

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2026
NAME OF PROVIDER OR SUPPLIER  Canterbury Place		STREET ADDRESS, CITY, STATE, ZIP CODE  310 Fisk Street Pittsburgh, PA 15201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, facility documentation, clinical record review, staff and resident interviews it was determined that the facility neglected to provide the necessary means and services for a resident to contact staff for help when the call system malfunctioned for one of two trach residents (Resident R1). Findings include: Review of facility policy Abuse, Prevention, Intervention Reporting and investigation dated 1/2/26, indicated: Residents are to be free from verbal, sexual, physical, emotional/mental abuse, self-abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion at all times. Definitions: Neglect is defined as failure to provide goods and services necessary to avoid physical harm. Mental anguish or mental illness. Review of admission Record indicated Resident R1 was admitted on [DATE]. Review of Resident R1 MDS (minimum data set - a periodic assessment of resident needs), dated 1/24/26, indicated diagnosis of cancer( a disease of uncontrolled proliferation by transformed cells subject to evolution by natural selection), malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), and malignant neoplasm of larynx, unspecified ( cancer of your larynx or voice box). Section C BIMS (brief interview for mental status) indicated a summary score of 15 - cognitively intact. Review of facility documentation submitted to state agency dated 1/24/26, indicated: On 1/24/26, the resident reported that during the night shift, a nurse removed her call bell from the wall due to a technical issue but did not reconnect it afterward. The resident stated that the call bell was left on the floor and was not accessible to her. She further reported that she experienced an episode emesis and was unable to call for assistance due to the disconnected call bell. Review of facility documentation, witness statement dated 1/26/26, NA (Nurse Aide) Employee E2 indicated: Resident R1 put call light on I answered it she let me know that her feeding was done, and I informed RN (Registered Nurse) Employee E3. I went to answer my other call lights and made sure everyone was taken care of before I went to go pump, I let the nurse know I was going to pump, and she will need to answer the call lights. When I got done pumping a couple of call lights were going off including Resident R1. RN Employee E3 told me the call light wasn't working I told her I'll take a look at it. I went in and tried to fix the light but didn't know how. Review of facility documentation Team Corrective Action, dated 1/28/26, indicated: The call system has multiple functions, Nurse call, TV on/off, volume/channel selection, etc. On the day in question, it was not entirely functioning the unit was able to call nurses, turn tv remote off and on but the volume elements were inoperable. This nurse tried all elements available on the remote unit removing wall compartment several times in an attempt to restart/reboot the wall connection several times. Removing the cord was the only one that was effective in stopping the sound emanating from the unit which the resident was objecting. At this point I apologized for the equipment failure, admitted that it was not functioning properly and there is no overnight maintenance personnel to fix it at this time. I disconnected the unit from the</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wall. Prior to this meeting today there no policy and procedures were in place, no backup cords, no ding bells, no education and no contingency plan was in effect to address this equipment failure. Summary I did not provide Pt. with alternative call system. No alternative call system was available. Review of facility documentation indicated: Resident R1's call bell malfunctioned (tv volume was staying on). Facility staff unplugged the call bell from the wall. Left resident without a way to call for help. Facility staff neglected to provide any other way for Resident R1 to contact staff for help. Resident R1 is trach dependent and cannot speak. Resident R1 reported getting sick (emesis) and not being able to call for help. Resident R1 had to walk out to the nurse's station for help. During an interview on 2/11/26, at 1:51 p.m. Resident R1 confirmed that the call bell system was making a noise preventing her from sleeping and staff could not correct the system. That the call bell system was pulled out of the wall by RN Employee E3 and no other means of was provided to let staff know of her needs. That she threw up and to go find staff for assistance. Resident R1 indicated that staff did not come in to check on her, nor did she have a working call bell which is why she went out to find help. Interview on 2/12/26, at 1:40 p.m. NHA (Nursing Home Administrator) and DON (Director of Nursing) were informed that the facility neglected to provide the necessary means and services for a resident to contact staff for help when the call system malfunctioned for a trach dependent resident (Resident R1). 