies will be addressed immediately, to ensure compliance. The results of these audits will be reviewed at monthly Quality Assurance meetings starting 8/25/2025. Documentation of Quality Assurance meetings will be kept.
Ongoing: Beginning 7/25/2025 to prevent recurrence of missing signatures the Executive Director and/or the Director of Nursing will review the signature page to ensure compliance before placing the Support Plan in the resident's medical record. The Executive Director will be responsible for monitoring and ensuring compliance. Audit of signature page will start on 7/25/2025 and be completed by Executive Director. The audits will be documented and will be reviewed at monthly Quality Assurance meetings starting 8/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/25/2025*

Implemented ([redacted] - 10/20/2025)

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**: *10/16/2025*

Address: *5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *WG SOUTH HILLS SH LLC*

Address: [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**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/15/2025*

Inspection Dates and Department Representative

08/15/2025 - 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: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

08/15/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/07/2025*

Inspections / Reviews *(continued)*

09/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/12/2025*

09/15/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/30/2025*

10/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted]25; however, resident #1's resident-home contract was not completed until 3/18/25.

Plan of Correction ***Directed [redacted] - 09/15/2025)***

ACTION: On 7/29/2025 and 7/30/2025 the Operations Specialist audited all the current resident home-contracts for completion and to ensure compliance with regulation 2600.25a. Audit documentation will be kept. By 9/16/25 a new admission checklist shall be created to ensure timely and complete resident-home contracts that are completed at admission in accordance with regulation 2600.25a. The checklist will be implemented by 9/17/25. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record.[redacted] 9/15/25).

TRAINING: On 9/16/25 the Regional Director of Operations educated the Sales Director, Administrative Assistant, Director of Nursing and Assistant Director of Nursing on Regulation 2600.25a. Starting 9/17/25 all staff persons involved in the admission process shall be educated on the new admission checklist by the Regional Director of Operations.
Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 8/1/25 the Executive Director is responsible for maintaining compliance with Regulation 2600.25a. Starting 8/1/2025, the Regional Director of Operations will monitor and ensure that each new written contract is reviewed within the required time upon move-in weekly for 4 weeks, then monthly. Audit documentation will be kept. An overview of the new admission checklist will be discussed by the leadership team at monthly Quality Assurance meetings starting on 9/25/2025. Documentation of Quality Assurance meetings will be kept.

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: *09/25/2025*

Not Implemented [redacted] - 10/20/2025)

42v - Resident-Home Contract

2. Requirements

42v - Resident-Home Contract *(continued)*

2600.
42.v. A resident has the right to receive services contracted for in the resident-home contract.

Description of Violation

Resident #1 was admitted to the home on [redacted]/25. According to resident #1's resident-home contract, dated [redacted]/25, resident #1 was assessed as level 2 level of care, which is an additional $1,172 per month. Resident #1's most recent level of care assessment, dated [redacted], indicates resident #1 requires moderate assistance with bathing from direct care staff persons and would receive bathing assistance 2 times a week. However, according to the bath sheets for resident #1, resident #1 only received assistance with bathing on the following dates since admission: 8/5/25, 7/15/25, 7/12/25, 7/8/25, 7/5/25, 6/28/25, 6/23/25, 6/21/25, 6/17/25, 6/10/25, 6/3/25, 5/17/25, 5/10/25 and 4/3/25

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION: The home did not keep the shower schedule up to date. Monitoring to ensure the shower schedule is current and residents are being bathed was not done by the Executive Director or the Director of Nursing. Both are no longer employed. On 8/16/25 resident #1 was showered by staff. On 9/5/25 resident #1's level care care assessment was reviewed by the Regional Director of Clinical Services. It was determined that resident has been a level 4 since admission on [redacted]/25 but that there was a billing error in the contract which resulted in a lower charge than what was owed.
On 9/2/25 the shower schedule for all residents was reviewed by the Regional Director of Operation to ensure compliance with regulation 2600.42v.

TRAINING: Starting on 9/5/25 through 9/12/25, the direct care staff will be trained on regulation 2600.42v with the focus being on the shower schedule and bathing residents who are assessed to need assistance. Training records will be kept in accordance with regulation 2600.65i.

ONGOING: The Director of Nursing or the Assistant Director of Nursing will review and audit the bath schedules by checking 15 residents per week for the next 9 weeks. Documentation of the audit findings will be kept. Starting 9/5/25 new residents who move in will be assessed and added to the bathing schedule by the administrative assistant. The Director of Nursing or Assistant Director of Nursing will monitor this area by checking that residents are scheduled and receive bathing assistance according to their assessment. Starting 9/16/25 the Director of Nursing or Assistant Director of Nursing will ensure that new residents are added to the shower schedule, complete a monthly review of the home's shower schedule along with reviewing the shower sheet documentation. Any areas identified as noncompliant will be investigated by the Director of Nursing or the Assistant Director of Nursing.Starting 9/16/25 the interim Executive Director will monitor and follow up with the Director of Nursing monthly to ensure compliance. An overview of the audit findings will be discussed with the leadership team at monthly Quality Assurance meetings starting on 9/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented ([redacted] - 10/20/2025)

88a - Surfaces

3. 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

Numerous brown and black stains were present on the carpet throughout the living area of resident #1's bedroom.

88a - Surfaces (continued)

At approximately 1:15 PM, there was a dark brown stain, approximately 3" in diameter, in front of the sofa in resident #2's bedroom. Resident #2 indicated the stain is from an incontinent accident.

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION:
The stains on resident #1 and #2's carpet were treated and cleaned on 8/16/25.
Starting 9/1/25 deep cleaning of all resident rooms have started which includes shampooing carpets. All resident units will be deep cleaned and all carpet in the community will be shampooed by 9/30/25. Work will be completed by the home's housekeeping and maintenance staff as well as contracted vendors. A record of these cleanings will be kept.

TRAINING: The home hired a Director of Maintenance on 9/2/25. As part of the Director's onboarding he has received training on room cleaning checklists and additional cleaning tasks that are scheduled in the home's work order system.
All housekeeping and maintenance staff received training on regulation 2600.88a as well as on the weekly cleaning checklist starting on 9/5/25 and will be completed by 9/12/25 by the Regional Director of Operations. Training records will be kept in accordance with regulation 2600.65i.

ONGOING: In addition to weekly housekeeping services and as-needed carpet cleanings, the home has developed a quarterly cleaning schedule to shampoo carpet in all resident units. These quarterly cleanings will be completed by the housekeeping and maintenance staff. A record of the completed cleaning tasks will be tracked and maintained in the home's work order system. The Executive Director and regional support staff will monitor task compliance monthly. An overview of the cleaning checklist will be discussed by the leadership team at the monthly Quality Assurance meetings starting 9/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented ([redacted] 10/20/2025)

141a 1-10 Medical Evaluation Information

4. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #3's medical evaluation, dated [redacted]25, does not include an assessment of resident #3's special health or dietary needs, and body positioning/movement. These sections of resident #3's medical evaluation are blank.

