STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395146	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	310 Fisk Street Pittsburgh, PA 15201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility submitted documents, facility documentation, clinical record, and staff interviews, it was determined that the facility failed to ensure that one of three residents reviewed (Closed Resident Record CR1) was free of neglect during care which resulted in actual harm of a fracture of their right femur (thigh bone). Findings include: Review of facility policy Recognizing Sign and Symptoms of Abuse/Neglect, dated 12/9/25, indicated all types of resident abuse, neglect, exploitation or misappropriation of resident property are strictly prohibited. Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Sign of neglect: accidents among residents who need supervision. Review of facility policy Activities of Daily Living (ADLs), Supporting, dated 12/9/25, indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the service necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:Hygiene (bathing, dressing, grooming and oral care);Mobility (transfer and ambulation, including walking);Elimination (toileting);Dining (meals and snacks); andCommunication (speech, language, and any functional communication systems). A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of Closed Resident Record CR1's admission record indicated that Resident CR1 was admitted to the facility 1/8/21. Review of Resident CR1's Minimum Data Set (MDS - an assessment tool used to facilitate the management of care) assessment dated [DATE], indicated diagnoses hemiplegia (paralysis or severe weakness affecting one side of the body, usually caused by brain or spinal cord injury), respiratory failure, and muscle wasting. Review of Section C: Cognitive Patterns indicated Resident CR1 had a BIMS score of 15, cognitively intact. Review of Section GG - Functional Abilities - Mobility, Question GG0170A indicated the resident was coded at a 01 for dependent, helper does all of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of Resident CR1's plan of care, updated 2/25/26, revealed Bed Mobility: (Resident CR1) requires one person assist to turn and position and requires assist of two staff to pull up in bed. Review of clinical health status progress note dated 5/8/26, at 3:57 p.m., revealed witnessed fall/no injury notes at time of fall. After someone shouted that the resident (CR1) fell, found the resident (CR1) laying on the floor, on her right side, facing the window. When asked what happened, Nurse Aide (NA) Employee E6 said she (CR1) rolled off the bed while she (NA Employee E6) was changing her. Resident (CR1) said she hot her head, no bruising and hematoma noted. Resident (CR1) denies pain on her head. Resident (CR1) complained of pain on her right leg. Review of clinical physician progress note, late entry dated 5/8/26, at 11:13 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	p.m., indicated pain in right hip/leg: ordered x-ray (medical imaging that uses radiation to take pictures of the inside of your body). Review of clinical health status progress note dated 5/9/26, at 3:51 p.m., revealed resident (CR1) remains alert and verbally responsive, x-ray vendor came in and did stat x-ray, currently awaiting results. Review of clinical health status progress note dated 5/9/26, at 1017 p.m., revealed resident (CR1) and family has decided against hospitalization of positive x-ray that reveals right femur fracture. Review of facility provided document Radiology Results Report, dated 5/9/26, at 4:31 p.m., revealed Conclusion: there is a probable subtle supracondylar fracture (break right above the knee joint) in the distal right femur which could be acute. Review of facility submitted document PB-22 (Report form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property), dated 5/14/26, indicated on 5/8/26, at 3:57 p.m., resident (CR1) received ADL care provided by NA (Employee E6). While NA (E6) was performing perineal care, she (NA Employee E6) rolled the resident (CR1) towards the window, moved away to grab a towel, and the resident (CR1) fell from bed to the floor. On 5/9/26, nurse on duty observed increased swelling and internal rotation of right lower extremity and notified medical doctor (MD). MD ordered STAT X-ray. X-ray was obtained on 5/9/26, st 3:22 p.m. X-ray results obtained and showed a probable subtle supracondylar fracture on the distal right femur. A review of the initial fall incident was conducted. It was determined that NA (Employee E6) provided care to a resident (CR1), bed elevated on an APM (alternating pressure mattress) mattress when resident slipped off and fell. Neglect was substantiated. Review of facility provided witness statement dated 5/8/26, at 4:15 p.m., provided by NA Employee E6 stated that I (NA Employee E6) was changing (CR1) as I (E6) always do I(E6) had the towels on her chair in her room as I (E6) rolled her to clean her back side and put the brief on. I (E6) walked over to grab the towels to clean her off and she (CR1) said falling by the time I (E6) went back over to adjust her she (CR1) slipped and fell on the floor. Review of facility witness statement dated 