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	11/18/2025

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon review of clinical and hospital records, interviews with staff, and review of facility submitted documents and policies, it was determined the facility did not ensure residents receive treatment and care in accordance with professional standards of practice, by failing to ensure physician orders were transcribed accurately on admission for two of three records reviewed (Closed Record Resident R1 and Resident R2).Findings include: Review of facility policy Medication and Treatment orders, dated 1/2/25, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Only authorized licensed practioners, or individuals authorized to take verbal orders from practioners, shall be allowed to write orders in the medical chart. Review of clinical record indicated that Closed Record (CR) Resident R1 was admitted to facility 8/21/25, and discharged on 9/4/25, to a lower level of care. Review of CR Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/27/25, indicated diagnoses of encephalopathy (group of conditions that cause brain dysfunction, leading to symptoms such as confusion, memory loss, and personality changes), chronic obstructive pulmonary disease (chronic lung disease that includes conditions such as chronic bronchitis and emphysema), and dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to do everyday activities). Review of facility submitted document dated 10/28/25, indicated that upon admission, CR Resident R1's medication Hydroxyurea (used primarily to treat certain types of cancer and sickle cell anemia, working by slowing the growth of cancer cells and improving red blood cell flexibility) was transcribed incorrectly. The order was Hydroxyurea 1000mg PO daily, however it was transcribed as hydroxyurea 1000mg PO BID. This dosage continued till her discharge on [DATE], and that dosage continued as part of her discharge instructions. On 10/06/2025, the daughter of the resident reported to the facility that the resident was in the hospital, she believed resulting from the error. Resident's provider was made aware. Review of CR Resident R1's physician order dated 8/21/25, indicated to administer Hydroxyurea Oral Capsule 500 mg (milligrams) Give 2 capsules by mouth two times a day for Thrombocytosis. Review of CR Resident R1's clinical record hospital referral summary dated 8/19/25, indicated Hydroxyurea 1000 mg oral (by mouth) daily listed on Medications [ordered list]. Further review of clinical record hospital medication list results dated 8/19/25, indicated Hydroxyurea 1000 mg oral (by mouth) daily. Also noted that this medication was restarted 8/15/2025, and is being continued daily; it is also an ongoing home medication. During an interview on 11/18/25, at 10:28 a.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure CR Resident R1's physician orders on admission were transcribed accurately. Review of clinical record indicated that Resident R2 was admitted to the facility 10/6/25. Review of Resident R2's MDS dated [DATE], indicated diagnoses of fracture of olecranon (elbow), benign prostatic hyperplasia (enlarged prostate gland), and heart disease. Review of Resident R2's active physician order dated 10/17/25, indicated to administer Omeprazole (medication used to treat conditions caused by excess stomach acid) Oral Capsule Delayed Release 20 mg Give 1 capsule by mouth two times a day for GERD (gastroesophageal reflux disease). Review of Resident R2's admission physician order dated 10/6/25, and discontinued on 10/17/25, indicated to administer Omeprazole Oral Capsule Delayed Release 20 mg Give 1 capsule by mouth in the morning for GERD. Review of Resident R2's clinical record physician progress note dated 10/17/25, indicated Resident R2 denies any heartburn or reflux and wasn't clear on why he was taking the Omeprazole BID prior to admission. Review of records indicated possible switch to Pantoprazole (medication that reduces stomach acid production) daily but orders resumed Omeprazole 20 mg BID (twice a day) upon hospital discharge - has been receiving Omeprazole 20 mg daily - resume at BID dosing. Review of Resident R2's clinical record hospital Discharge summary dated [DATE], indicated to administer Omeprazole (20 mg Delayed Release Capsule) 1 cap by mouth 2 times per day. During an interview on 11/18/25, at 3:03 p.m., the NHA and Director of Nursing (DON) confirmed that the facility failed to ensure physician orders were transcribed accurately on admission for two of three records reviewed (Closed Record Resident R1 and Resident R2). 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)(3)(5) Nursing services.