REPEAT VIOLATION: 2/10/2025

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION: Resident #3 ceased to breathe on [redacted]/25.
Initial audit was completed on 7/23/25 by the Regional Clinical Specialist to ensure that medical evaluations do not have blank areas and in the medical record. Documentation of the audit will be kept. A new admission checklist shall be created to ensure timely and complete medical evaluations are completed at admission in accordance with regulation 2600.141a. with implementation by 9/17/25.

TRAINING: By 9/12/25 the Regional Director of Operations trained the Director of Nursing and Assistant Director of Nursing on Regulation 2600.141a 1-10. By 9/16/25, the Regional Director of Clinical Services and/or the Regional Director of Operations shall educate all persons involved in the admission process. Training documentation will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 9/12/25 the Director of Nursing and/or the Assistant Director of Nursing will review the new resident medical evaluation upon admission, significant change status within 5 days and annual medical evaluations that are due to be done the specific month due to ensure that the Provider filled out the form completely. If the medical evaluation is incomplete, the Provider will be notified by the Director of Nursing or the Assistant Director of Nursing to complete blank areas.
By 9/25/25, the Director of Nursing and/or the Assistant Director of Nursing will audit 10 medical evaluations monthly for the next six months to ensure compliance with audit documentation kept. The Executive Director is responsible for monitoring the completeness of the medical evaluations to ensure compliance with Regulation 2600.141a 1-10 before the Administrative Assistant files it in the resident's record. This area will be discussed by the leadership team at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/25/2025*

141a 1-10 Medical Evaluation Information *(continued)*

Not Implemented [redacted] - 10/20/2025)

185a - Implement Storage Procedures

5. 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

The home's "Narcotic/Controlled Substance Monitoring" policy, which was revised on [redacted]/23, indicates, "A narcotic count is to be completed and the narcotic shift change form is to be signed by 2 qualified staff prior to accepting responsibility for the medication cart keys." However, during numerous shift changes, to include the following, the narcotic shift change form was not completed..

The narcotic shift change form was not completed on the following dates/times for the ground level medication cart:

- *On 8/5/24 during the 11:00 PM shift change*
- *On 8/4/24 during the 3:00 PM and 11:00 PM shift changes*
- *During all 3 shift changes on 8/3/25*
- *On 8/2/25 during the 3:00 PM and 11:00 PM shift changes*
- *During all 3 shift changes on 8/1/25*

The narcotic shift change form was not completed on the following dates/times for medication cart A:

- *On 8/4/25 by the outgoing staff person during the 7:00 AM shift change*
- *On 8/3/25 by the oncoming staff person during the 11:00 PM shift change*
- *On 8/1/25 by the oncoming staff person during the 3:00 PM shift change*
- *On 8/1/25 by the oncoming and outgoing staff persons during the 11:00 PM shift change*

The narcotic shift change form was not completed on the following dates/times for medication cart 1:

- *During all 3 shift changes on 8/5/25*
- *During all 3 shift changes on 8/4/25*
- *During all 3 shift changes on 8/3/25*
- *During all 3 shift changes on 8/2/25*
- *During all 3 shift changes on 8/1/25*
- *On 8/6/25 by the outgoing staff person during the 7:00am shift change*

No narcotic shift change form was present for August, 2025 for the 3rd floor medication cart.

Resident #3's controlled drug use record indicates 15 syringes of Lorazepam-2mg/ml were delivered to the home on 7/11/15. The controlled drug use record indicates a dose of this medication was administered to resident #3 on [redacted]/25 and 2 doses were administered to resident #3 on [redacted]25, which would leave 12 doses present in the home. However, the count on the controlled drug use record went from 12 to 9 on 8/6/25 without any documentation indicating when the additional 3 doses were administered.

185a - Implement Storage Procedures (continued)

On 8/6/25, 8 syringes of resident #3's Lorazepam-2mg/ml were destroyed because they were discontinued; however, according to controlled drug use record, 9 syringes were still present in the home at the time the medication was destroyed.

Resident #3's was prescribed Tramadol HCL 50mg tablet-Take 1 tablet by mouth every 4 hours as needed. On 7/23/25, the pharmacy delivered 28 tablets of the medication to the home and the controlled drug use record was created; however, the count on the controlled drug use record went from 28 to 26 without any documentation indicating when the 2 tablets were administered.

Resident #3 was prescribed Tramadol HCL 50mg tablet-Take 1 tablet by mouth twice daily. According to the controlled drug use record for this medication, resident #3 was administered the medication on [redacted]/25 at 9:00 AM and the remaining number of tablets was 13. Resident #3 was then administered the medication on [redacted]/25 at 8:00 PM and the remaining number of tablets was 12. Resident #3 was then administered the medication on [redacted]5 at 12:00 PM; however, the remaining number of tablets indicates 13.

Resident #4 is currently prescribed Oxycodone 15mg tablet-Take 1 tablet by mouth twice daily at 9:00 AM and 6:00 PM, as well as prescribed Oxycodone 15mg tablet-Take 1 tablet by mouth every 8 hours as needed. At the time of inspection, 56 Oxycodone-15mg tablets were present in the blister pack for the twice daily dose; however, the inventory shift count report indicated 55 tablets are present in the home. Additionally, at the time of inspection, 85 Oxycodone-15mg tablets were present in the blister pack for the as needed dose; however, the inventory shift count report indicated 86 tablets are present in the home.

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION: Medication Technicians did not follow the policy on Narcotic/Controlled Substance Monitoring and were not being monitored by the Director of Nursing, Assistant Director of Nursing or the Executive Director to see that the policy was being followed. The Director if Nursing and Executive Director in the home at the time of violation are no longer employed at the community. On 8/7/25 an electronic narcotic count was put into place by the Regional Director of Clinical Services after medication technicians were trained by the Regional Director of Clinical Services from 8/7/25 to 9/12/25. By 9/11/25 the Medications Technicians, Director of Nursing, Assistant Director of Nursing and Executive Director will be trained on the policy by the Regional Director of Clinical Services, or the Regional Director of Operations or the Regional Clinical Specialist. Documentation of training will be kept. The electronic narcotic record will ensure compliance with regulation 2600.185a. Training documentation will be kept in accordance with regulation 2600.65i. Starting on 8/7/25 a member of the management team, Regional Clinical Specialist, Life Enrichment Director, Sales Director, Executive Director, and the Dietary Director was present between each shift for narcotic count to ensure compliance with regulation 2600.185a. Documented shift count observations will be kept. The electronic narcotic count eliminates paper narcotic shift change forms. Starting 8/7/25, a designated staff person; Clinical Special, Director of Nursing or Assistant Director of Nursing shall review all narcotics for all current residents, which shall include a review of the physical counts of all narcotics compared to the home's controlled drug records to ensure compliance and accuracy. The review shall also include ensuring the electronic counts were completed at each shift change monthly for ~~2~~ [redacted]. ([redacted] The audits shall be conducted daily for 1 month then weekly thereafter for all residents prescribed a controlled substance. The reviews shall also ensure Documentation of the audits shall be kept for 2 months. [redacted] 9/15/25).

