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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and the Pennsylvania Nursing Practice Act, clinical record review, incidents submitted to the local State field office, and staff interviews, it was determined that the facility failed to ensure that residents received necessary treatment and services, consistent with professional standards of clinical practice for one of four residents (Resident R1).Findings include: Review of facility policy Skin Care and Wound Management dated 12/9/25, indicated assigned/due treatments are assigned in the electronic medical record under the ETAR (Electronic Treatment Administration Record) tab. Review of the facility Licensed Practical Nurse (LPN) job description indicated the LPN is to provide care to residents in accordance with physician orders, recognized standards of practice and established company policies and procedures. Responsibilities include sets up and administers prescribed medications and treatments. Review of the facility Registered Nurse (RN) job description indicated the RN is to provide care to residents in accordance with physician orders, recognized standards of practice and established company policies and procedures. Responsibilities include sets up and administers prescribed medications and treatments. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.18 Standards of nursing conduct (a)(5) indicates the registered nurse shall document and maintain accurate records. 21.18(b)(8) indicates the registered nurse may not falsify or knowingly make incorrect entries into the patient's record or other related documents. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.148 Standards of nursing conduct (a)(5) indicates a licensed practical nurse shall document and maintain accurate records. 21.148 (b)(8) indicates a licensed practical nurse may not falsify or knowingly make incorrect entries into the patient's record or other related documents. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Peripheral Vascular Disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R1's comprehensive care plan dated 10/14/24, indicated the resident has potential impairment to skin integrity related to immobility, PVD, Sweet syndrome (a rare inflammatory skin disorder characterized by fever and painful, red or purple skin lesions), and incontinence. Interventions include follow facility protocols for treatment of injury. Review of a facility submitted document dated 6/11/26, indicated the following: Nurse practitioner (NP) was in to see Resident R1 after nursing staff reported that resident has a dressing placed to LLE (left lower extremity) skin tear on 5/21 with orders for daily xeroform (a medicated gauze dressing that keeps wounds moist and helps prevent infection) dressing. RN and NP assessed area and found the original one area of ulceration was now a few shallow ones, resident denies pain on assessment. On date, during a routine dressing change, the facility nurse identified that resident's LLE skin tear dressing, originally applied on had not been changed since 5/21/26. Review of the electronic medical record showed that multiple licensed nurses documented that the dressing was changed according to the treatment order during this period. Review of a nursing progress note dated 3/6/26, stated, Patient has, what appears to be a skin tear (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
	395146	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a traumatic wound caused by mechanical forces that partially or fully separates the skin layers, often resulting in a skin flap) on left front tibia (shin), below the knee, measures 0.3 cm (centimeters) x 0.3 cm. Appears to have been scratched since obvious dried blood over skin tear. Patient denies pain. No swelling. Very superficial, band aide applied over area. Review of a physician order dated 3/11/26, indicated left lower extremity skin tear - cleanse with soap and water, apply xeroform and dry dressing daily every day shift for skin tear. Review of Resident R1's May 2026 and June 2026 TAR revealed the above treatment documentation:5/21/26: documented completed5/22/26: blank, no documentation to indicate treatment was completed or refused by resident5/23/26: documented completed5/24/26: documented completed5/25/26: documented completed5/26/26: documented completed5/27/26: documented completed5/28/26: documented completed5/29/26: blank, no documentation to indicate treatment was completed or refused by resident5/30/26: not completed due to healed5/31/26: blank, no documentation to indicate treatment was completed or refused by resident6/1/26: documented completed6/2/26: documented completed6/3/26: blank, no documentation to indicate treatment was completed or refused by resident6/4/26: documented completed6/5/26: documented completed6/6/26: documented completed6/7/26: documented completed6/8/26: documented completed6/9/26: documented completed6/10/26: documented completed Review of a Skin/Wound progress note dated 6/16/26, stated, Resident seen by wound team this morning. Healing abrasion (scrape) present to LLE. Wound is dry. No drainage. A couple scabbed areas remain. To apply skin prep (a liquid product used to create a protective barrier) QD (every day) and leave OTA (open to air). Review of a witness statement dated 6/15/26, completed by LPN Employee E2 stated, I inadvertently did not do the wound care on