28 Pa. Code 201.14(a)Responsibility of licensee.28 Pa. Code201.18(b)(e)(1)Management.28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical and facility record review, facility provided documents, staff and resident interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in Resident R2 being transferred to the hospital for a hematoma. This failure was determined to be past non-compliance. Findings include: Review of facility policy 1/23/26, Accidents and Incidents indicated: All accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the Administrator. The nature of the injury/illness (e.g. bruise, fall, nausea, etc.). The circumstances surrounding the accident or incident. Where the accident or incident took place; The name of witnesses and their accounts of the accident or incident; the injured person account of the accident or incident; the disposition of the injured (i.e. transferred to hospital, put to bed, sent home, returned to work, etc.) This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device. Review of admission Record indicated Resident R2 was originally admitted on [DATE], and readmitted on [DATE]. Review of Resident R2's MDS ( minimum data set - a periodic assessment of resident needs) dated 1/5/26, indicated the diagnosis of spinal stenosis (happens when the space inside the backbone is too small), other obesity due to excess calories (abnormal or excessive fat accumulation that presents a risk to health), and muscle weakness (when your muscles can't work with the expected force). Review of progress notes indicated Incident Note dated 2/8/26, Resident complained of hurting of left leg while care being performed crying currently She has tightness in her legs and had a loose stool overnight she stated no one hit her but held her legs open to clean her and now her left leg has a bruise and is painful daughter wants sent to hospital and declined Md offer to stat test for any abnormalities vs WNL (with in normal limits) resp easy 911 called for transport Md called POA (power of attorney) here and behold and medication record sent with resident. Review of hospital documentation Final Report dated 2/8/26, indicated: There is a 9 x 7 x16.6 cm. hematoma within the soft tissue plane of the left medial thigh with a small spot of active bleeding. Review of facility submitted documentation dated 2/8/26, indicated that Resident R2: requires a Hoyer lift, and it was identified that an incorrect Hoyer pad had been used. During an interview on 2/13/26, at approximately 2:45 p.m. NHA and DON were informed that the facility failed to provide adequate supervision for one resident resulting in Resident R2 being transferred to the hospital for a hematoma. NHA and DON submitted the following for Review of the facility Past non-compliance Immediate Corrective Actions F689 Mechanical (Accidents/Supervision/Assistive Devices: Hoyer Lifts &amp; Transfers). Immediate Corrective Actions indicated the following: Resident (s) involved in the incident were assessed for injury and care needs addressed immediately. Area on Aging Notified Family Notified Physician Notified Staff suspended pending investigation Resident interviews conducted by social service director to ensure resident safety Residents were assessed by clinical staff for injury and care needs assessed. Risk Management assessment performed Clinical staff. Care plan updated to reflect Risk/Actual Skin Integrity Impairment. All resident that utilizes a Hoyer lift was assessed for injuries. The mechanical lift and sling used during the incident were inspected for safety and removed from service if defective. Staff directly involved were re-educated on proper mechanical lift operation and correct sling sizing. Systemic Changes: All nursing staff received reeducation on: Proper use of Hoyer and mechanical lifts Two -person transfer requirements. Correct sling/pad selection based on manufacturer guidelines and resident body size. Ensuring sling compatibility with the specific lift model Sling type and appropriate size (small/medium/large/extra-large) Special considerations such as</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>amputations, contractures, or weight distributionAll nursing staff will receive re-education on:Proper use of Hoyer and mechanical liftsTwo - person transfer requirementsCorrect sling/pad selection based on manufacturer guidelines and resident body sizeEnsuring sling compatibility with the specific lift modelSpecial considerations such as amputations, contractures, or weight distributionAudits were performed for any resident that utilizes a Hoyer lift to ensure that pad sizing is appropriate. Review of the facility Past non-compliance Immediate Corrective Actions F689 Mechanical (Accidents/Supervision/Assistive Devices: Hoyer Lifts &amp; Transfers) was verified on 2/13/26, at 2:55 p.m. that the past noncompliance was in effect until 1/9/26, when the facility completed their plan as stated. On 2/13/26, the NHA and DON were informed that the facility failed to provide adequate supervision for one resident resulting in Resident R2 being transferred to the hospital for a hematoma.28 Pa. Code: 201.14 (a)Responsibility of licensee28 Pa. Code: 201.18 ( e)(1) Management.28 Pa. Code 207.2 (a) Administrator's responsibility.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of job descriptions, facility and clinical records, and staff interviews it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to make certain that the facility provide a fully functioning call bell system for one resident resulting in an immediate jeopardy situation for one of three residents (Resident R1). Findings include: The job description for the NHA specified that the job scope is to oversee the overall operations of the Community and is responsible for resident care, customer service, and the welfare and safety of residents. The job description for the DON specified that the job scope is to plan, organize, develop, and direct the overall operation of the Nursing services department. Facilitates the coordination of nursing services and other departments to maintain quality of care for residents. Based on the findings of this report that identified that the facility failed to provide a fully functioning call bell system for on resident resulting in an immediate jeopardy situation. The facility failed to provide fundamental principles that apply to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and facility policy.