TRAINING: By 9/12/25 the Director of Nursing and Assistant Director of Nursing will be educated on regulation 2600.185a by Regional Director of Clinical Services. By 9/12/25 all medication technicians will be educated on

185a - Implement Storage Procedures (continued)

regulation 2600.185a, by the Executive Director. Training records will be kept in accordance with regulation 2600.65i.

ONGOING: Effective 9/16/25 the Clinical Specialist, Director of Nursing or Assistant Director of Nursing will review all narcotics for all current residents, which shall include a review of the physical counts of all narcotics compared to the home's controlled drug records to ensure compliance and accuracy weekly for 3 months and then monthly thereafter. The electronic shift count and electronic signatures will be accurately done between shifts due to the electronic controls that are in place. The electronic narcotic count must be signed by the off-going and oncoming medication technicians before medications can be given by the oncoming shift. Beginning 9/12/25 the Director of Nursing will monitor compliance with regulation 2600.185a, as they will be notified if there is an issue with the count/signatures, which will result in an investigation and resolution. An overview of the audits will be discussed by the leadership team at the monthly Quality Assurance meetings for 2 months starting 9/25/2025. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 09/25/2025

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented [redacted] - 10/20/2025)

187b - Date/Time of Medication Admin.

6. 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 #3's August 2025 medication administration record (MAR) does not include the initials of the staff person who administered numerous medications to resident #3 on numerous dates/times, to include the following:

- *Buspirone 5mg tablet-Take 1 tablet by mouth twice daily, which was not documented as administered at 8:00 PM on 8/1/25*
- *Eliquis 5mg tablet-Take 1 tablet by mouth twice daily, which was not documented as administered at 8:00 PM on 8/1/25*
- *Lactulose solution 10gm/15-Take 30ml=20mg 3 times daily, which was not documented as administered at 4:00 PM and 8:00 PM on 8/1/25*
- *Lidocaine 4% patch-Apple 1 patch topically to left knee lateral (outside) in the morning and remove at bedtime, which was not documented as applied at 8:00 AM on 8/9/25, and was not documented as removed at 8:00 PM on 8/1/25 and 8/10/25*
- *Lorazepam 2mg/ml-Give 1 syringe=0.5ml (1 mg) by mouth sublingually every 6 hours, which was not documented as administered at 12:00 PM on 8/9/25*
- *Mag Oxide 400mg tablet-Give 1 tablet by mouth twice daily, which was not documented as administered at*

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

8:00 PM on 8/1/25

- Melatonin 3mg tablet-Take 2 tablets=6mg by mouth at bedtime, which was was not documented as administered at 8:00 PM on 8/1/25
- Metoprolol Tar 25mg tablet-Take ½ tablet=12.5mg by mouth twice daily, which was not documented as administered at 8:00 PM on 8/1/25
- Tramadol HCL 50mg tablet-Take 1 tablet by mouth twice daily, which was not documented as administered at 8:00 PM on 8/1/25
- Trazadone 50mg tablet-Take 1 tablet by mouth at bedtime, which was not documented as administered at 8:00 PM on 8/1/25

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Directed [redacted] - 09/15/2025)***

ACTION: On 9/11/25 a mandatory training is scheduled for all medication technicians.
All medication technicians were observed during medication passes through August 2025 by a certified medication trainer or licensed staff. Through investigating this noncompliance finding, it was discovered that there were not enough computers for the medication technicians to immediately document that medications were given which contributed to noncompliance. The former Executive Director did not ensure the medication technicians had enough computers for each medication cart.
As soon as this noncompliant finding was brought to the attention of the regional team, computers were ordered for each med cart.
New additional computers for the medication carts were ordered by the Regional Director of Operations and put in place for use on 8/18/25 to assist the medication technicians to immediately record the administered medication.

TRAINING: By 9/12/25 the Director of Nursing and Assistant Director of Nursing will be educated on Regulation 2600.187b, by Regional Director of Clinical Services. By 9/12/2025 all Medication Technicians will be educated on Regulation 2600.187b, by the Director of Nursing. Training documentation will be kept in accordance with Regulation 2600.65i.

ONGOING: Effective 9/15/2025 the Director of Nursing and/or Assistant Director of Nursing will review Medication Administration Records weekly for 3 months to ensure all medication is administered and recorded. After 3 months the audits will be done monthly. (DIRECTED: At least 6 different resident MAR's shall be reviewed during each audit. [redacted] 9/15/25) Documention of the audits will be kept. An overview of the findings will be discussed with the leadership team at the monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meetings will be documented and kept.

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

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: *09/25/2025*

Not Implemented [redacted] - 10/20/2025)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #3 was prescribed Tramadol HCL 50mg tablet-Take 1 tablet by mouth twice daily; however, according to resident #3's August 2025 MAR and the controlled drug use report, this medication was not administered to resident #3 on 8/1/25 at 8:00 PM.

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept [redacted] - 09/08/2025)***

ACTION: On 9/11/25 all medication technicians are scheduled to attend a mandatory in-service which will include a review of 2600.187d.
TRAINING: On 9/11/25 the Director of Nursing, Assistant Director of Nursing and all medication technicians will be educated on regulation 2600.187d, by Regional Director of Clinical Services. Documentation of training records will be kept in accordance with regulation 2600.65i.
ONGOING: Effective 9/15/25 Director of Nursing or Assistant Director of Nursing will review 10 MARs weekly to ensure all medication is administered. Documentation will be kept. Effective 10/1/2025 monthly observations of medication pass of each person who administers medication to be completed by staff person trained in medications administration or a licensed nurse. Documentation of findings will be kept.? An overview of the findings will be discussed by the leadership team at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *09/25/2025*

Not Implemented [redacted] - 10/20/2025)

187d - Follow Prescriber's Orders *(continued)*

225a - Assessment 15 Days

8. 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 #1 was admitted to the home on [redacted]/25; however, no assessment was completed for resident #1.

Resident #3 was admitted to the home on [redacted]/25; however, resident #3's assessment was not completed until [redacted]/25. Additionally, resident #3's assessment, dated [redacted]25. does not include numerous diagnoses indicated on resident #3's medical evaluation, dated [redacted]/25, to include Paroxysmal Atrial Fibrillation and history of malignant neoplasm of breast. Also, resident #3's assessment does not include an assessment for resident #3's irritability, judgement, agitation, aggression, hallucinations, communications of needs, understanding instructions, short-term memory, long-term memory and ability to use and avoid poisonous materials. These sections of resident #3's assessment are blank.

