

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/16/2026
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents' care plans were updated and revised to reflect the resident's specific care needs for three of six residents (Resident R22, R29, and R31). Findings include: Review of the facility policy Goals and Objectives, Care Plans dated 12/9/25, indicated care plan goals and objectives are defined as the desired outcomes for a specific resident problem. Care plans will be modified accordingly. Review of clinical record indicated Resident R29 was admitted to the facility on [DATE], with diagnoses that included pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and the right side of the heart), glaucoma and dysphagia (difficulty swallowing). Review of Resident R29's Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 11/6/25, indicated the diagnoses remain current. Physician orders dated 9/1/25 indicated regular diet, regular texture, regular thin consistency. Review of Resident R29's progress note dated 12/12/25 indicated that resident was choking. Resident was in her bed. Her daughter was in the room with her. her daughter responded resident had a bite of the hamburger, this time around she was having more difficulty coughing the piece of hamburger up. When I got there resident had already recovered from the choking and was at her baseline. Resident was assessed and was offered a pureed diet and she refused. Her daughter who was present with her responded That will never happen. Review of Resident R29's care plan reviewed on 1/13/26, indicated no need for a modified diet. During an interview on 1/14/26, Registered Dietitian Employee E9 confirmed the facility failed to revise care plan for Resident R29 as required. Review of the admission record indicated Resident R22 admitted to the facility on [DATE]. Review of Resident R22's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/10/25, indicated the diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and falls. Section N0415 High-Risk Drug Classes indicated anticoagulants (blood thinning medication) was being taken by the resident. (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
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R22's physician order dated 12/6/25, indicated Eliquis (blood thinner) 5mg (milligrams) twice a day for pulmonary emboli (a life-threatening blockage, in a lung artery). Review of Resident R22's current care plan failed to include a goal and interventions for management and monitoring of anticoagulant use as required. Interview on 1/13/26, at 2:27 p.m. the Director of Nursing confirmed Resident R22's care plan failed to include a goal and interventions for management and monitoring of anticoagulant use as required. Review of the admission record indicated Resident R31 admitted to the facility on [DATE]. Review of Resident R31's MDS dated [DATE], indicated the diagnoses of end stage renal disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), anemia (the blood doesn't have enough healthy red blood cells), and diabetes. Review of Resident R31's physician order dated 12/16/25, indicated fluid restriction was discontinued due to Resident R31's adamant refusal to comply with the fluid restriction. Review of Resident R31's care plan on 1/13/26, at 2:54 p.m. indicated resident has potential for dehydration or potential for fluid deficit related to dialysis and fluid restriction. Interview on 1/13/25, at 2:55 p.m. The Director of Nursing confirmed the facility failed to discontinue the fluid restriction from Resident R31's care plan on 12/16/25, when the physician discontinued it. Interview on 1/16/26, at 1:30 p.m. the Director of Nursing confirmed the facility failed to ensure that residents' care plans were updated and revised to reflect the resident's specific care needs for three of six residents (Resident R22, R29, and R31). 28 Pa. Code: 211.12(d)(1)(5) Nursing services. 28 Pa. Code: 211.11(d) Resident Care Plan.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to provide an Assessment Involuntary Movement Scale (AIMS- a widely used tool designed to measure the severity of tardive dyskinesia (TD- a disorder characterized by involuntary movements that can occur as a side effect of long term use of antipsychotic medication) assessment at least quarterly for three of five residents (Resident R30, R36, R102). Findings include: Review of the facility policy Assessment Involuntary Movement Scale last reviewed 12/9/25, indicated to ensure early identification, monitoring, and appropriate clinical response to involuntary movements particularly those associated with antipsychotic medication use, through consistent use of the AIMIS scale for residents receiving nursing services. AIMS must be completed prior to initiation of any antipsychotic medication, must be completed every three months (quarterly) for all residents receiving antipsychotic medications. Review of the admission record indicated Resident R30 was admitted to the facility on [DATE]. Review of Resident R30's MDS (MDS - a periodic assessment of care needs) dated 12/31/25, indicated the diagnosis of hypertension (high blood pressure), atrial fibrillation (A-fib-irregular and often rapid heartbeat) and dementia. Section N0415 indicated antipsychotic use. Review of Resident R30's AIMS evaluation indicated last completion