

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

October 11, 2023

[REDACTED], ADMINISTRATOR
CANTERBURY PLACE
310 FISK STREET
PITTSBURGH, PA, 15201

RE: CANTERBURY PLACE
310 FISK STREET
PITTSBURGH, PA, 15201
LICENSE/COC#: 42949

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/30/2023, 08/31/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: CANTERBURY PLACE License #: 42949 License Expiration: 06/17/2024
 Address: 310 FISK STREET, PITTSBURGH, PA 15201
 County: ALLEGHENY Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: CANTERBURY PLACE
 Address: 310 FISK STREET, PITTSBURGH, PA, 15201
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 10/14/2016 Issued By: City of Pittsburgh

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 35 Waking Staff: 26

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Incident Exit Conference Date: 08/31/2023

Inspection Dates and Department Representative

08/30/2023 - On-Site: [REDACTED]
 08/31/2023 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 78 Residents Served: 23
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 3
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 23
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 2
 Have Mobility Need: 12 Have Physical Disability: 2

Inspections / Reviews

08/30/2023 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/29/2023

10/02/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 10/10/2023
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/06/2023

Inspections / Reviews *(continued)*

10/10/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/10/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/17/2023

10/11/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/10/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]/23 at approximately [redacted] p.m., there was an allegation of verbal abuse against staff person A regarding resident #1. The allegation was not reported to the local Area Agency on Aging until 8/22/23.

Plan of Correction

Accept [redacted] - 10/02/2023)

On 8/22/2023 as soon as the Personal Care Home Administrator was notified on the allegation of abuse that occurred on [redacted]/2023, Area Agency on Aging was immediately notified via phone call and written report was submitted. The allegation was also submitted to the Dept. of Human Services. Following the investigation, all Medication Technicians were trained on reporting allegations of abuse including the types of incidents to be reported, reporting time frames, who to contact when an allegation occurs, completing mandatory forms, important information to be included in the Description of Incident including the who, what, where, when, and whys of the incident and appropriate follow up. Additionally, the DRC/PCHA reviewed with the Medication Technicians two sample incidents and subsequent reporting to ensure their understanding. Yearly OAPSA training and reporting incidents will continue to be conducted with all personal care staff. Personal Care Home Administrator and Director of Resident Care will monitor yearly trainings.

Licensee's Proposed Overall Completion Date: 09/28/2023

Implemented [redacted] - 10/11/2023)

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted]/23 at approximately [redacted] p.m., there was an allegation of verbal abuse against staff person A regarding resident #1. Staff person A continued to work unsupervised in the home until [redacted] p.m. on [redacted]/23, and also worked unsupervised during the [redacted] p.m. to [redacted] p.m. shifts on [redacted]/23 and [redacted]/23.

Plan of Correction

Accept [redacted] - 10/02/2023)

After the allegation was reported to the Director of Resident Care and the Personal Care Home Administrator the employee was immediately suspended. The PCHA notified the Area Agency on Aging, and the Department of Human Services. The facility then began their internal investigation. The employee was returned after the investigation was completed and was monitored while providing direct care by Director of Resident Care on three residents during the first three weeks after her return. Subsequently the employee has weekly check ins for two months with the Director of Resident Care, was reminded to seek assistance with resident care if needed. All personal care staff were reeducated on resident rights including dignity respect of residents, OAPSA, and caring for residents exhibiting aggressive behaviors. Yearly OAPSA and resident rights will continue to be conducted with all personal care staff.

15b - Supervisor Plan (continued)

Personal Care Home Administrator and Director of Resident Care will monitor yearly trainings.

Licensee's Proposed Overall Completion Date: 10/28/2023

Implemented (█ - 10/11/2023)

16c - Written Incident Report

3. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On █/23 at approximately █ p.m., there was an allegation of verbal abuse against staff person A regarding resident #1. The allegation was not reported to The Department until 8/22/23.

Plan of Correction

Accept (█ - 10/02/2023)

On 8/22/2023 as soon as the Personal Care Home Administrator was notified on the allegation of abuse that occurred on █/2023, Area Agency on Aging was immediately notified via phone call and written report was submitted. The allegation was also submitted to the Dept. of Human Services. Following the investigation, all Medication Technicians were trained on reporting allegations of abuse including the types of incidents to be reported, reporting time frames, who to contact when an allegation occurs, completing mandatory forms, important information to be included in the Description of Incident including the who, what, where, when, and whys of the incident and appropriate follow up. Additionally, the DRC/PCHA reviewed with the Medication Technicians two sample incidents and subsequent reporting to ensure their understanding. Yearly OAPSA training and reporting incidents will continue to be conducted with all personal care staff. Personal Care Home Administrator and Director of Resident Care will monitor yearly trainings.

Licensee's Proposed Overall Completion Date: 09/28/2023

Implemented (█ - 10/11/2023)

42c - Treatment of Residents

4. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On █/23 at approximately █ p.m., after staff person A provided resident #1 with incontinence care, staff person A began to leave the room and said resident #1 was a pig.

Plan of Correction

Accept (█ - 10/10/2023)

After the allegation was reported to the Director of Resident Care and the Personal Care Home Administrator the employee was immediately suspended. The PCHA notified the Area Agency on Aging, and the Department of Human Services. The facility then began their internal investigation. The employee was returned after the investigation was completed and was monitored while providing direct care by Director of Resident Care on three residents during the first three weeks after her return. Subsequently the employee has weekly check ins for two months with the

42c Treatment of Residents (continued)

Director of Resident Care, was reminded to seek assistance with resident care if needed.

All personal care staff were reeducated on resident rights including dignity respect of residents, OAPSA, and caring for residents exhibiting aggressive behaviors. Yearly OAPSA and resident rights will continue to be conducted with all personal care staff. Personal Care Home Administrator and Director of Resident Care will monitor yearly trainings.

Director of Resident Care will increase supervision/rounding by charge during resident care to ensure all nursing assistants are promptly and proficiently assisting residents with their care needs in a manner that's compliant with §2600.42(b). If assistance is needed in providing resident care, charge will assist accordingly.

Licensee's Proposed Overall Completion Date: 10/28/2023

Implemented [REDACTED] - 10/11/2023)