



**Sent via e-mail to: khamati@abseniorliving.com
Mailing Date: April 28, 2020**

Mr. Nader Hamati
President & Chief Executive Officer
Above & Beyond at the Knights LLC
4293 Chatter Way
Allentown, Pennsylvania 18103

RE: Above & Beyond at the Knights
1545 Greenleaf Street
Allentown, Pennsylvania 18102
License #: 226470

Dear Mr. Hamati:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 16, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Anne Graziano". The signature is written in a cursive, flowing style.

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: ABOVE & BEYOND AT THE KNIGHTS

License Number: 22647

Address: 1545 GREENLEAF STREET,, ALLENTOWN, PA 18102

County: LEHIGH

Region: NORTHEAST

Administrator

Name: Naila Hamati

Phone: 6104347433

Email: ABOVEANDBEYONDAL@AOL.COM

Legal Entity

Name: ABOVE AND BEYOND AT THE KNIGHTS LLC

Address: 4293 CHATTER WAY, ALLENTOWN, PA, 18103

Certificate(s) of Occupancy

Type: C-2 LP

Date: 04/12/1989

Issued By: Labor & Industry

Staffing Hours

Resident Support Staff: 88

Total Daily Staff: 210

Waking Staff: 158

Inspection

Type: Full

BHA Docket #:

Notice: Unannounced

Reason: Renewal & Complaint

Inspection Dates and Department Representative

01/16/2020 - On-Site: Gerald Dumas, Amy Deluca, Corey Pica

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 150

Residents Served: 88

Secured Dementia Care Unit

In Home: Yes

Area: NA

Capacity: 32

Residents Served: 24

Hospice

Current Residents: 8

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 87

Diagnosed with Mental Illness: 6

Diagnosed with Intellectual Disability: 4

Have Mobility Need: 34

Have Physical Disability: 4

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

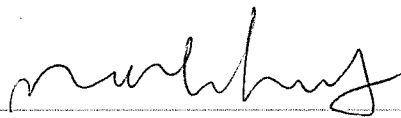
The home did not have a CO monitor installed in the kitchen 15 feet away from the gas stove as required by the Care Facility Carbon Monoxide monitor Act.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

CO monitor was installed in the kitchen 15 feet away from the gas stove (see attached photo)

Legal Entity Representative



Signature

Naila Furicchia, ED

Printed Name and Title

2/18/2020

Date

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The above plan of correction is approved as of

3-4-2020

(Date)

Plan of correction implementation status as of

3-4-2020

(Date)

The above plan of correction was approved by

ag

(Initials)

Implemented

Not Implemented

81b - Resident Personal Equipment

Regulations

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

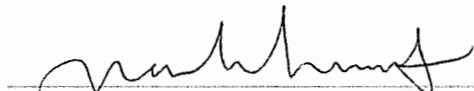
Beds in rooms 205 and 301 had enabler bars attached to the beds that did not have covers over them to prevent possible entrapment.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Enabler bars were covered immediately after the inspection to ensure resident safety. Direct care staff were retrained on the allowed use of enabler bars and that they be securely covered. Lead care managers will conduct weekly rounds of all rooms and ensure that any enabler bars have been documented and approved by wellness coordinator, and that they are covered for the next 6 months, then monthly thereafter. Executive director will conduct room inspections monthly for the presence of enabler bars and their appropriate covering and use in the next 6 months, then periodically thereafter.

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85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The glucometer belonging to resident # 1 had dried blood on the label taped to the glucometer

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Glucose meter was cleaned by direct care staff when inspector brought the dried blood to staff attention. Staff with responsibility to check blood sugars was retrained on infection control standards for glucose meters. Glucose meters are checked weekly by wellness coordinator to ensure accuracy. Executive Director will check glucose meters monthly for 6 months, then periodically afterward to ensure compliance with infection control and weekly meter checks.

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101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

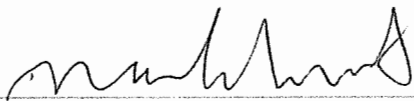
The lamp next to the bed closest to the wall in room 107 was broken and couldn't be turned on.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Lamp next to the bed in 107 was replaced with a working lamp. Staff were retrained that each bed requires a working lamp next to it at all times. Maintenance to conduct monthly inspections of all rooms to ensure working lamps at every bedside for 6 months, then periodically. Executive Director to conduct random room inspections for 6 months, then periodically to ensure working lamps at bedside.

