

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

July 8, 2024

[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 05/16/2024, 06/03/2024 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: 12/13/2024
 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

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 112 Waking Staff: 84

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint Exit Conference Date: 06/03/2024

Inspection Dates and Department Representative

05/16/2024 - On-Site: [REDACTED]
 06/03/2024 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 150 Residents Served: 84

Secured Dementia Care Unit

In Home: Yes Area: SDCU Capacity: 26 Residents Served: 26

Hospice

Current Residents: 18

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 84
 Diagnosed with Mental Illness: 3 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 28 Have Physical Disability: 0

Inspections / Reviews

05/16/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/05/2024

07/03/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 07/08/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 07/08/2024

Inspections / Reviews *(continued)*

07/08/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/08/2024

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

15c - Supervision

1. Requirements

2600.

15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [REDACTED], Resident [REDACTED] alleged that Staff Person A grabbed [REDACTED] shoulder and tried to force [REDACTED] into the shower. Resident [REDACTED] alleged that this caused [REDACTED] shoulder pain. A plan of supervision was immediately put into place for Staff Person A, who was removed from providing care for Resident [REDACTED]. This plan of supervision was not submitted to the Department as required.

Plan of Correction

Accept [REDACTED] - 07/03/2024)

Allegedly on [REDACTED] (per date of incident noted on LIS) staff person A (witnessed by another staff person "B") put hand on resident [REDACTED] shoulder as supportive/suggestive gesture while encouraging resident to take shower in accordance with resident's RASP for hygiene. Resident [REDACTED] diagnoses include [REDACTED] and [REDACTED], and this resident frequently resists showers/personal hygiene cueing and assistance per RASP. At the time of alleged incident, resident [REDACTED] became verbally abusive toward staff person A (including ethnic slurs) and refused staff efforts to provide shower, and another staff person who witnessed the entire alleged incident recommended that staff person A cease efforts to provide shower. Once efforts to provide shower ceased, resident's negative behaviors ceased. At that time, there was no report to any staff member that resident was "grabbed" or "had shoulder pain". Executive Director was informed that Resident [REDACTED] refused shower; no shower was provided at that time per resident's wishes.

Approximately 2 weeks later, [REDACTED] of resident called ED and requested change in shower schedule for resident, as well as request that staff person A not provide shower care. (ED did not specifically question [REDACTED] why [REDACTED] did not want staff person A to provide care, as Staff person A wears clothing consistent with religious practices, and ED felt it may be due to personal bias, and wanted to maintain rights of both resident and staff person A simultaneously, [REDACTED] did not offer a reason for the request at time of call). Based on request, staff scheduling was adjusted to allow another staff member to provide shower care to resident [REDACTED] (the change was not a "plan of supervision" at the time, it was to meet personal request).

On or around [REDACTED] representative from Lehigh County AAA called and requested copy of resident's DME and RASP, (which was provided at that time). When asked why AAA needed that information, ED was informed AAA received a phone complaint that resident was made to take a shower; and also said that AAA representative came on-site to investigate on [REDACTED] unannounced. AAA agent did not inform anyone from the home that there was any allegation of abuse or shoulder injury at that time; AAA informed ED that no further action was required by the home when asked.

Approximately a week later, ED contacted [REDACTED] (who has Power of Attorney for resident [REDACTED]) to inquire if there were any complaints or issues that the home needed to address (because of AAA visit)--[REDACTED] stated there were no complaints or issues and that he would contact Lehigh County AAA to address their inquiry. At no time was ED or other staff members informed that resident [REDACTED] complained of shoulder pain, or that pain occurred as a result of staff person A providing hands-on assistance at the time of alleged incident.

On [REDACTED], DHS representative on-site unannounced for "complaint visit". Routine complaint inspection occurred, DHS given access to requested documents and interviews with staff and residents as requested (including phone interview with ED who was on vacation at the time). DHS did not provide specific details regarding reason for visit. DHS representative did not provide on-site visit on [REDACTED]

The first notification of allegation of abuse was actually this LIS: therefore we are responding for plan of correction

15c - Supervision (continued)

as required by Chapter 2600 and not to signify agreement with this violation.

