

Department of Human Services
Bureau of Human Service Licensing

October 5, 2022

[REDACTED]
ABOVE AND BEYOND AT THE KNIGHTS LLC
[REDACTED]

RE: ABOVE & BEYOND AT THE KNIGHTS
1545 GREENLEAF STREET
ALLENTOWN, PA, 18102
LICENSE/COC#: 22647

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/27/2022, 08/01/2022, 08/23/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: ABOVE & BEYOND AT THE KNIGHTS License #: 22647 License Expiration: 12/13/2022
Address: 1545 GREENLEAF STREET, ALLENTOWN, PA 18102
County: LEHIGH Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: 6104347433 Email: [REDACTED]

Legal Entity

Name: ABOVE AND BEYOND AT THE KNIGHTS LLC
Address: 4293 CHATTER WAY, ALLENTOWN, PA, 18103
Phone: 6104347433 Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 04/12/1989 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 106 Waking Staff: 80

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint Exit Conference Date: 08/23/2022

Inspection Dates and Department Representative

07/27/2022 - On-Site: [REDACTED]
08/01/2022 - Off-Site: [REDACTED]
08/23/2022 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 150 Residents Served: 78

Secured Dementia Care Unit

In Home: Yes Area: n/a Capacity: 32 Residents Served: 24

Hospice

Current Residents: 20

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 78
Diagnosed with Mental Illness: 4 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 28 Have Physical Disability: 0

Inspections / Reviews

07/27/2022 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *09/03/2022*

09/15/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *09/20/2022*

10/05/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

202 - Prohibitions

1. Requirements

2600.

202. The following procedures are prohibited:

5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 05/23/22 resident #1 suffered a fall from a recliner chair in the common area of the home. According to a staff interview resident #1 was frequently restless on 2nd shift and was placed in the recliner with the chair reclined back in order to better monitor the resident during 2nd shift. Resident #1 was unable to get up from the recliner without assistance. Resident #1 would be seen by staff trying to get out of the recliner over the side of the chair. It was determined that staff on 2nd shift used the recliner to prevent the resident from wandering and falling. Restraints of any kind are prohibited by this regulation.

Plan of Correction**Accept**

We are providing a POC in response to the violation, and this does not imply that we agree with the violation issued. Resident #1 had a physician's order for use of recliner for positioning and medical needs. Assessment of the resident at the time of the alleged "fall" did not reveal any injury or harm to the resident. Pre-admission assessment of Resident #1 showed no needs for ambulation and/or positioning as well as minimal mobility needs to evacuate in case of emergency.

In response to violation, direct care staff were retrained that a recliner chair is not permitted for any resident who is not able to independently get in/out of the chair. We retrained wellness staff to obtain prescribers orders if recliner chairs were needed for a resident for positioning or medical reasons. This order must be indicated in resident's RASP, as well as inform staff that recliner has been ordered & reason. In order to ensure ongoing compliance with regulation, ED or lead will audit & document resident recliner use: once daily on evening shift for 2 weeks, then once per month for 3 months and periodically afterward. Audit includes visually checking for residents in recliner chairs, if they are in chair verifying that resident is able to get in/out independently. If resident unable to get out independently, involved staff will be retrained on permitted use of recliners and recliner use audit will restart with daily for 2 weeks. ED will review audit documentation to ensure continued compliance, and verify anyone requiring recliner for positioning needs has current prescriber order, included in RASP, and staff are all aware of specific need for recliner.

Completion Date: 12/06/2022

Update: 09/15/2022

Please send Resident 1's current RASP.

Document Submission**Implemented**

We are providing a POC in response to the violation, and this does not imply that we agree with the violation issued. Resident #1 had a physician's order for use of recliner for positioning and medical needs. Assessment of the resident at the time of the alleged "fall" did not reveal any injury or harm to the resident. Pre-admission assessment of Resident #1 showed no needs for ambulation and/or positioning as well as minimal mobility needs to evacuate in

202 - Prohibitions (continued)

case of emergency.

In response to violation, direct care staff were retrained that a recliner chair is not permitted for any resident who is not able to independently get in/out of the chair. We retrained wellness staff to obtain prescribers orders if recliner chairs were needed for a resident for positioning or medical reasons. This order must be indicated in resident's RASP, as well as inform staff that recliner has been ordered & reason. In order to ensure ongoing compliance with regulation, ED or lead will audit & document resident recliner use: once daily on evening shift for 2 weeks, then once per month for 3 months and periodically afterward. Audit includes visually checking for residents in recliner chairs, if they are in chair verifying that resident is able to get in/out independently. If resident unable to get out independently, involved staff will be retrained on permitted use of recliners and recliner use audit will restart with daily for 2 weeks. ED will review audit documentation to ensure continued compliance, and verify anyone requiring recliner for positioning needs has current prescriber order, included in RASP, and staff are all aware of specific need for recliner.

Resident #1 was admitted on [REDACTED] and discharged on [REDACTED], therefore RASP was not completed.