</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, facility documents, staff and resident interviews it was determined that the facility failed to provide a fully functioning call bell system for one resident resulting in an immediate jeopardy situation for one of three residents (Resident R1). Findings include:</p> <p>Review of facility policy Answering the Call Light dated 1/2/26, indicated: The purpose of this procedure is to ensure timely responses to the residents requests and needs. General Guidelines - Be sure that the call light is plugged in and functioning at all times. Some residents may not be able to use their call light. Be sure you check these residents frequently.</p> <p>Review of admission Record indicated Resident R1 was admitted on [DATE].</p> <p>Review of Resident R1 MDS (minimum data set - a periodic assessment of resident needs), dated 1/24/26, indicated diagnosis of cancer( a disease of uncontrolled proliferation by transformed cells subject to evolution by natural selection), malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), and malignant neoplasm of larynx, unspecified ( cancer of your larynx or voice box). Section C BIMS (brief interview for mental status) indicated a summary score of 15 - cognitively intact.</p> <p>Review of facility documentation submitted to state agency dated 1/24/26, indicated: On 1/24/26, the resident reported that during the night shift, a nurse removed her call bell from the wall due to a technical issue but did not reconnect it afterward. The resident stated that the call bell was left on the floor and was not accessible to her. She further reported that she experienced an episode of emesis and was unable to call for assistance due to the disconnected call bell.</p> <p>Review of Resident R1's witness statement indicated while RN (Registered Nurse) Employee E3 was doing my feeding, the TV sound came on, and she couldn't get it to shut off. Resident asked her if she could fix it, RN Employee E3 yanked it out of the wall, left it out and stated no, I'm not a mechanic. RN Employee E3 left it like that.</p> <p>Review of facility documentation witness statement dated 1/26/26, RN Employee E3 indicated upon entering the resident's room while providing nursing care, resident indicated wanting the TV turned off. The monitor was off but not the sound from the remote. All procedures to cut the TV speaker off were unsuccessful. The remote was placed in the drawer, under the bedding, at the top of the bed and all were unacceptable to the resident. I apologized for the equipment failure and finished my duties. Before leaving the room, the resident wrote that if the noise was not stopped, she was going to sleep on the couch down the hall. That is what caused me to do the only thing I knew to stop the noise from the remote in her room, disconnect the remote from the wall and let it ring at the nurse's station.</p> <p>Review of facility documentation, witness statement dated 1/26/26, NA (Nurse Aide) Employee E2 indicated: Resident R1 put call light on I answered it she let me know that her feeding was done, and I informed RN Employee E3. I went to answer my other call lights and made sure everyone was taken care of before I went to go pump, I let the nurse know I was going to pump, and she will need to answer the call lights. When I got done pumping a couple of call lights were going off including Resident R1. RN Employee E3 told me the call light wasn't working I told her I'll take a look at it. I went in and tried to fix the light but didn't know how.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of facility documentation witness statement undated/unsigned indicated: The call bell was going off when I came in at 2am but the room was dark and I didn't know if someone was there or not didn't see a patient at all, all night come out or the light inside the room on as if anything was wrong. I went to answer the light the nurse assigned stated the light has been broken this shift and its fine no need to go in.</p> <p>Review of facility documentation Team Corrective Action, dated 1/28/26, indicated: The call system has multiple functions, Nurse call, TV on/off, volume/channel selection, etc. On the day in question, it was not entirely functioning the unit was able to call nurses, turn tv remote off and on but the volume elements were inoperable. This nurse tried all elements available on the remote unit removing wall compartment several times in an attempt to restart/reboot the wall connection several times. Removing the cord was the only one that was effective in stopping the sound emanating from the unit which the resident was objecting to. At this point I apologized for the equipment failure, admitted that it was not functioning properly and there are no overnight maintenance personnel to fix it at this time. I disconnected the unit from the wall. Prior to this meeting today no policy and procedures were in place, no backup cords, no ding bells, no education and no contingency plan was in effect to address this equipment failure. Summary I did not provide Pt. with alternative call system. No alternative call system was available.</p> <p>Review of facility documentation to include Resident R1's MAR (medication administration record used to document medications and treatments to residents) failed to include documentation from 1:25 a.m. till 4:00 a.m. in the morning.</p> <p>During a phone interview on 2/11/26, at 3:06 p.m. RN Employee E3 indicated: She was the RN who took the call bell out of the wall. That the call bell was malfunctioning and she was unable to fix it. That the facility did not provide training to her prior to the re-education during the suspension on 1/28/26, that prior to that she was unaware of any hand bells, extra call bell cords etc. That she was the nurse in charge of the building, and on both carts for the third floor until later in the shift when another nurse came in around two a.m.