date of 7/8/25. Review of the admission record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's MDS dated [DATE], indicated the diagnosis of heart failure (heart doesn't pump the way it should), hypertension and dementia. Section N0415 indicated antipsychotic use. Review of Resident R36's AIMS evaluation indicated last completion date 9/20/25. Review of the admission record indicated Resident R102 was admitted to the facility on [DATE]. Review of Resident R102's MDS dated [DATE], indicated the diagnosis of Parkinsons disease (affects muscle control and movement), Atrial fibrillation, and dementia. Section N0415 indicated antipsychotic use. Review of Resident R102's AIMS evaluation indicated last completion date 9/20/25. During an interview completed on 1/16/26, at 11:40 a.m. The Director of Nursing confirmed the AIMS Assessments should be completed quarterly and confirmed the facility failed to provide an AIMS assessment at least quarterly for three of five residents (Resident R30, R36, R102). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for five of seven residents (Resident R21, R30, R33, R36, and R50) and failed to have a current hospice agreement that included the vendors name. Findings include: Review of the facility Hospice Program last reviewed 12/9/25, indicated Hospice services are available to residents at the end of life. Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. Hospice providers who contract with this facility must have a written agreement with the facility outlining the responsibilities of the facility and the hospice agency. It is the responsibility of the hospice to manage the residents' care as it relates to terminal illness and related conditions including determining the appropriate hospice plan of care. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care. Review of the admission record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/10/25, indicated the diagnosis of diabetes (high sugar in the blood), dementia (a group of symptoms affecting memory, thinking and social abilities) and osteoarthritis (joint pain). Review of Resident R21's current physician orders indicated admission to an outside vendor's Hospice Services on 10/16/25. Review of Resident R 21's hospice binder on 1/15/26, failed to include a hospice plan of care. Review of the admission record indicated Resident R30 was admitted to the facility on [DATE]. Review of Resident R30's MDS dated [DATE], indicated the diagnosis of hypertension (high blood pressure), atrial fibrillation (irregular and often rapid heartbeat) and dementia. Review of Resident R30's current physician orders indicated admission to an outside vendor's Hospice Services on 12/26/25. Review of Resident R30's hospice binder on 1/15/26, failed to include a hospice plan of care. Review of the admission record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated the diagnosis of coronary artery disease (CAD-narrowing of arteries), hyperlipidemia (high fat in the blood) and dementia. Review of Resident R33's current physician orders indicated admission to an outside vendor's Hospice Services on 12/26/25. Review of Resident R33's hospice binder on 1/15/26, failed to include a hospice plan of care. Review of the admission record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's MDS dated [DATE], indicated the diagnosis of heart failure (heart doesn't pump the way it should), hypertension and dementia. Review of Resident R36's current physician orders indicated admission to an outside vendor's Hospice Services on 10/18/25. Review of Resident R 36's hospice binder on 1/15/26, failed to include a hospice plan of care. Review of the admission record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's MDS dated [DATE], indicated the diagnosis of CAD, hypertension, and Parkinson's disease (a brain condition that affects muscle control and movement). Review of Resident R50's current physician orders indicated admission to an outside vendor's Hospice Services on 12/26/25. Review of Resident R50's hospice binder on 1/15/26, failed to include a hospice plan of care. During an interview completed on 1/15/26, at 11:18 a.m. upon asking Registered Nurse (RN) Employee E12 concerning hospice binders and hospice care plans stated, I'm not aware of what should be in the binder the hospice nurse is here now, I will get her. During an interview completed on 1/15/25, at 11:30 upon asking Hospice RN Employee E11 where the hospice care plan could be found replied in their binders. Hospice RN Employee E11 reviewed five binders all failed to have a care plan. RN Employee E11 confirmed the care plans were not in the binders and stated, I can get them sent over right now, and I will put them in. Review of the facility provide Agreement for Hospice Service in a long-term care facility on 1/15/26, failed to provide a current (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospice agreement with the vendor's name. During an interview completed on 1/15/26, at 2:43 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for five of seven residents (Resident R21, R30, R33, R36, and R50) and failed to have a current hospice agreement that included the vendors name. 28 Pa. Code: 201.14 (a) Responsibilities of licensee.28 Pa. Code: 201.18 (a)(b)(1)(3) Management.28 Pa. Code: 201.20(a)(b)(c)(d) Staff development.28 Pa. Code: 211.10 (c)(d) Resident care policies.28 Pa. Code 211.11(d) Resident care plan.