Resident R1's medical record and I accidentally signed off the dressing on the MAR (medication administration record). I had asked oncoming nurse to do dressing. Review of Resident R1's clinical record revealed LPN Employee E2 documented the treatment as completed on 6/10/26. Review of a witness statement dated 6/12/26, completed by LPN Employee E3 stated, That wound was healed and her put a dressing on a healed just a pink area wound made it a wound cause the people that seen it and worked there knew it didn't need anything wrong for signing it but never the less it was healed and when you got the whole floor you're busy no excuse but that's the truth. Review of Resident R1's clinical record revealed LPN Employee E3 failed to document the treatment as completed on 5/31/26, and documented the treatment as completed on 6/7/26. Review of a witness statement dated 6/12/26, completed by LPN Employee E4 stated, Last time I seen it was healed nurses before me can witness. Review of Resident R1's clinical record revealed LPN Employee E4 documented the treatment as completed on 5/25/26, 5/26/26, 5/28/26, 6/1/26, 6/2/26, 6/4/26, 6/5/26, 6/8/26, and 6/9/26. On 5/30/26, LPN Employee E4 documented the treatment as not performed due to the area healed. Review of a witness statement dated 6/16/26, completed by RN Employee E5 stated, There were two dates when RN recorded her initials and did not change dressing. RN either signed while charting with intent to change dressing and forgot or there were two times RN came in to change dressing and had to attend to roommates repositioning and one time when nurse aide refused to clean up roommate who was covered in chocolate. RN will change dressing then sign in chart moving forward. Review of Resident R1's clinical record revealed RN Employee E5 documented the treatment as completed on 5/23/26, and 6/6/26. During an interview on 6/30/26, at 12:30 p.m. RN Employee E6 stated, I would not mark a treatment as completed without actually doing it. During an interview on 6/30/26, at 1:08 p.m. RN Employee E7 stated, I would not sign off a treatment if I did not actually complete it. During an interview on 6/30/26, at 1:10 p.m. RN Employee E8 stated, I would not sign off a treatment as completed if I did not do it. During an interview on 6/30/26, at 1:14 p.m. RN Employee E1, RN Employee E9, and RN Employee E10 all stated, I would not document a treatment a completed without actually completing the treatment. During an interview on 6/30/26, at 1:45 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents received necessary treatment and services, consistent with professional standards of clinical practice for Resident R1. 28 Pa. Code: (continued on next page)

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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and facility job descriptions, clinical record review, incidents submitted to the local State field office, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for one of four residents (Resident R1).Findings include: Review of facility policy Skin Care and Wound Management dated 12/9/25, indicated all residents have head-to-toe skin inspection upon admission/readmission, then completed weekly, and as needed by nursing. It is documented in the electronic medical record NRSG: Weekly Skin. Assigned/due treatments are assigned in the electronic medical record under the ETAR (Electronic Treatment Administration Record) tab. Wound assessments/observation are required at a minimum weekly and when there is a change. Review of the facility Licensed Practical Nurse (LPN) job description indicated the LPN is to provide care to residents in accordance with physician orders, recognized standards of practice and established company policies and procedures. Responsibilities include sets up and administers prescribed medications and treatments. Review of the facility Registered Nurse (RN) job description indicated the RN is to provide care to residents in accordance with physician orders, recognized standards of practice and established company policies and procedures. Responsibilities include sets up and administers prescribed medications and treatments. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/26, indicated diagnoses of high blood pressure, Peripheral Vascular Disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Resident R1's comprehensive care plan dated 10/14/24, indicated the resident has potential impairment to skin integrity related to immobility, PVD, Sweet syndrome (a rare inflammatory skin disorder characterized by fever and painful, red or purple skin lesions), and incontinence. Interventions include follow facility protocols for treatment of injury. Review of a facility submitted document dated 6/11/26, indicated the following: Nurse practitioner (NP) was in to see Resident R1 after nursing staff reported that resident has a dressing placed to LLE (left lower extremity) skin tear on 5/21 with orders for daily xeroform (a medicated gauze dressing that keeps wounds moist and helps prevent infection) dressing. RN and NP assessed area and found the original one area of ulceration was now a few shallow ones, resident denies pain on assessment. On date, during a routine dressing change, the facility nurse identified that resident's LLE skin tear dressing, originally applied on had not been changed since 5/21/26. Review of the electronic medical record showed that multiple licensed