REPEAT VIOLATION: 7/11/2024

Plan of Correction ***Directed ([redacted] - 09/15/2025)***

ACTION: The former Director of Nursing did not complete the assessment, and the former Executive Director did not monitor compliance with regulation 225a. It was discovered that no tracking system was in place. Starting 9/16/25 a new admission checklist shall be created to ensure timely and complete assessments are completed at admission in accordance with 2600.225a. Also, all staff persons involved in the admission process shall be educated on the new admission checklist. Documentation will be kept.
On 8/21/25 resident #1's assessment was completed, by Executive Director. Resident #3 ceased to breathe on [redacted]/25.
A comparison review of the Resident #1's assessment to the medical evaluation was completed by the Executive Director on 8/21/25.
TRAINING: By 9/12/25 the Director of Nursing and Assistant Director of Nursing will be educated on regulation 2600.225a by Regional Director of Clinical Services. By 9/16/25 all staff persons involved in the admission process shall be educated on the new admission checklist.Training record documentation will be kept in accordance with regulation 2600.65i.

225a - Assessment 15 Days (continued)

ONGOING: By 9/30/25, all current residents will have a complete, accurate assessment. Effective 10/1/2025 the Director of Nursing and/or the Assistant Director of Nursing will monitor completion and accuracy of assessments by reviewing 5 assessments a week for the next 90 days. Starting 11/1/2025, a quarterly review of 10 assessments will be implemented to ensure long-term compliance. Effective 8/1/2025 all new residents will have a written initial assessment that is documented on the department's assessment form within 15 days of the admission, by the Director of Nursing or the Assistant Director of Nursing. All admissions will be reviewed within 15 days to ensure written assessment is completed by the Director of Nursing and/or the Assistant Director of Nursing for 3 months. Documentation to be kept and reviewed by the leadership team at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/20/2025)

225c - Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment, dated [redacted]25, does not include the diagnoses of Spinal Stenosis as indicated on resident #2's most recent medical evaluation, dated [redacted]/25.

REPEAT VIOLATON: 2/10/2025

225c - Additional Assessment *(continued)*

Plan of Correction ***Directed [redacted] - 09/15/2025)***

ACTION: On 9/5/25 resident #2's assessment was updated to include diagnosis of spinal stenosis, by the Regional Director of Clinical Services. From 7/23/25 to 9/30/25, all current resident assessments will be reviewed to ensure they have an accurate and complete assessment. The updates will be done by 9/30/25.

TRAINING: By 9/12/25 the Director of Nursing and Assistant Director of Nursing will be educated on regulation 2600.225c by the Regional Director of Operations. Training record documentation will be kept in accordance with regulation 2600.65i.

ONGOING: Effective 8/1/25 all medical evaluation diagnosis are to be reviewed and included on annual assessments, by the Director of Nursing and Assistant Director of Nursing. (DIRECTED: By 9/30/25: The director of nursing/designee shall review all current resident records to ensure each resident has a current assessment completed in its entirety. [redacted] 9/15/25). Effective 10/1/2025 the Director of Nursing and/or the Assistant Director of Nursing will monitor completion and accuracy of assessments by reviewing 5 assessments a week for the next 90 days. Starting 11/1/2025 a quarterly review of 10 assessments will be implemented to ensure long-term compliance. Documentation to be kept and reviewed at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 09/25/2025

Directed Completion Date: *09/30/2025*

Not Implemented ([redacted] - 10/20/2025)

227a - Support Plan 30 Days

10. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted to the home on [redacted]25; however, no support plan was completed for resident #1.

Resident #3 was admitted to the home on [redacted]; however, resident #3's initial support plan was not completed until [redacted]/25.

227a - Support Plan 30 Days (continued)

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION: The former Director of Nursing did not complete the support plan for resident #1 and did not complete the support plan timely for resident #3. It was discovered that there was no tracking system in place, and the former Executive Director did not monitor compliance with regulation 227a. Starting 9/16/25 a new admission checklist shall be created to ensure timely and complete assessments are completed within 30 days of admission in accordance with regulation 2600.227a. Also, all staff persons involved in the admission process shall be educated on the new admission checklist by 9/16/25. Documentation will be kept. On 9/5/25, resident #1 support plan was completed by the Executive Director after being directed to complete the support plan by the Regional Director of Clinical Services.

TRAINING: By 9/12/25 Director of Nursing and the Assistant Director of Nursing will be educated on regulation 2600.227a, by Regional Director of Clinical Services. Also, all staff persons involved in the admission process shall be educated on the new admission checklist by 9/16/25 by Regional Director of Operations. Training record documentation will be kept in accordance with regulation 2600.65i.

ONGOING: Effective 8/1/2025 all residents requiring personal care services will have a written support plan developed and implemented within 30 days of admission to the home. The support plan will be documented on the Department's support plan by the Director of Nursing and/or the Assistant Director of Nursing. From 7/23/25 through 9/30/25, the Regional Director of Clinical Services reviewed all other resident records to ensure they have a completed support plan. By 9/16/25 a new admission checklist shall be created to ensure timely and complete support plans are completed at admission in accordance with 2600.227a. The admission checklist will be implemented on 9/17/25. The Executive Director will monitor compliance with regulation 2600.227a by reviewing the new admission checklist prior to filing the support plan in the resident's record. Documentation to be kept and discussed at monthly Quality Assurance meetings starting 9/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented ([redacted]/20/2025)

227d - Support Plan Medical/Dental

11. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2's most recent assessment, dated [redacted]25, indicates 10 different diagnoses, to include Gastroesophageal Reflux Disease without Esophagitis, Anemia, Osteoarthritis, Hyperlipidemia, Essential Hypertension and recurrent Depressive Order; however, resident #2's most recent support plan, dated [redacted]/25, indicates the same plan that "med techs will follow physicians prescribed orders" for each of the 10 different diagnoses.

227d - Support Plan Medical/Dental (continued)

Plan of Correction ***Accept [redacted] - 09/15/2025)***

ACTION: Resident #2 support plan updated on 8/11/25 by the Operations Specialist. All support plans will be reviewed to ensure compliance with regulation 227d by the Regional Director of Clinical Services, Director of Nursing and/or the Assistant Director of Nursing by 9/30/25. The Director of Nursing and/or Assistant Director of Nursing will monitor completion and accuracy of all current support plans by reviewing 5 support plans a week for the next 90 days starting on 10/1/25. Audit documentation will be kept. Starting 11/1/2025, the Executive Director will complete a quarterly review of 10 assessments that will be implemented to ensure long-term compliance. The audits will be documented and reviewed by the leadership team at the monthly Quality Assurance meetings starting 9/25/2025. Quality Assurance meeting documentation will be kept.
Licensee's Proposed Overall Completion Date: 09/25/2025

TRAINING: By 9/12/25 the Director of Nursing and Assistant Director of Nursing will be educated on regulation 2600.227d by the Regional Director of Clinical Services. By 9/30/25 the medication technicians and direct care staff will be educated in support plans by the Director of Nursing and the Assistant Director of Nursing. Training records will be kept in accordance with regulation 2600.65i.