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation and staff interview, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for one of five residents (Resident R64). Findings include: Review of facility policy Dignity dated 12/9/25, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered. Review of the clinical record indicated Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/28/25, indicated diagnoses of benign prostatic hyperplasia (BPH- a common enlargement of the prostate gland in aging men that squeezes the urethra), obstructive uropathy (a blockage in the urinary tract that prevents normal urine flow), and depression. Section H0100 indicated an indwelling catheter was present. Review of a physician order dated 1/1/26, indicated catheter care for indwelling catheter (a flexible tube inserted into the bladder for continuous urine drainage) every shift for catheter care. Cleanse area every shift. Review of Resident R64's care plan dated 12/29/25, indicated the resident has an indwelling catheter due to obstructive uropathy. During an observation on 1/12/26, at 1:11 p.m. Resident R64 was walking with Therapy Employee E2 in the foyer at the top of the public stairwell with the urinary catheter bag in full view of any passerby, without a dignity or privacy bag to cover the urine. During an interview on 1/12/26, at 1:11 p.m. Therapy Employee E2 confirmed Resident R64's catheter draining bag did not have a privacy cover and that the facility failed to ensure that care was provided in a way that maintained Resident R64's dignity. Pa. Code: 201.14(a) Responsibility of licensee. Pa. Code: 211.10(d) Resident care policies. Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation that residents were given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for one of four residents reviewed (Resident R48). Findings include: Review of the facility policy Advanced Directives dated 12/9/25, indicated prior to or upon admission of a resident, the social services director or designee inquires of his/her family members and/or their legal representative, about the existence of any written advanced directives. If the resident indicates that they have not established an advanced directive the facility staff will offer assistance in establishing advanced directives. Staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. Review of the admission record indicated Resident R48 admitted to the facility on [DATE]. Review of Resident R48's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/6/26, indicated the diagnoses of high blood pressure, end stage renal disease (kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and anemia (the blood doesn't have enough healthy red blood cells). Review Resident R48's Social Service Initial Assessment and Social History dated 1/6/26, failed to reveal an advanced directive or documentation that Resident R48 was given the opportunity to formulate an Advanced Directive. Interview on 1/13/26, at 2:55 p.m. the Director of Nursing confirmed that the facility failed to provide documentation that residents were given the opportunity to formulate an advance directive for one of four residents reviewed (Resident R48). 28 Pa. Code: 201.29(b) Resident rights.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to notify the physician of a change in condition for one of five residents (Resident R41). Findings include: Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE], with diagnoses that included polyneuropathy (nerve disease caused by damage to many nerves), edema and obesity. Review of Resident 's Medicare 5-day MDS assessment(minimum data assessment)- periodic assessment of resident care needs) dated 12/29/25, indicated the diagnosis remained current. Review of Resident R41's physician orders dated 12/29/25 Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 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 - 1000 = 6 units Call provider if CBG >340, subcutaneously with meals for IDDM Review of blood sugar summary indicated: 12/31/2025 22:05 423.0 mg/dL 1/5/2026 16:52 424.0 mg/dL 1/8/2026 10:56 399.0 mg/dL 1/8/2026 12:37 388.0 mg/dL Review of Resident R41 progress notes dated 12/1/2025-1/8/2026 revealed there was no indication it was reported to the physician. During an interview on 1/14/26, at 1:40 p.m. Director of Nursing confirmed there was no physician notification for elevated blood sugar as required. 28 Pa. Code: 211. 12(d)(1) Nursing services.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, resident and staff interviews it was determined that the facility failed to display (for the residents and family members) the required information on the grievance process for the building. Findings include: Review of facility policy Resident Grievance/Complaint Procedures dated? 