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121a - Unobstructed Egress

Regulations

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

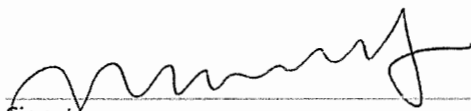
The emergency exit door across from the first floor library was difficult to open on multiple attempts using the door's push bar to exit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Maintenance fixed door at time of inspection with hinge lubricant. Maintenance checked door daily to ensure ability to easily open for 2 weeks after date of inspection, then weekly for 2 months, then monthly for 1 year. Executive director to randomly check door to ensure it easily opens monthly for 6 months, then periodically.

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184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident # 4's prescription for Lisinopril is prescribed as follows: "Take one tablet by mouth 2 times a day." The resident's bottle of Lisinopril does not agree with the prescription or medication administration record.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Prescriber increased the dose from once daily to twice daily and we were using up the current bottle. Med techs retrained to double check that pharmacy label and MAR match exactly, and if dosage change to label bottle with "change" label on instructions. Wellness coordinator will check bottled medications after prescriber changes orders to ensure that MAR and pharmacy label match. Executive director will check Resident #4 and other random resident's medications to ensure MAR and pharmacy label instructions match monthly over the next 6 months then periodically.

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185a - Implement Storage Procedures

Regulations

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

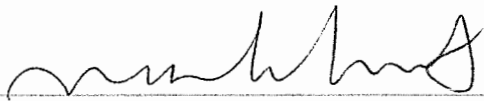
Glucometers belonging to residents # 1 and # 2 were not calibrated to the correct month day and time.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Wellness coordinator retrained on procedure to calibrate month/date/year/time on glucose meters. Wellness coordinator to check that information is correct on all glucose meters weekly, and correct if it is not. Executive director to randomly check glucose meters once a month over the next 6 months then periodically afterward to ensure compliance.

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231c - Preadmission Screening

Regulations

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident # 3 was transferred to the home's secure dementia unit on 8/1/2019. The home did not complete a cognitive screening within 72 hours prior to the transfer.

The prescreen form dated 7/29/2019 did not include the source of the information used to complete the screening, or the part III determination indicating the home could meet the needs of the resident.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Admissions coordinators and wellness coordinators retrained on completion of prescreening tool, and time frame to complete document. Executive director reviewed current charts of all residents of SDCU for correct completion of required documents. Executive director to review all new admissions to SDCU for the next 6 months to ensure required documents are completed correctly and on time, then periodically afterward.

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231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

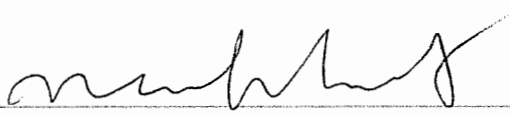
Resident # 3 was transferred to the home's secure dementia unit on 8/1/2019. The home did not update the record by obtaining a signed consent from the resident or family acknowledging that the resident agreed to reside in a locked unit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Signed consent for admission to SDCU was obtained for Resident #3. Records for current SDCU residents reviewed for correct completion of required documents. Admissions coordinators and Wellness coordinator retrained on correct documentation for resident admission to the SDCU. Executive Director will review admissions documents on all new admissions to the SDCU for the next 6 months and periodically thereafter to ensure compliance.

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233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

In the home's memory care unit, the code to open the emergency door in the common living area, was not posted near the device.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Code to open the emergency door in the common living area in SDCU was posted at the time of the inspection. Codes to all other doors in the SDCU were clearly posted next to them at the time of inspection. Maintenance retrained on the need to have codes posted next to exit doors in SDCU. Maintenance checked that codes were posted daily for 2 weeks, then weekly for the next 6 months. Maintenance will check codes are posted monthly thereafter. Executive director to check codes monthly for the next 6 months then periodically thereafter to ensure continued compliance.

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234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident # 4 was admitted to the home's secure unit on 11/22/19. The resident 's support plan was completed on 11/27/19 which is 72 hours beyond the date of admission to the home.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Records for current SDCU residents were reviewed for accuracy and completeness. Admissions coordinators and wellness coordinator retrained on required documentation and timing for SDCU residents. Executive director to review initial support plans on all newly admitted residents to the SDCU for the next 6 months and periodically thereafter to ensure compliance.

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