ONGOING: Effective 10/1/2025 the Director of Nursing and/or the Assistant Director of Nursing will monitor completion and accuracy of support plans by reviewing 5 assessments a week for the next 90 days. Starting 11/1/2025 a quarterly review of 10 assessments will be implemented to ensure long-term compliance. The audits will be documented and will be reviewed by the leadership team at the monthly Quality Assurance meetings starting 9/25/2025. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/20/2025)

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**: *10/16/2025*

Address: *5300 CLAIRTON BOULEVARD, PITTSBURGH, PA 15236*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *WG SOUTH HILLS SH LLC*

Address: [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**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/08/2025*

Inspection Dates and Department Representative

09/08/2025 - 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: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

09/08/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2025*

Inspections / Reviews *(continued)*

09/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/27/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/06/2025*

10/03/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/17/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/17/2025*

10/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/17/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

On 9/2/25, resident #1's support plan, dated [redacted]/25, was updated to indicate resident #1 requires 1:1 supervision, which will be provided by staff/family, due to an incident that occurred on [redacted]/25 where resident #1 left the home unattended. However, on 9/8/25 at 11:15 AM, and then again at 1:19 PM, resident #1 was unsupervised and alone in resident #1's bedroom.

According to resident #2's most recent assessment, dated [redacted]/24, resident #2 requires physical assistance with showering. The direct care staff persons complete bath sheets for any resident that requires assistance with showers; however, at the time of inspection, no bath sheet was present for resident #2. Also, resident #2 indicated direct care staff persons "never never help me with a shower".

According to resident #2's most recent assessment, dated [redacted]/24, resident #2 requires some physical assistance with personal hygiene. On numerous occasions, resident #2 requested assistance from direct care staff persons by using the home's call bell system. According to the home's SMART care call bell report, resident #2's call bell was never responded to approximately 15 times between 8/26/25 through 9/7/25. Also, on numerous occasions, the response time to resident #2's call bell was over 30 minutes, to include the following occurrences:

- *On 9/7/25 at 3:44 PM, the response time to resident #2's call bell was 114 minutes*
- *On 9/4/25 at 9:58 PM, the response time to resident #2's call bell was 96 minutes*
- *On 9/4/25 at 1:26 PM, the response time to resident #2's call bell was 66 minutes*
- *On 9/2/25 at 3:28 PM, the response time to resident #2's call bell was 83 minutes*
- *On 9/1/25 at 10:44 PM, the response time to resident #2's call bell was 80 minutes*
- *On 8/28/25 at 6:32 PM, the response time to resident #2's call bell was 63 minutes*

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: On 9/2/25 resident #1 left the home unsupervised due to a change in cognition. Home immediately contacted resident's [redacted] discuss a plan for one-on-one supervision until next steps could be determined. Home concluded that resident was more appropriate for a Secure Dementia Care Unit and not Personal Care. The home issued a 30-day notice on [redacted]/25 and required supervision to be in place until the move was scheduled.
On 9/8/25 staff were immediately assigned to resident #1, at 1:19 pm, when the inspector found resident without supervision. Resident's family had left without informing the home of their plans.
As part of a previous plan of correction, staff were trained on documenting shower assistance between 8/15/25-8/22/25. Starting 9/5/25 new residents who move in will be assessed and added to the bathing scheduled by the Administrative Assistant. On 9/23/25 and 9/25/25 all care staff attended mandatory meetings, at this meeting the expectation for shower documentation and timely call bell response was reviewed as well and management of the call bell equipment. Daily call bell response reports are now generated and sent to the Director of Nursing, Assistant Director of Nursing and Interim Executive Director to review daily.

TRAINING: As part of a previous plan of correction, staff were trained on documenting shower assistance between 8/15/25-8/22/25. Staff were retrained on this again during mandatory care staff meetings on 9/23/25 and 9/25/25. Documentation of these trainings will be kept in accordance with regulation 2600.65i.

23a - Activities of Daily Living Assistance (continued)

ONGOING: The Assistant Director of Nursing will check 15 resident shower sheets, and interview 15 residents who require assistance with bathing per week for the next 9 weeks to ensure compliance with the shower schedule. The Assistant Director of Nursing will check 15 resident call bell logs, and interview 15 residents who per week for the next 9 weeks to ensure timely response times to call bells. (DIRECTED: The audits and resident interviews shall begin on 10/7/25. The audits and resident interviews shall be conducted monthly immediately following the weekly audits/interviews. Documentation of the resident interviews shall be kept for 2 months. 10/3/25).
Documentation with the audit findings will be kept. The Interim Executive Director will monitor these audit findings as they are completed weekly.
An overview of this regulation and audit of shower sheets and call bell management will be discussed with the leadership team at the monthly Quality Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 10/02/2025

Directed Completion Date: *10/07/2025*

Not Implemented - 10/20/2025)

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions *(continued)*

Description of Violation

At 10:01 AM, there was a strong odor present in resident #4's bedroom. Also, there were large, dark stains inside the toilet in resident #4's bathroom.

At 10:10 AM, there were no paper towels, mechanical air blower or other sanitary means of hand drying present in resident #5's bathroom.

At 10:12 AM, there were 4 used blue gloves on the ground outside the emergency exit door near the media room.

At 10:21 AM, there was a strong odor present in resident #6's bedroom.

At 10:32 AM, there were large, dark stains inside the toilet in resident #7's bathroom. Also, numerous smears, which appear to be feces, were present on the back of the toilet seat riser on resident #7's toilet.

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: On 9/8/25 resident #4's room was sprayed with air freshener, trash had recently been removed from the room which caused the odor. Carpet was cleaned in resident #4's room on 9/29/25. Resident #5 had paper towels added to the bathroom by the housekeeper. Carpet was cleaned in resident #7's room on 10/2/25. The blue gloves near the emergency exit were removed. Air freshener was sprayed in resident #6's apartment by the housekeeper, trash had just been removed from the room which caused the odor.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/designee shall inspect the bedrooms and bathrooms of residents #4, #5, #6 and #7 to ensure sanitary conditions are maintained. [redacted] 10/3/25

TRAINING: On 9/10/25 the management team, which includes the Administrative Assistant, Maintenance Director, Sales Director, Dietary Director, Director of Nursing, Assistant Director of Nursing, and Life Enrichment Coordinator, were trained on the new Manager Daily Rounds by the Interim Executive Director. By 10/17/25 all direct care staff will be reeducated on regulation 2600.85a, as well as the homes procedures for reporting items that need cleaning. Starting 9/10/25 daily rounds will be conducted by each manager during the week and by the Manager on Duty on the weekends, a checklist will be utilized during manager rounds to identify issues such as odors, trash, needed repairs, etc. (DIRECTED: At least 8 different resident bedrooms and bathrooms shall be checked during each daily round. [redacted] 10/3/25). On 9/11/25 the housekeeping staff were trained on a new cleaning checklist. Documentation of these trainings will be kept in accordance with regulation 2600.65i.