On [REDACTED] home contacted DHS regional office to discuss violations; "plan of supervision" was actually a resident & family request for alternate caregiver for personal reasons which were not shared with the home. As requested by the violations, a mandatory abuse report and DHS reportable incident report (including notification of staff person assignment change) was completed by Wellness Supervisor and Executive Director; and submitted to DHS via fax. Staff involved in alleged incident were retrained regarding Reporting of Abuse and required documentation.

Licensee's Proposed Overall Completion Date: 07/02/2024

Implemented [REDACTED] 07/08/2024)

16c - Written Incident Report**2. 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 [REDACTED], Resident [REDACTED] alleged that Staff Person A grabbed [REDACTED] shoulder and tried to force [REDACTED] into the shower. Resident [REDACTED] alleged that this caused [REDACTED] shoulder pain. The home did not submit an incident report to the Department regarding the allegation of abuse.

Plan of Correction

Accept [REDACTED] 07/03/2024)

Allegedly on [REDACTED] (per date of incident noted on LIS) staff person A (witnessed by another staff person "B") put hand on resident [REDACTED] shoulder as supportive/suggestive gesture while encouraging resident to take shower in accordance with resident's RASP for hygiene. Resident [REDACTED] diagnoses include [REDACTED] and [REDACTED], and this resident frequently resists showers/personal hygiene cueing and assistance per RASP. At the time of alleged incident, resident [REDACTED] became verbally abusive toward staff person A (including ethnic slurs) and refused staff efforts to provide shower, and another staff person who witnessed the entire alleged incident recommended that staff person A cease efforts to provide shower. Once efforts to provide shower ceased, resident's negative behaviors ceased. At that time, there was no report to any staff member that resident was "grabbed" or "had shoulder pain". Executive Director was informed that Resident [REDACTED] refused shower; no shower was provided at that time per resident's wishes. Approximately 2 weeks later, [REDACTED] of resident called ED and requested change in shower schedule for resident, as well as request that staff person A not provide shower care. (ED did not specifically question [REDACTED] why [REDACTED] did not want staff person A to provide care, as Staff person A wears clothing consistent with religious practices, and ED felt it may be due to personal bias, and wanted to maintain rights of both resident and staff person A simultaneously; [REDACTED] did not offer a reason for the request at time of call). Based on request, staff scheduling was adjusted to allow another staff member to provide shower care to resident [REDACTED] (the change was not a "plan of supervision" at the time, it was to meet personal request).

On or around [REDACTED], representative from Lehigh County AAA called and requested copy of resident's DME and RASP, (which was provided at that time). When asked why AAA needed that information, ED was informed AAA received a phone complaint that resident was made to take a shower; and also said that AAA representative came on-site to investigate on [REDACTED] unannounced. AAA agent did not inform anyone from the home that there was any allegation of abuse or shoulder injury at that time; AAA informed ED that no further action was required by the home when asked.

16c - Written Incident Report (continued)

Approximately a week later, ED contacted [REDACTED] [REDACTED] (who has Power of Attorney for resident [REDACTED]) to inquire if there were any complaints or issues that the home needed to address (because of AAA visit)- [REDACTED] [REDACTED] stated there were no complaints or issues and that he would contact Lehigh County AAA to address their inquiry. At no time was ED or other staff members informed that resident [REDACTED] complained of shoulder pain, or that pain occurred as a result of staff person A providing hands-on assistance at the time of alleged incident.

On [REDACTED], DHS representative on-site unannounced for "complaint visit". Routine complaint inspection occurred, DHS given access to requested documents and interviews with staff and residents as requested (including phone interview with ED who was on vacation at the time). DHS did not provide specific details regarding reason for visit. DHS representative did not provide on-site visit on [REDACTED].

The first notification of allegation of abuse was actually this LIS: therefore we are responding for plan of correction as required by Chapter 2600 and not to signify agreement with this violation.

On [REDACTED] home contacted DHS regional office to discuss violations; "plan of supervision" was actually a resident & family request for alternate caregiver for personal reasons which were not shared with the home. As requested by the violations, a mandatory abuse report and DHS reportable incident report (including notification of staff person assignment change) was completed by Wellness Supervisor and Executive Director; and submitted to DHS via fax. Staff involved in alleged incident were retrained regarding Reporting of Abuse and required documentation.

Licensee's Proposed Overall Completion Date: 07/02/2024

Implemented [REDACTED] - 07/08/2024)