12/9/25, indicated: Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at this facility. Grievances also may be voiced or filed regarding care that has not been furnished. Review of facility policy Grievance Program (Concern and Comment) dated 12/9/25, indicated: Purpose: To help guide our communities in the Grievance Process and ensure that a thorough, complete, and accurate investigation has been completed to the best of our knowledge in accordance with F585 483.10 (j)(1)(2)(3) and (4). The facility will post in prominent locations throughout the facility The Right to File Grievances orally (meaning spoken) or in writing: the right to file anonymously. This will include a. The contact information of the Grievance Officer with whom a grievance can be filed, that is, his , or her name, business address (mail and email) and business phone number. B. a reasonable expected time frame for completing the review of the grievance is usually 5 days but no longer than 10 days. C. The right to obtain a written decision regarding his or her grievance. D. The contact information of independent entities with whom grievances may be filed, that is, the pertinent State Agency, Quality Improvement Organization, State Survey Agency and State Long Term Care Ombudsman program or protection and advocacy system. During the resident council on 1/13/26, at 10:45 a.m. residents indicated that they were not aware of the grievance officer, nor did they know where the grievances boxes were located with the grievance forms. During an observation on 1/12/26, at 10:17 a.m. on the first-floor bulletin board failed to have a grievance officer with whom a grievance can be filed, how to file a grievance, a business address (mail and email), During an observation on 1/14/26, at 1:48 pm. on the second-floor nursing unit bulletin board failed to have a grievance officer with whom a grievance can be filed, how to file a grievance, a business address (mail and email). During an observation on 1/14/26, at 2:13 p.m. on the third-floor nursing unit bulletin board failed to have a grievance officer with whom a grievance can be filed, how to file a grievance, a business address (mail and email). During an observation on 1/16/26, at 9:18 a.m. on the first-floor secure nursing unit bulletin board failed to have a grievance officer with whom a grievance can be filed, how to file a grievance, a business address (mail and email). During an interview on 1/16/26, at 10:33 a.m. Nursing Home Administrator confirmed that the facility failed to display (for the residents and family members) the required information on the grievance process for the building. 28 Pa. Code 201.29 Resident rights.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents received proper treatment for pressure ulcers/injuries (PU/PI's - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of four residents (Resident R11, and R93). Findings include: Review of the facility wound policy Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 12/9/25, indicated In addition, the nurse shall describe and document/report the following - a full assessment of pressure sore including location, stage, length, width, and depth presence of exudates or necrotic tissue. Review of Resident R11's admission record indicated she was originally admitted on [DATE], and re-admitted on [DATE]. Review of Resident R11's MDS dated [DATE], indicated diagnoses of non-Alzheimer's dementia with behavioral disturbance (brain diseases that mainly affect frontal and temporal lobes of the brain. These areas of the brain are associated with personality, behavior, and language, depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Review of Resident R11's clinical progress notes indicated: 10/19/2025: Skin/Wound Note Text: Resident has an open area on the Sacrum/Coccyx. Review of the clinical progress notes failed to include a stage, measurements or description of the wound. No description of Resident R11 wound was noted until 11/4/25 in the wound notes indicating: a Pressure Injury Stage 4. During an interview on 1/16/26, at 10:06 a.m. Director of Nursing (DON) confirmed that wounds once identified should be staged, measured and a description of the wound should be included in the clinical record. During an interview on 1/16/26, at 10:08 a.m. DON and Nursing Home Administrator confirmed that the facility failed to stage, measure and describe a wound in the clinical record of Resident R11 timely. Review of the admission record indicated Resident R93 was admitted to the facility on [DATE]. Review of Resident R93's MDS dated [DATE], indicated diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and heart failure (heart doesn't pump blood as well as it should). Section M0300 the current number of unhealed pressure ulcers/injuries indicated one unstageable (a deep wound where the extent of damage can't be determined because the base is obscured by slough or eschar), deep tissue injury (DTI -a serious pressure injury damaging soft (continued on next page)		

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No. 0938-0391

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 01/16/2026