ONGOING: A quarterly carpet cleaning schedule was created by the Interim Executive Director and will be implemented on 10/1/25. All resident apartments will have carpets cleaned and a record of this cleaning will be kept in the home's work order tracking system. Compliance with this cleaning schedule will be monitored by the Executive Director and the Regional Director of Operations.
An overview of the rounds and cleaning checklist will be discussed with the leadership team at the monthly Quality

85a - Sanitary Conditions (continued)

Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 10/02/2025

Directed Completion Date: *10/17/2025*

Not Implemented [redacted] - 10/20/2025)

88a - Surfaces

3. 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

At 9:58 AM, the emergency exit door in the hallway near bedroom G5 did not completely close and had to be physically pushed shut to latch into the doorframe. Also, when this exit door was closed, it required excessive force by an agent of the Department to open.

Plan of Correction ***Accept [redacted] - 10/03/2025)***

ACTION: The emergency exit door by G5 needed adjustments made to the door hardware so that it would open without force. The emergency exit door was fixed by the home's maintenance director at the time of inspection on 9/8/25. Additionally, all exit doors were checked on 9/10/25 to ensure they were opening and closing properly.

88a - Surfaces (continued)

TRAINING: The home's maintenance director, maintenance assistant and housekeepers were trained on regulation 2600.88a on 9/11/25 by the Interim Executive Director. Training records will be kept in accordance with regulation 2600.65i.

ONGOING: Starting 9/1/25, monthly tasks are scheduled within the home's work order system to check all corridor and exit doors throughout the community to ensure they are working properly by the maintenance director or the maintenance assistant. These monthly tasks will be monitored monthly by the Executive Director by printing and signing the completed task from the home's work order system.
An overview of regulation 2500.88a will be discussed with the leadership team at the monthly Quality Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *10/02/2025*

Not Implemented [redacted] - 10/20/2025)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

At 10:25 AM, no operable lamp or other source of lighting was present at resident #8's bedside.

REPEAT VIOLATION: 4/22/2024, et. al.

Plan of Correction ***Accept [redacted] - 09/30/2025)***

ACTION: At the time of inspection on 9/8/25, a working lamp was placed at resident #8's bedside. It was determined that the lamp had been moved by the resident.
An audit of all resident units started on 9/10/10 and will be completed by 10/10/25 to ensure each resident has a working light source at their bedside.

TRAINING: By 10/10/25 all staff will receive training on regulation 2600.101j7. In addition, a posting will be added to the employee breakroom, wellness office and the housekeeping checklist binder. Training records will be kept in accordance with regulation 2600.65i. In addition, a 'resident room readiness' posting was placed in the breakroom and wellness office on 9/26/25 as a visual reminder to staff on what should be in each room. This includes a working lamp at the bedside.

ONGOING: Starting 10/1/25, as part of the weekly housekeeping checklist, housekeeping staff will check for a working light source at each resident's bedside during their scheduled weekly housekeeping service. The completed housekeeping checklist will be kept in a binder for tracking. These checklists will be monitored by the Maintenace Director and the Executive Director weekly.
An overview of the housekeeping checklist findings will be discussed with the leadership team at the monthly Quality Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

101j7 - Lighting/Operable Lamp *(continued)*

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented [redacted] - 10/20/2025)

101o - Walls, Floors, Ceilings

5. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

There was an approximate 3" x 4" hole in the wall behind the recliner in resident #3's bedroom.

At 10:01 AM, there were numerous, dark stains present on the carpeting throughout resident #4's bedroom.

At 10:21 AM, there were numerous, dark stains present on the carpeting throughout resident #6's bedroom. Also, debris was also present on the carpeting throughout resident #6's bedroom, to include paper, candy and food crumbs.

Plan of Correction ***Directed ([redacted] 10/03/2025)***

ACTION: The hole in resident #3's wall was due to [redacted] recliner hitting the wall. The hole has been patched. Carpet stains in Resident #3 and Resident #6's rooms were cleaned on 9/9/25.
A new Maintenance Director started on 9/2/25, at the time of inspection he was still finishing training. Since finishing that training, the Maintenance Director is completing any outstanding work orders in the home's work order system.

DIRECTED: By 10/15/25: The maintenance director/designee shall clean the carpeting throughout resident #4's bedroom. [redacted] 10/3/25

TRAINING: On 9/11/25 the home's housekeeping and maintenance staff were trained on regulation 2600.101o by the Interim Executive Director. By 10/17/25 all direct care staff will be reeducated on regulation 2600.85a, as well as the homes procedures for reporting items that need cleaning, by the Interim Executive Director. Training record documentation will be kept in accordance with regulation 2600.65i. (DIRECTED: By 10/17/25: All direct care staff persons shall be reeducated by the administrator on ensuring all resident bedrooms have walls, floors and ceilings, which are finished, clean and in good repair. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 10/3/25).

ONGOING:
A full-time Maintenance Director is now in place and monitoring the home's work order system daily. In addition, the Interim Executive Director is also monitoring work orders weekly along with their completion status.
Effective 10/1/25 the Executive Director will monitor 20 resident bedrooms per month to ensure walls, floors, and ceilings, are clean and in good repair. Documentation of findings will be kept.

101o - Walls, Floors, Ceilings (continued)

Proposed Overall Completion Date: 10/17/2025

Directed Completion Date: *10/17/2025*

Not Implemented [redacted]/20/2025)

102h - Toilet Paper

6. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

At 10:32 AM, there was no toilet paper for the toilet in resident #7's bathroom.

Plan of Correction ***Accept [redacted] - 09/30/2025)***

ACTION: Resident #7 ran out of toilet paper before staff identified he needed more. Toilet paper was added to resident #7's bathroom at the time of inspection on 9/8/25 by the housekeeper. Between 9/8/25 and 9/9/25 all

102h - Toilet Paper (continued)

rooms and public restrooms were checked by the housekeeping and care staff to ensure they had toilet paper.

TRAINING: All staff have been trained on regulation 2600.102h between 9/11/25 and 9/30/25 by the Interim Executive Director. Training records will be kept in accordance with regulation 2600.65i. In addition, a 'resident room readiness' posting was placed in the breakroom and wellness office on 9/26/25 as a visual reminder to staff on what should be in each room. This includes a supply of toilet paper.

ONGOING: As part of the weekly housekeeping services, community housekeepers will restock apartments with toilet paper. Checking for toilet paper is part of the weekly housekeeping checklist, copies of these checklists are maintained in binder and reviewed by the Maintenance Director weekly. On a daily basis care staff will monitor toilet paper supplies in resident rooms. If a resident is low or out of toilet paper they will be able to access more to restock immediately.
An overview of regulation 2600.102h will be discussed with the leadership team at the monthly Quality Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/20/2025)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 10:12 AM, a large flag on a flagpole was laying on the egress route outside the emergency exit door near the media room.

Plan of Correction ***Accept [redacted] - 09/30/2025)***

ACTION: A flag and flagpole were removed from a common area used by residents and temporarily placed by the door. On 9/8/25, the flag and flagpole were removed from the egress route at the time of inspection by the Maintenance Director. Additionally, all egress areas including stairways, hallways, doorways and passageways were found to be unobstructed.