5/8/26, at 3:57 p.m., Licensed Practical Nurse (LPN) Employee E7 stated she (Employee E7) responded to emergency request that resident (CR1) rolled off bed onto floor. NA (Employee E6) said she went to get a towel and resident (CR1) rolled onto floor, citing resident (CR1) said she (CR1) was falling but NA (E6) was unable to stop fall. She (CR1) was lying prone on her back by the window on the floor. Review of facility provided witness statement dated 6/2/26, an interview conducted by the Director of Nursing (DON) of the event with NA Employee E6, revealed NA Employee E6 had Resident CR1, warmed up water, got my towels to change her (CR1) in bed. Lay her down flat, then raised her bed to my level; cleaned up area, rolled her side (right) toward the window; went over to grab the towels, she (CR1) said I'm falling. By the time NA (Employee E6) got back there, it was too late. It happened so quick. DON further questioned: Which way did you roll her? NA Employee E6 answered, I rolled her towards window. During interviews conducted with unit NA's on 6/3/26, from 12:55 p.m. through 1:25 p.m., when questioned about proper standards of care for dependent residents bed mobility, specifically when turning/positioning/rolling onto side in an elevated bed position and supervision: - NA Employee E10 responded that you always roll a resident towards you and you never leave a resident alone unsupervised especially if they have been positioned on their side. Always have supplies within reach. - NA Employee 11 responded that you never leave a resident elevated in bed, on their side, and you always roll resident towards you. - NA Employee E12 responded that you never walk away from resident during care, especially when in an elevated position on their side. Always roll resident towards yourself during care.- NA Employee E13 responded that she knew never to leave a resident unsupervised during care when in an elevated position on their side, and always roll a resident towards you.- NA Employee E14 responded that he would never leave a resident in an elevated position unsupervised. He further stated that you always roll a resident towards you during care. During an interview on 6/3/26, at 2:30 p.m., the Nursing Home Administrator (NHA) and the DON confirmed that the facility failed to ensure Resident CR1 was free from neglect when NA Employee E6 walked away during care, leaving Resident CR1 in an elevated bed position, lying on her side, resulting in a femur fracture from a fall towards the window side of her bed. 28 Pa. Code 201.14(a) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201.29(a)(c) Resident Rights28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS - a periodic assessment of care needs) accurately reflected the resident's status for two of six residents (Residents R2 and R3).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of care needs), dated October 2025, indicated the following instructions:Section O0110. Special Treatments, Procedures, and ProgramsCheck all of the following treatments, procedures, and programs that were performed.K1. Hospice - mark if indicated while a resident. Review of the admission record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of heart failure (heart doesn't pump blood as well as it should), high blood pressure, and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Section O0110 K1. Hospice - was not marked as while a resident. Review of Resident R2's physician order dated 10/18/25, indicated admit to level of care: Hospice Services. Review of Resident R2's current care plan indicated resident has a terminal prognosis related to dementia end stage and receives hospice services. Interview on 6/3/26, at 10:39 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E15 confirmed Resident R2 receives hospice services and the MDS dated [DATE], did not include hospice and it was a data entry error.Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's MDS dated [DATE], indicated diagnoses of heart failure, high blood pressure, and Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). Section O0110 K1. Hospice - was not marked as while a resident. Review of Resident R3's physician order dated 8/20/25, indicated admit to level of care: Hospice Services. Review of Resident R3's current care plan indicated resident has a terminal prognosis related to need forhospice care. Interview on 6/3/26, at 11:15 a.m. RNAC Employee E15 confirmed Resident R3 receives hospice services and the MDS dated [DATE], did not include hospice and it was a data entry error. 