</p> <p>Interview on 2/12/26, at 1:40 p.m. NHA (Nursing Home Administrator) and DON (Director of Nursing) were informed that the facility failed to provide an active and accessible call bell to Resident R1.</p> <p>On 2/12/26, at 1:40 p.m. NHA and DON were provided with the Immediate Jeopardy template and corrective action plan was requested.</p> <p>Review of the immediate action plan on 2/13/26, at 12:24 p.m. indicated:</p> <p>-Resident R1's call bell was tested to ensure proper functioning. Nursing staff verified that the resident had access to a functioning call system and that it was positioned appropriately to meet the resident's needs. An assessment of Resident R1 was completed to ensure no adverse outcomes occurred as a result of the one call bell being unplugged per the resident's request.</p> <p>Upon verification, witness statements clearly identified there was not a call bell in place until 6:30a.m. the morning of 1/25/26, and the resident was without one prior to replacement at 6:30 a.m. Assessment was completed as stated with no injuries found.</p> <p>-Total of 145 staff from all departments were educated. Education signatures verified 114, telephonic education 31. Nursing staff on site 14/14 verified education and understanding 4/4 housekeepers</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>on site verified education and understanding.</p> <p>-All resident rooms and common areas with call bell access were inspected to assess functionality. Nursing and maintenance staff tested each call bell to ensure proper operation and accessibility. No issues with functionality were identified.</p> <p>Upon verification all call bells were tested and inspected for functionality, with no issues identified. An outside vendor was on site on 2/12/26, and examined the system, all activation points tested and in good working condition.</p> <p>-The facility conducted a root cause analysis to determine the reason for the one individual call bell functional issue; concluding user error, the bell was unplugged per the resident's request. Audit performed for the call bell system, including all resident rooms and common areas where resident may initiate a call. Verified as complete on 2/13/26.</p> <p>-A preventative maintenance schedule has been implemented to ensure ongoing monitoring of the call bell system. Staff were re-educated on daily visual checks of call bell accessibility and reporting procedures for any identified issues of functionality. Verified as complete on 2/13/26.</p> <p>-The Maintenance Director or designee will conduct three times weekly call bell functionality audits for 30 days, followed by monthly audits thereafter. Documentation of system checks will be maintained. Results will be reviewed at the Quality Assurance and performance Improvement (QAPI) meeting to ensure sustained compliance. Any deficiencies identified will be corrected immediately and reported to administration.</p> <p>-Verified the TELS system (an electronic tracking of maintenance concerns) had added conduct a test of the nurse call system.</p> <p>-Immediate corrective action for Resident R1 was completed on 1/25/26. Additionally, facility-wide call bell testing was completed on 1/26/26. Ongoing preventative maintenance and monitoring will continue as outlined above.</p> <p>During phone interviews on 2/13/26, employees indicated:</p> <p>10:46 a.m. NA Employee E4 stated that she received several trainings recently on abuse, neglect, and what to do if the call bell stops working. Staff were taught where to find a hand bell if the call bell isn't working and the process to follow.</p> <p>11:00 a.m. NA Employee E5 stated that she received several recent trainings on abuse, neglect and what to do on the hand bells. She stated she was aware the facility had them but thought only nursing could get them for residents. The training taught her where to find the call bells, and what the process is and she was previously unaware.</p> <p>During interviews on 2/13/26, employees indicated:</p> <p>11:00 a.m. NA Employee E6 indicated even down here, (memory care unit) the resident must always have a call bell in reach even if they never use it.</p> <p>11:05 a.m. NA Employee E7 indicated yes, we have ding-bells now in the nurse's station if there is</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>a broken call bell and to never leave the resident without one.</p> <p>11:10 a.m. NA Employee E8 indicated we received education and that we are to never leave the resident alone without a call bell in reach.</p> <p>11:13 a.m. RN Employee E9 indicated they received training and pointed to a ding bell located behind the nurse's station that was available in the event of a broken call bell system.</p> <p>11:18 a.m. NA Employee E10 indicated they received training and verbalized understanding that there are alternative methods staff can use if a call bell is broken.</p> <p>11:21 a.m. NA Employee E11 indicated they received training and now have ding bells if needed.</p> <p>11:28 a.m. RN Employee E12 indicated they received training and now were aware of alternative methods when a call bell breaks.</p> <p>11:30 a.m. RN Employee E13 indicated they were trained and knew even before the training that you never leave a resident without a call bell.</p> <p>Review of immediate action plan was verified on 2/13/26, at 1:33 p.m. the Immediate Jeopardy situation was in effect from 1/24/26, through 2/13/26, when the facility completed their plan as stated.</p> <p>Interview with the Nursing Home Administrator on 2/13/26, at 3:00 p.m. confirmed the facility failed to provide a fully functioning call bell system for one resident resulting in an immediate jeopardy situation for one of three residents (Resident R1).</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p>		