nurses documented that the dressing was changed according to the treatment order during this period. Review of a nursing progress note dated 3/6/26, stated, Patient has, what appears to be a skin tear (a traumatic wound caused by mechanical forces that partially or fully separates the skin layers, often resulting in a skin flap) on left front tibia (shin), below the knee, measures 0.3 cm (centimeters) x 0.3 cm. Appears to have been scratched since obvious dried blood over skin tear. Patient denies pain. No swelling. Very superficial, band aide applied over area. Review of a physician order dated 3/11/26, indicated left lower extremity skin tear - cleanse with soap and water, apply xeroform and dry dressing daily every day shift for skin tear. Review of Resident R1's May 2026 and June 2026 TAR revealed the above treatment documentation:5/21/26: documented completed5/22/26: blank, no documentation to indicate treatment was completed or refused by resident5/23/26: documented completed5/24/26: documented completed5/25/26: documented completed5/26/26: documented completed5/27/26: documented completed5/28/26: documented completed5/29/26: blank, no documentation to indicate treatment was completed or refused by resident5/30/26: not completed due to healed5/31/26: blank, no documentation to indicate treatment was completed or refused by resident6/1/26: documented (continued on next page)

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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Place	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed6/2/26: documented completed6/3/26: blank, no documentation to indicate treatment was completed or refused by resident6/4/26: documented completed6/5/26: documented completed6/6/26: documented completed6/7/26: documented completed6/8/26: documented completed6/9/26: documented completed6/10/26: documented completed Review of a Skin/Wound progress note dated 6/16/26, stated, Resident seen by wound team this morning. Healing abrasion (scrape) present to LLE. Wound is dry. No drainage. A couple scabbed areas remain. To apply skin prep (a liquid product used to create a protective barrier) QD (every day) and leave OTA (open to air). Review of a witness statement dated 6/15/26, completed by LPN Employee E2 stated, I inadvertently did not do the wound care on Resident R1's medical record and I accidentally signed off the dressing on the MAR (medication administration record). I had asked oncoming nurse to do dressing. Review of Resident R1's clinical record revealed LPN Employee E2 documented the treatment as completed on 6/10/26. Review of a witness statement dated 6/12/26, completed by LPN Employee E3 stated, That wound was healed and her put a dressing on a healed just a pink area wound made it a wound cause the people that seen it and worked there knew it didn't need anything wrong for signing it but never the less it was healed and when you got the whole floor you're busy no excuse but that's the truth. Review of Resident R1's clinical record revealed LPN Employee E3 failed to document the treatment as completed on 5/31/26, and documented the treatment as completed on 6/7/26. Review of a witness statement dated 6/12/26, completed by LPN Employee E4 stated, Last time I seen it was healed nurses before me can witness. Review of Resident R1's clinical record revealed LPN Employee E4 documented the treatment as completed on 5/25/26, 5/26/26, 5/28/26, 6/1/26, 6/2/26, 6/4/26, 6/5/26, 6/8/26, and 6/9/26. On 5/30/26, LPN Employee E4 documented the treatment as not performed due to the area healed. Review of a witness statement dated 6/16/26, completed by RN Employee E5 stated, There were two dates when RN recorded her initials and did not change dressing. RN either signed while charting with intent to change dressing and forgot or there were two times RN came in to change dressing and had to attend to roommates repositioning and one time when nurse aide refused to clean up roommate who was covered in chocolate. RN will change dressing then sign in chart moving forward. Review of Resident R1's clinical record revealed RN Employee E5 documented the treatment as completed on 5/23/26, and 6/6/26. During an interview on 6/30/26, at 12:30 p.m. RN Employee E6 stated, I would not mark a treatment as completed without actually doing it. During an interview on 6/30/26, at 1:08 p.m. RN Employee E7 stated, I would not sign off a treatment if I did not actually complete it. During an interview on 6/30/26, at 1:10 p.m. RN Employee E8 stated, I would not sign off a treatment as completed if I did not do it. During an interview on 6/30/26, at 1:14 p.m. RN Employee E1, RN Employee E9, and RN Employee E10 all stated, I would not document a treatment a completed without actually completing the treatment. Review of Resident R1's clinical record failed to include documentation that a weekly skin assessment was performed for the following weeks:4/5/26 - 4/11/264/12/26 - 4/18/264/19/26 - 4/25/264/26/26 - 5/2/265/3/26 - 5/9/265/17/26 - 5/23/265/31/26 - 6/6/266/7/26 - 6/13/26 During an interview on 6/30/26, at 1:45 p.m. the Director of Nursing (DON) confirmed that the facility failed to complete and document a weekly skin assessment for Resident R1 on the above-mentioned dates. During an interview on 6/30/26, at 1:45 p.m. the DON confirmed that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for Resident R1. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.