NAME OF PROVIDER OR SUPPLIER Canterbury Place		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fisk Street Pittsburgh, PA 15201	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tissues beneath intact skin)was present. Review of a physician order dated 11/21/25, indicated DTI to left heel. Cleanse with normal saline, apply xeroform (a treatment used as a non-adherent primary layer for low draining wounds) to thewound bed, apply 4x4 gauze and wrap with kerlix (a woven gauze bandage), change daily. Review of Resident R93's Skin and Wound Evaluation dated 12/24/25, indicated unstageable pressure injury to left heel with measurements of 1.2 cm (centimeters) long by 1.1 cm wide. Slough (yellowish, soft, stringy, non-viable tissues that blocks healing) filled 50% (percent) of wound bed. Further review of Resident R93's clinical record indicated that the left heel PI was not measured on 12/17/25, 12/31/25, or 1/7/26, as required for monitoring wound progress/deterioration. Review of Resident R93's care plan failed to include a goal and interventions for management and monitoring of the left heel PI. Interview on 1/13/26, at 9:26 a.m. Registered Nurse (RN) Employee E1 confirmed Resident R93's left heel PI was not measured weekly as required and the care plan failed to include a goal and interventions for management and monitoring of the left heel PI. Interview on 1/16/26, at 1:30 p.m. the Director of Nursing confirmed the facility failed to make certain that residents received proper treatment for PU/PIs for two of four residents (Resident R11, and R93). 28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 211.10 (c)(d) Resident care policies.28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy, interview with staff and resident, it was determined the facility failed to provide tracheostomy care consistent with professional standards of practice for one of two residents receiving oxygen (Resident R39). Findings include: Review of the facility policy Tracheostomy Care dated 12/9/25, indicated a replacement tracheostomy tube (a hollow tube inserted into a surgical opening in the neck (stoma) directly into the windpipe to provide long-term ventilation) must be available at the bedside at all times. Review of the admission record indicated R39 was admitted to the facility on [DATE]. Review of Resident R39's Minimum Data Set (MDS- a periodic assessment of care needs) dated 12/31/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Section O - E1 indicated that resident received tracheostomy care. Review of Resident R39's current physician orders indicated trach care daily and as needed . Monitor trach site for signs and symptoms of infection, increased secretions, and dislodgement: Trach size 6.0 cuffless every shift. Oxygen at 4 liters via trach mask. Review of Resident R39's care plan dated 12/30/25, indicated resident has a trach. Resident will have no abnormal drainage around trach site through the review date. Intervention - trach - Shiley, uncuffed #6. Review of Resident R39's clinical admission assessment dated [DATE], at 5:18 p.m. indicated lungs clear throughout. No difficulty breathing. Head of bed elevated. Spare trach kit at bedside. Observation on 1/14/26, at 1:43 p.m. Resident R39 was sitting out of bed in a stationary chair. Resident had trach mask connected to oxygen concentrator. A backup trach Shiley, uncuffed #6 failed to be present. Interview and observation on 1/14/26, at 1:24 p.m. with Registered Nurse (RN) Employee E4, confirmed there was not a backup trach in the room as required. Interview on 1/14/26, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide tracheostomy care consistent with professional standards of practice for one of two residents receiving oxygen (Resident R39). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R36). Findings include: Review of the facility policy Goals and Objectives, Care Plans last reviewed 12/9/25, indicated care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Review of the admission record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/23/25, indicated the diagnosis of heart failure (heart doesn't pump the way it should), hypertension and dementia. Review of Resident R36's physician progress notes dated 8/19/25, indicated past medical history that included but not inclusive to CAD, hypertension, hyperlipidemia, Post Traumatic Stress Disorder (PTSD). Review of Resident R36's care plan with revision on 10/20/25, indicated that Resident R36 had trauma but failed to identify what the triggers were and how to avoid them. During an interview on 1/15/25, at 2:39 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R36). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications properly and securely in one of two medication rooms (Renaissance unit), four of four medication carts (First Floor Carts A and B, and Renaissance Hall front and back), and failed to ensure medication carts were secured when not in presence of the nurse. Findings include: Review of the facility policy Storage of Medications dated 12/9/25, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. During an observation on 1/13/26, at 11:14 a.m. the Renaissance unit medication room refrigeration contained an ice pack. During an interview completed on 1/13/26, at 11:19 a.m. Licensed Practical Nurse (LPN) Employee E10 confirmed the ice pack was stored in the refrigerator and stated, the ice pack is used for the laboratory and should be stored in the laboratory refrigerator. During an observation on 1/13/26, at 1:24 p.m. the First Floor Cart A contained the undated medication of albuterol nebulizers (respiratory medication to help in breathing). Interview on 1/13/26, at 1:25 p.m. Licensed Practical Nurse (LPN) Employee E6 confirmed the albuterol was not dated when opened as required. During an observation on 1/13/26, at 1:30 p.m. the First Floor Cart B contained the following:-moxifloxacin eye drops (eye drop to treat infection) not stored in a box or bag. Opened and undated. During an interview on 1/13/26, at 1:31 p.m. Registered Nurse (RN) Employee E7 confirmed the medications were opened and not dated as required and the eye drops were not stored in a box or bag. During an observation completed on 1/13/26, at 10:20 a.m. the Renaissance front medication cart contained the following:-Miralax (laxative) bottle opened and undated.