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

December 7, 2023

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

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/01/2023, 11/02/2023 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: *ABOVE & BEYOND AT THE KNIGHTS* **License #:** *22647* **License Expiration:** *12/13/2023*

Address: *1545 GREENLEAF STREET, ALLENTOWN, PA 18102*

County: *LEHIGH* **Region:** *NORTHEAST*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *ABOVE AND BEYOND AT THE KNIGHTS LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff:** *112* **Waking Staff:** *84*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *11/02/2023*

Inspection Dates and Department Representative

11/01/2023 - On-Site: [redacted]

11/02/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served:** *79*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *32* **Residents Served:** *24*

Hospice

Current Residents: [redacted]

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *79*

Diagnosed with Mental Illness: [redacted] **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *32* **Have Physical Disability:** [redacted]

Inspections / Reviews

11/01/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/23/2023*

Inspections / Reviews *(continued)*

11/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/06/2023*

12/04/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/07/2023*

12/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] during initial walkthrough of memory care, on top of the Med cart was empty pill packets with residents' private information including names and mediations. The Med cart was unattended.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

At the time of inspection, the Med Tech was actively administering medications in the common area, the same location of the med cart. Med cart was locked, and EMAR med pass screen was minimized during pass to maintain confidentiality, meds had just been poured from the packets that were on top of the med cart, and were being saved for documentation purposes.
However, in response to this violation, the following actions were taken: Med tech retraining and ongoing inspection to ensure compliance. All Med Techs were retrained to maintain resident confidentiality during med pass and avoid leaving empty pill packets on top of med cart. Supervisor and designee instructed to conduct random checks of med carts during med passes to ensure ongoing compliance for the next 2 weeks, to make sure med techs were incorporating this into their practice. Med trainer or designee will continue to conduct random checks of med carts for the next 6 months for ongoing compliance

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 12/04/2023)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract for Resident #1, dated [redacted] and Resident #2, dated [redacted], was not signed by the resident.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

Review of contracts to identify root cause uncovered mistaken interpretation of guidelines by staff member responsible for reviewing contracts. Therefore, staff member and other key management staff were retrained to request resident signatures on contracts and other required documents. If residents are unable or unwilling to sign, a pre-inked stamp stating such was purchased and will be used on the documents to identify that the resident was given the opportunity to review and sign documents, and did not. Resident's signature area will be stamped, and witnessed with date and signature of staff person who attempted to get resident to sign documents. All documents starting from [redacted] forward were reviewed for signatures--if not documented, residents were showed documents to review and sign.
To ensure ongoing compliance with resident signatures, ED (or designee) will review the next 10 admission documents to ensure that resident has signed or was given the opportunity to sign the documents.

Licensee's Proposed Overall Completion Date: *05/01/2024*

25b - Contract Signatures *(continued)*

Implemented [redacted] - 12/07/2023)

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1, admitted on [redacted] and Resident #2, admitted on [redacted], did not sign their residents' rights.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

Review of contracts to identify root cause uncovered mistaken interpretation of guidelines by staff member responsible for reviewing contracts. Therefore, staff member and other key management staff were retrained to request resident signatures on contracts and other required documents. If residents are unable or unwilling to sign, a pre-inked stamp stating such was purchased and will be used on the documents to identify that the resident was given the opportunity to review and sign documents, and did not. Resident's signature area will be stamped, and witnessed with date and signature of staff person who attempted to get resident to sign documents. All documents starting from [redacted] forward were reviewed for signatures--if not documented, residents were showed documents to review and sign.
To ensure ongoing compliance with resident signatures, ED (or designee) will review the next 10 admission documents to ensure that resident has signed or was given the opportunity to sign the documents.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented [redacted] - 12/07/2023)

85d - Trash Receptacles

4. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The trash can located in the secured memory care unit kitchen did not have a cover.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

On day of inspection, trash can in memory care was removed and replaced with one that had a cover. Staff were educated in the need to have covered trash receptacles at all times. Maintenance and housekeeping staff conducted rounds to identify and replace any other trash cans that did not comply with regulations. Administrator (or designee) will conduct weekly rounds for the next 4 weeks and then periodically to ensure ongoing compliance with regulation.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 12/04/2023)

101j7 - Lighting/Operable Lamp

5. Requirements

101j7 - Lighting/Operable Lamp *(continued)*

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

Residents in rooms [redacted] and [redacted] did not have an operable lamp or other source of lighting that could be turned on at bedside.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

The room layout in room [redacted] and [redacted] was difficult to place lamp in an area accessible to bedside, therefore "tap" lights were purchased and installed by maintenance to provide resident with access to lighting for safety. To ensure ongoing compliance, administrator (or designee) will inspect all rooms in building to make sure there are currently lights available (if not, tap lights will be installed) and conduct monthly room inspections for 3 months.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 12/04/2023)

123a - Exit Doors

6. Requirements

2600.
123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The exit located in the dining room would not open without an excessive amount of force used, preventing immediate egress in the event of an emergency.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

Maintenance contacted on day of inspection to fix door. Door was adjusted to allow it to be easily opened without needing excessive force. To ensure ongoing compliance with regulation, administrator (or designee) will check the door weekly for the next month, then monthly for 6 months to make sure door is still able to be easily opened.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented [redacted] - 12/04/2023)

162c - Menus Posted

7. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

In the [redacted], located on the lower level, the home did not have posted in a public and conspicuous area the home's menu for the current week and upcoming week's menu.

Plan of Correction ***Accept [redacted] - 11/30/2023)***

Root cause analysis identified dining staff were posting "individual" day menus for 2 weeks. Change in practice was recommended, and a "weekly" menus template using a Sunday through Saturday format was developed. This

162c - Menus Posted (continued)

"weekly" menu will now be posted, along with the following week's menu. Individual "daily" menus will continue to be used during meal selection at the tables. To ensure ongoing compliance, administrator (or designee) will conduct weekly inspection to ensure menus are posted in Memory Care at dining room entrance for the next 2 months, and periodically afterward.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 12/04/2023)

224a - Preadmission Screen Form

8. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #4 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed until [redacted].

Plan of Correction ***Accept [redacted] - 11/30/2023)***

Root cause analysis determined that resident #4 was actually admitted on [redacted] (per review of medication administration records) but the face sheet listed admission date of [redacted] because the medication profile was submitted a day in advance of resident's arrival. To correct this violation, wellness staff were retrained that the admission date on the face sheet needs to match the date the resident actually "moves in" to the community, and not on the day preparatory paperwork is input into the EMAR. Furthermore, administrator was retrained that the preadmission screening could be done based on second-hand information obtained from family and health care/community resources, and did not require first-hand knowledge based on direct observation of the potential resident. To evaluate current compliance, facesheet "admission" dates were compared to preadmission screening dates for residents admitted from [redacted] to present. To ensure continued compliance with regulations. the next 10 admissions will be reviewed by administrator (or designee) to ensure preadmission screening done either prior to or day the resident moves into the community, and periodically afterward.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented [redacted] - 12/04/2023)