TRAINING: All staff will be trained on regulation 2600.121a by10/10/25 by the Interim Executive Director. Training documentation will be kept in accordance with regulation 2600.65i.

ONGOING: Daily rounds will be done by the management team, which includes the Maintenance Director, Administrative Assistant, Life Enrichment Director, Dietary Director, Sales Director, Assistant Director of Nursing and Interim Executive Director starting on 9/10/25 and documentation will be kept.
An overview of the daily round checklists will be discussed with the leadership team at the monthly Quality Assurance meeting on 9/25/25. Quality Assurance meeting documentation will be kept.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/20/2025)

141b1 - Annual Medical Evaluation

8. 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]/25; however, resident #2's previous medical evaluation was completed on [redacted]/23.

REPEAT VIOLATION: 4/22/2024, et. al.

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: 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 Services, documentation of this audit was kept. A tracking system was created to ensure timely completion/scheduling of annual medical evaluations. (DIRECTED: Beginning on 10/10/25: The director of nursing/designee shall review and update the tracking system monthly to ensure timely medical evaluations are completed in accordance with 2600.141b. Documentation of the tracking system shall be kept. [redacted] 10/3/25). All residents that need a new Medical Evaluation to be in compliance will have it done by 8/25/2025. The Executive Director and Director of Nursing will ensure compliance with Regulation 2600.141b1 by reviewing each Medical Evaluation received prior to securing it in the resident's medical record.

TRAINING: On 7/28/2025 Executive Director and Director of Nursing were trained on Regulation 2600.141 b1, by the Regional Director of Clinical Services as part of a previous plan of correction. Additionally, the new Director of Nursing and Assistant Director of Nursing were trained on 2600.141b1 by the Interim Executive Director on 9/10/25. Training documentation will be kept in accordance with Regulation 2600.65i.

ONGOING: By 8/25/2025 all residents will have a Medical Evaluation which is in compliance with Regulation 2600.141b1. The medical evaluation schedule will be reviewed and updated monthly to ensure the resident's Medical Evaluation is completed by their next annual due date, by the Director of Nursing/Assistant Director of Nursing. Medical Evaluation tracker to be reviewed. This area will be reviewed at the monthly Quality Assurance meeting beginning on 9/25/2025. Quality Assurance meeting documentation will be kept.

141b1 - Annual Medical Evaluation (continued)

Proposed Overall Completion Date: 10/02/2025

Directed Completion Date: *10/10/2025*

Not Implemented ([redacted] - 10/20/2025)

187b - Date/Time of Medication Admin.

9. 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 #7 is prescribed Gabapentin 600mg tablet-Take 1 and ½ tablets (900mg) by mouth 3 times a day; however, resident #7's September 2024 medication administration record (MAR) does not include the initials of the staff person who administered this medication to resident #7 on 9/4/25 at 2:00 PM.

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Accept [redacted] - 10/03/2025)***

ACTION: The Med Tech failed to follow the regulation. On 9/4/2025 an audit of resident #7's September 2025 Medication Administration Records was completed by the Director of Nursing, to ensure all medications are recorded. On 9/6/25 Med Tech signed off that resident #7 's 2:00pm 600mg gabapentin 600mg tablet –take 1 and ½ tablets (900mg) was signed off as being administered after the Med Tech reported it was given.

TRAINING: Med Tech who did not follow proper procedure for administering medications received a counseling from the Regional Director of Clinical Services on 9/11/25. On 9/11/2025 the Director of Nursing, Assistant Director of Nursing and all med techs were educated on Regulation 2600.187b, by Regional Director of Clinical Services. Training records will be kept in accordance with Regulation 2600.65i.

ONGOING: Starting 7/24/2025 the Director of Nursing and/or Assistant Director of Nursing will review 10 Medication Administration Records weekly for two months and then monthly to ensure all medication is administered and recorded. Documentation of findings will be kept. The Executive Director and/or the Regional Director of Clinical Services will monitor these audits. Documentation of findings will be reviewed at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *10/02/2025*

Not Implemented [redacted] - 10/20/2025)

187d - Follow Prescriber's Orders

10. Requirements

2600.

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

On 9/2/25 at 8:00 AM, resident #1 was not administered numerous medications, to include the following:

- *Bicalutamide 50mg tablet-Take 1 tablet by mouth once daily*
- *Buspirone 10mg tablet-Take 2 tablets by mouth 3 times daily*
- *Escitalopram 20mg tablet-Take 1 tablet by mouth once daily*
- *Lisinopril 5mg tablet-Take 1 tablet by mouth once daily*

Resident #1's September 2025 MAR indicates "IH" or in hospital for the administration of these medications; however, according to numerous staff persons and resident #1's progress notes, resident #1 was present in the home at 8:00 AM and was not sent to the hospital until sometime after 10:30 AM.

REPEAT VIOLATION: 3/25/2025

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: The med tech on duty was re-assigned to administer medications for Resident #1 was running behind on [redacted] med pass, due to a call off in the community. When [redacted] med tech went to administer the medication, [redacted] was informed that the resident had left for the hospital.

TRAINING: All med techs attended a mandatory training on 9/11/25 that was conducted by the Regional Director of Clinical Services. This training included a review of regulation 2600.187d. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [redacted] 10/3/25).

ONGOING: Effective 9/15/25 Director of Nursing or Assistant Director of Nursing will review 10 MARs weekly to ensure all medication is administered. Documentation will be kept. Effective 10/1/2025 monthly observations of medication pass of each person who administers medication to be completed by staff person trained in medications administration or a licensed nurse. Documentation of findings will be kept. An overview of the findings will be discussed by the leadership team at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meetings will be documented and kept.

Proposed Overall Completion Date: 10/02/2025

187d - Follow Prescriber's Orders *(continued)*

Directed Completion Date: *10/03/2025*

Not Implemented [redacted] - 10/20/2025)

225a - Assessment 15 Days

11. 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 #1 was admitted to the home on [redacted]/25; however, resident #1's assessment was not completed until [redacted]/25.

Resident #1's medical evaluation, dated [redacted]25, indicates resident #1 is prescribed a controlled carbohydrate diet; however, resident #1's assessment, dated [redacted]25, indicates resident #1 is on a no added salt (NAS) diet.

Resident #1's medical evaluation, dated [redacted]/25, indicates resident #1 has short term and long term deficits and needs assistance with high level decision making; however, resident #1's assessment, dated [redacted]/25, indicates resident #1 has no problems with short term memory, long term memory or judgement. On 9/2/25, resident #1 left the home unattended and walked to a local restaurant across a heavily traveled road, appeared to be confused and stated that [redacted] was going to get a haircut. Resident #1 was brough back to the home and was sent to the hospital for evaluation.

According to resident #7 and numerous direct care staff persons, resident #7 requires assistance from one staff person with showering; however, resident #7's assessment, dated [redacted]/25, indicates resident #7 is independent with personal hygiene.