-Geri-tussin (cough suppressant) bottle opened and undated. During an observation completed on 1/13/26, at 10:29 a.m. the Renaissance back medication cart contained a bag with a Humalog insulin pen (rapid acting) and a Lantus insulin pen (long acting) the insulin pens were opened and undated. During an interview completed on 1/13/26, at 10:30 a.m. LPN Employee E10 confirmed the medications were opened and undated. During an observation on 01/12/2026 12:30 PM on the first-floor nursing care unit, a medication cart was unlocked, and unattended by staff in front of the nursing station. During an interview on 01/12/26, at 12:32 p.m. LPN (Licensed Practical Nurse) interim unit manager Employee E13 confirmed that the medication cart was unlocked and unattended, and accessible to residents. Interview on 1/13/26, at 1:35 p.m., the Director of Nursing confirmed that the facility failed to store medications properly and securely in one of two medication rooms (Renaissance Unit) four of four medication carts (First Floor Carts A and B, and Renaissance Hall front and back), and failed to ensure medication carts were secured when not in presence of the nurse. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(2)(3) Nursing services.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for two of four quarters (January 2025, through March 2025 and July 2025, through September 2025). Findings include: Review of facility policy Quality Assurance and Performance Improvement Program Guidelines last reviewed 12/9/25, indicated the facility shall develop, implement, and maintain an ongoing, facility wide data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Review of the facility policy Quality Assurance and Performance Improvement last reviewed 12/9/25, indicated the following individuals serve on the committee: Administrator, Director of Nursing, Medical Director, Infection Preventionist, Pharmacy, Social Services, Activity Service, Environmental Services, Human Resources, Medical Records and Diagnostics. A review of the QAPI Committee meeting sign-in sheets from the period of January 2025, through December 2025, revealed that Medical Director was not in attendance for two of the four quarters (January 2025, through March 2025 and July 2025, through September 2025). During an interview on 1/16/25, at 11:20 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for two of four quarters (January 2025, through March 2025 and July 2025, through September 2025). 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to manage airborne isolation for Covid positive infections in one of seven rooms (Resident R37). Findings include: Review of the facility policy Coronavirus Disease (Covid-19) - Identification and Management of Ill Residents dated 12/9/25, indicated newly identified Covid-19 infection in resident; symptomatic residents regardless of vaccination status, are restricted to their rooms and cared for staff using a NIOSH (National Institute for Occupational Safety and Health) approved N95 or equivalent or higher level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown. Review of Resident R37's admission record indicated admission to the facility on 8/11/25. Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/14/25, indicated diagnosis of hypertension (high blood pressure), renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and depression. Review of Resident R37's physician order dated 1/8/25, indicated assess lungs and apical heart rate every shift for Covid for ten days. Covid isolation - contact and airborne precautions in private room due to positive Covid. Care and services to be provided in the resident's room for ten days. Review of Resident R37's care plan dated 1/8/26, indicated the resident has a respiratory infection of Covid related to exposure. The resident will be free from signs and symptoms of infection by review date. Airborne contact isolation. Observation on 1/12/26, at 11:00 a.m. Resident R37's door had a sign indicating airborne precautions with a door holder containing masks, N-95 respirators, gloves, gowns, and hand sanitizer. The door holder failed to have eye protection available for staff. Interview on 1/12/26, at 11:01 a.m. Nurse Aide (NA) Employee E3 indicated staff are to wear a gown and gloves in Resident R37's room and did not think eye protection was required. Interview on 1/12/26, at 11:03 a.m. Registered Nurse (RN) Employee E8 indicated they were unaware if eye protection was needed to care for Resident R37. Interview on 1/12/26, at 11:45 a.m. Infection Preventionist Employee E5, confirmed that eye protection was needed in a positive covid room and they would re-educate NA Employee E3 on eye protection requirements. Interview on 1/16/26, at 1:30 p.m. the Director of Nursing confirmed the facility failed to manage airborne isolation for Covid positive infections in one of seven rooms (Resident R37). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.28 (b)(1)(e)(1) Management.28 Pa Code: 211.10 (d) Resident care policies.		