28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, facility documents, clinical records, and staff interviews it was determined that the facility failed to ensure proper supervision for a resident (Resident R1) resulting in an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) from the facility. This failure created an immediate jeopardy situation (IJ) for sixteen residents identified as an elopement risk. The immediate jeopardy was cited as past noncompliance. Findings include: Review of the facility policy Wandering and Elopements dated 12/9/25, indicated the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of the facility policy Fire Safety In-Service dated 12/9/25, indicated that in the event of an activated fire alarm all doors that are equipped with electromagnetic hold-open devices automatically close. Security systems on the First Floor and Renaissance Hall (secured memory care unit) automatically are released. Review of the admission record indicated Resident R1 admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/16/26, indicated diagnoses of anemia (the blood doesn't have enough healthy red blood cells), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids). Section B0700 Makes self-understood, indicated rarely/never understood. Section B0800 Ability to understand others, indicated rarely/never understands. Section C1000 Cognitive skills for daily decision making indicated severely impaired - never/rarely made decisions. Review of Resident R1's Elopement Evaluation dated 1/28/26, indicated the following:History of elopement at home: Yes.Wandering behavior, a pattern or goal-directed: No.Wanders aimlessly or non-goal directed: Yes;Wandering behavior likely to affect the safety or well-being of self/others: Yes.Wandering behavior likely to affect the privacy of others: Yes.Recently admitted or re-admitted (within past 30 days) and has not accepted the situation: No.Elopement score: Five. High risk for wandering. Review of Resident R1's current care plan indicated resident is at high risk for wandering due to cognitive impairment related to dementia. Goal - resident will remain safe and free from elopement. Interventions - assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Maintain secure environment with doors alarmed and monitored. Respond promptly to wander guard alerts and provide supervision appropriate to assessed risk level while in the dementia unit. Review of Resident R1's progress note dated 4/23/26, at 4:16 a.m. indicated the fire alarm was activated at 11:16 p.m. All doors unlocked. Resident was not accounted for and staff found resident in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the courtyard outside approximately 20 minutes later. When staff realized the resident was not in bed and there was a second alarm sounding, this nurse and Nurse Aide (NA) went room to room looking for resident. Staff seen the resident in the courtyard outside of the activity/television room. Resident was observed ambulating and had a scrape noted to the left knee. Area cleaned and left open to air. Supervisor notified immediately. Resident's son made aware and on call physician. Review of facility provided documentation dated 4/22/26, indicated Resident R1 had an unwitnessed exit from building on Wednesday, April 22, 2026, at 11:29 p.m. Resident resides on the Renaissance Hall Unit, and wears a wander guard (a security bracelet that alarms if resident moves near or beyond an alarmed area). At approximately 11:26 p.m. the fire alarm sounded in duct work on the fourth floor of the building; therefore, deactivating locked doors. Fire Department arrived and by 11:40 p.m. determined no fire issues occurred on the fourth floor or within building; therefore, deeming the situation clear. Fire department reset the fire panel. Description of Follow-up Action: At 11:40 p.m. on Renaissance Hall Unit during a head count conducted by the staff, it was determined that the wander guard was alarming and Resident R1 was not accounted for. A search was immediately initiated. Staff saw resident at lounge doors and brought resident inside at 11:54 p.m. without incident. Evaluation by nurse was performed and noted that resident was at baseline for vitals and appearance. Physician and family representative were notified. Education on fire alarm response and egress was initiated on 04/23/26. Review of NA Employee E2's witness statement dated 4/23/26, indicated they were charting when the fire alarm went off at 11:15 p.m. They went down the long hall to put out the checks outside the residents' doors. They sat watch on the doors and the fire department entered. Fire department came back to the unit and said all clear after the noise was over. Upon reopening resident doors, they didn't see Resident R1. They started searching and observed Resident R1 through the patio doors outside in the courtyard. Staff ran and told the nurse, who got the code and brought resident back inside. Review of Licensed Practical Nurse (LPN) Employee E3's witness statement dated 4/23/26, indicated the fire alarm activated at 11:16 p.m. which unlocked all doors. NA Employee E2 and LPN Employee E3 closed resident room doors, and located residents. Resident R1 was not located. Both staff did a second round without success. Resident was found in the courtyard walking around. Review of Registered Nurse (RN) Employee E3's witness statement dated 4/23/26, indicated they were notified by LPN Employee E3 that a resident had gotten outside the facility. They were able to see her from the door and needed the code to the door. The code was provided and resident was assisted into the facility. Review of RN Employee E5's witness statement dated 4/25/26, indicated during shift change report on 4/23/26, from evening shift into night shift, the fire alarm went off, and RN contacted the Maintenance Director. The fire department arrived and the RN left after handing over to the oncoming RN. Interview