REPEAT VIOLATION: 7/11/2024

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: As part of a previous inspection plan of correction from July 2025, the home has started training and audits to ensure compliance with regulation 2600.225a. The home's previous Executive Director and Director of Nursing who did not complete assessments accurately and timely are no longer employed by the home.
On 7/23/25 an audit on current resident assessments was completed by the Regional Director of Clinical Services. All current residents will have completed assessments by 9/30/2025. On 9/8/25 resident #1's assessment was updated to reflect current diet ordered by physician, CCHO diet, by the Regional Director of Clinical Services. Audit documentation will be kept. Resident # 7 no longer resides in the community.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator shall update resident #1's assessment which includes an update to resident #1 short term memory, long term memory, judgement and supervision needs. A copy of resident #1's updated assessment shall be kept in resident #1's record and made available to all direct care staff persons.[redacted] 10/3/25

TRAINING: Mandatory in-service training on assessment procedures and documentation accuracy was provided to

225a - Assessment 15 Days (continued)

all clinical staff by 9/11/2025 by the Regional Director of Clinical Services. On 7/28/2025 the Executive Director and Director of Nursing were educated on regulation 2600.225a by Regional Director of Clinical Services. Between 8/7/2025 and 9/16/25 all staff responsible for assessment documentation, which includes the Director of Nursing, Assistant Director of Nursing, Administrative Assistant, and Sales Director, were educated on regulation 2600.225a by the Interim Executive Director. Training records will be kept in accordance with Regulation 2600.65i.

DIRECTED: By 10/10/25: The administrator shall develop and implement procedures for updating resident assessments and support plans as resident care needs change. Documentation of the system shall be kept. All staff persons involved in completing resident assessments and support plans shall be educated by the administrator on the new system by 10/10/25. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] *10/3/25*

ONGOING: Starting 9/1/2025 the Director of Nursing and/or the Assistant Director of Nursing will monitor completion and accuracy of assessments by reviewing 10 assessments a week for the next 90 days. Starting 11/1/2025 a quarterly review of 20 assessments will be implemented to ensure long-term compliance. Starting 9/1/2025 all residents shall have a written initial assessment that is documented on the department's assessment form within 15 days of the admission, by the Director of Nursing, Assistant Director of Nursing, or the Executive Director. All admissions will be reviewed within 15 days to ensure written assessment is completed by the Director of Nursing for 3 months. These audits will be monitored by the Executive Director monthly. Documentation to be kept and reviewed at monthly Quality Assurance meetings beginning 9/25/2025. Quality Assurance meeting documentation will be kept.

Proposed Overall Completion Date: 10/02/2025

Directed Completion Date: *10/10/2025*

Not Implemented [redacted] ***- 10/20/2025)***

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

225c - Additional Assessment *(continued)*

1. Annually.

Description of Violation

Resident #2's most recent medical evaluation, dated [redacted]/25, includes diagnoses of leg edema/shortness of breath and pain; however, these diagnoses are not included on resident #2's most recent assessment, dated [redacted]/24.

REPEAT VIOLATION: 2/10/2025

Plan of Correction ***Directed [redacted] - 10/03/2025)***

ACTION: The Director of Nursing is responsible for ensuring that assessments are updated accurately and completely. The Director of Nursing in place at the time this assessment was completed, is no longer employed by the home.
On 7/23/25 an audit of all current resident assessments was completed by the Regional Director of Clinical Services. On 9/10/25 resident # 2's assessment was completed to include diagnosis leg edema/shortness of breath and pain, by the Regional Director of Clinical Services. All current residents to have completed assessments by 9/30/2025. Documentation of audits will be kept.

TRAINING: The Director of Nursing or the Assistant Director of Nursing are responsible for ensuring the assessments are updated accurately and completely. On 9/16/25 the Director of Nursing/Assistant Director of Nursing were educated on regulation 2600.225c, by Regional Director of Clinical Services. All current residents will have completed assessments by 9/30/2025. Documentation of audits will be kept.

DIRECTED: By 10/10/25: The administrator shall develop and implement procedures for updating resident assessments and support plans as resident care needs change. Documentation of the system shall be kept. All staff persons involved in completing resident assessments and support plans shall be educated by the administrator on the new system by 10/10/25. Documentation of the education shall be kept in accordance with 2600.65i.[redacted] 10/3/25

ONGOING: Beginning 9/16/2025 the Director of Nursing will monitor compliance by conducting audits on all new assessments completed for that month to ensure all sections are completed, and that all information is placed on the residents' assessment. On 9/1/2025 a new tracking system was implemented by the Director of Nursing and Resident Care Coordinator to ensure timely completion and accuracy of annual assessments. The Executive Director will monitor compliance by conducting 10 audits monthly of resident assessments to ensure all sections are completed, accurate, and all related information is in place on residents assessments. These audits will be documented and reviewed during the monthly Quality Assurance meeting held on 9/25/2025. Any audit discrepancies will be addressed immediately. The results of the audits will be evaluated quarterly to ensure compliance.

225c - Additional Assessment (continued)

Proposed Overall Completion Date: 10/02/2025

Directed Completion Date: *10/10/2025*

Not Implemented [redacted] - 10/20/2025)

227a - Support Plan 30 Days

13. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted to the home on [redacted]/25; however, resident #1's support plan was not completed until [redacted]/25.

Plan of Correction ***Accept [redacted] - 09/30/2025)***

ACTION: As part of a previous inspection plan of correction from July 2025, the home has started training and audits to ensure compliance with regulation 2600.227a. The home's previous Executive Director and Director of Nursing, who did not complete support plans accurately and timely are no longer employed by the home.
On 7/23/25 an audit on current residents' support plans was completed by the Regional Director of Clinical Services. All current residents will have completed support plans by 9/30/2025. Audit documentation will be kept.

TRAINING: On 7/28/2025 the Executive Director and Director of Nursing were educated on Regulation 2600.227a by the Regional Director of Clinical Services.
On 7/31/2025 all care staff were trained on Regulation 2600.227a by the Regional Director of Clinical Services. Training record documentation will be kept in accordance with Regulation 2600.65i.
All staff involved in the admission process, which includes the Sales Director, Administrative Assistant and the Assistant Director of Nursing, were trained on regulation 2600.227a on 9/16/25 by the Interim Executive Director.

ONGOING: The Executive Director will conduct weekly audits starting 9/25/2025 of newly admitted residents to confirm that support plans are being initiated and completed within the regulatory timeframes. The Executive Director, Director of Nursing and/or the Assistant Director of Nursing will review the audits and will address any identified deficiencies. The audits will be documented and maintained for review. Regulation 2600.227a findings

227a - Support Plan 30 Days (continued)

will be discussed at monthly Quality Assurance meetings starting 9/25/2025. Quality Assurance meetings will be documented and kept.

Licensee's Proposed Overall Completion Date: *09/30/2025*

Not Implemented [redacted] - 10/20/2025)