on 6/2/26, at 11:00 a.m. LPN Employee E9 confirmed Resident R1 eloped during a fire alarm event the night of 4/22/26. That the doors unlock and staff must station themselves at the doors to prevent residents from getting out. Interview and tour with LPN Employee E9 on 6/2/26, at 1:00 p.m. indicated Resident R1's room is in the back hall. The opposite end of the hallway was a set of double fire doors that resident would have gone through, then through a large dining area, around a corner to an exit door that has a key code to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the courtyard. The courtyard also has a magnetized locking gate that opens into the front driveway of the facility where there are several parking areas for cars. Interview on 6/2/26, at 1:33 p.m. the Nursing Home Administrator was made aware that Immediate Jeopardy (IJ) was called due to the elopement of Resident R1 on 4/22/26. The NHA was provided with an Immediate Jeopardy template, and a corrective action plan was requested. Review of the facility's immediate action plan on 6/2/26, at 2:35 p.m. indicated the following:-On 4/22/26, at 11:26 p.m. the fire alarm activated on the fourth-floor duct work.-On 4/22/26, at 11:40 p.m. the fire department reset the fire panel after they cleared the building ending the fire alarm announcements and fire bell ringing. At the same time, staff in the Renaissance Hall realized the wander guard was sounding and immediately started to head count for all residents.-Staff realized resident was missing and initiated a search. NA checked the dining room area and the exit door seeing resident in the courtyard closer to the television room doors and ran around to that area to get resident. As NA moved to the television lounge, they notified the nurse that the resident was outside, and they brought resident back in through television lounge doors at 11:54 p.m.-Root cause identified on 4/23/26, that an employee did not station themselves at all exit doors.-Head count was performed at time of elopement, on 4/22/26.-Resident R1 was assessed and within limits on 4/22/26. -Care plan reviewed and every one-hour checks were implemented on 4/22/26.-Doctor was called/notified of elopement on 4/23/26.-Family was notified of elopement on 4/23/26.-Reviewed and revised elopement policy 4/23/26.-Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was performed discussing the event on 4/23/26.-Elopement assessment verified as current and resident actively identified as high risk for elopement, on 1/28/26.-Education was completed for wandering and elopements by 4/26/26. -Monitoring audits of fire drills were completed on four occasions and completed on 5/7/26. On 6/2/26, at 3:45 p.m. the following items have successfully been verified as met per the immediate action plan:-Root cause identified on 4/23/26, that an employee did not station themselves at door during fire drill and magnetic lock release.-Assessment was verified as accurately identifying resident at risk for elopement, dated 1/28/26.-Care plan was verified to be updated with every hour checks implemented on 4/22/26.-Resident was assessed and only a scrape to left knee found. Area cleansed and left open to air on 4/22/26.-Resident's family was notified of elopement on 4/23/26.-Resident's physician was notified of elopement on 4/23/26.-Elopement policy was revised to emphasize supervision and stationing staff at doorways and stairwells during fire drills. on 4/23/26.-Education on elopement policies and procedures to emphasized staff members being stationed at each unlocked exits/stairwell completed by 4/23/26.-Verified all facility staff 115 of 126 received training.-In person interviews 27 of 27 in person staff interviews confirmed receiving training with emphasis on stairwell and exit doors during fire drills.-Housekeeping contract staff verified eight of nine received education.-Therapy contract staff seven of seven staff verified received education.-Dietary contract staff 16 of 20 verified received education.-All new hires will be trained prior to the first shift on the floor.-Ad Hoc QAPI Meeting was performed discussing the event on 4/23/26.-Audits verified as complete as well as fire drills conducted, completed by 5/7/26. Interview with the Nursing Home Administrator on 6/2/26, at 3:45 p.m. confirmed that the facility failed to make certain residents receive adequate supervision for a resident resulting in an elopement from the facility on 4/22/26, at 11:29 p.m. (Resident R1). This placed all residents identified as an elopement risk at risk for Immediate Jeopardy and that the Immediate Jeopardy situation has successfully met the task of Past Noncompliance effective on 5/7/26, when the action plan was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	achieved by the facility. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, facility provided document, observations and staff interview, it was determined that the facility to maintain equipment in a sanitary condition for four of six meal delivery carts (Meal delivery cart 3, 4, 6, and 9)Findings include: Review of facility policy Cleaning and Sanitizing, dated 12/9/25, indicated team members maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Cleaning logs/scheduled are available for all small and large equipment. Review of facility provided document Trayline Cleaning List, indicated Task: Spray out carts; Frequency: Daily; Task: Spray out the carts; Frequency: Weekly. During multiple observations on 6/2/26, from 11:54 a.m., through 12:36 a.m., during lunch meal service, revealed the following: Meal delivery cart 3's exterior door panels and lower bumper panels were covered with old food debris and dark spots and splashes of a dark substance; top of cart had dried, old food debris, as delivered to the 3rd floor with lunch trays contained inside. Meal delivery cart 4's exterior door panels and lower bumper panels were covered with old food debris and dark spots and splashes of a dark substance; top of cart had dried, old food debris, as delivered to the 2nd floor with lunch trays contained inside. Meal delivery cart 6's exterior door panels and lower bumper panels were covered with old food debris and dark spots and splashes of a dark substance; top of cart had dried, old food debris, as delivered to the 1st floor with lunch trays contained inside. Meal delivery cart 9's exterior door panels and lower bumper panels were covered with old food debris and dark spots and splashes of a dark substance; top of cart had dried, old food debris, as delivered to the Ground floor with lunch trays contained inside. During an interview on 6/2/26, at 12:45 p.m., after Food Service Director (FSD) Employee E1 completed lunch meal service cart delivery process, FSD Employee E1 confirmed above observations of meal cart 3, 4, 6, and 9's unsanitary conditions, confirming that the facility failed to maintain equipment in a sanitary condition. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility by failing to ensure proper supervision for a resident (Resident R1) resulting in an elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) from the facility on 4/22/26, which created an immediate jeopardy situation for all residents identified as an elopement risk.Findings include: The job description for the Nursing Home Administrator specified the duties and responsibilities of the Administrator-Skilled Nursing Facility include performing a variety of tasks associated with creating a fulfilling resident experience, including resident care coordination, teammate oversight, and regulatory reporting and compliance for the Skilled Nursing areas of the Community. Supervise all department heads to ensure the community is operating according to standards and in compliance with regulatory guidelines. The job description for the Director of Nursing specified the DON will 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 care for residents Based on findings identified in this report, the facility failed to ensure proper supervision for a resident, resulting in Resident R1 eloping from the facility, which placed the resident in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 6/3/26, at 3:45 p.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for all residents identified as an elopement risk. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395146	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	310 Fisk Street Pittsburgh, PA 15201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide QAPI (Quality Assurance and Performance Improvement) training to one of five direct care facility staff reviewed (Licensed Practical Nurse (LPN) Employee E7).Findings include: Review of LPN Employee E7's personnel file indicated a date of hire of 8/1/24. Review of LPN Employee E7's education training records on 6/3/26, failed to include education on QAPI during the past year of employment as required. Interview on 6/3/26, at 10:30 a.m. Infection Preventionist Employee E16 confirmed that the facility failed to provide QAPI training to one of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395146	A. Building B. Wing	06/03/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Compliance and Ethics training to one of five direct care facility staff reviewed (Licensed Practical Nurse (LPN) Employee E7).Findings include: Review of LPN Employee E7's personnel file indicated a date of hire of 8/1/24. Review of LPN Employee E7's education training records failed to include education on Compliance and Ethics training during the past year of employment as required. Interview on 6/3/26, at 10:30 a.m. Infection Preventionist Employee E16 confirmed that the facility failed to provide Compliance and Ethics training to one of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395146	A. Building B. Wing	06/03/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Behavioral training to one of five direct care facility staff reviewed (Licensed Practical Nurse (LPN) Employee E7).Findings include: Review of LPN Employee E7's personnel file indicated a date of hire of 8/1/24. Review of LPN Employee E7's education training records failed to include education on Behavioral training during the past year of employment as required. Interview on 6/3/26, at 10:30 a.m. Infection Preventionist Employee E16 confirmed that the facility failed to provide Behavioral training to one of five direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee28 Pa. Code: 201.20(a) Staff Development