



## VIRGINIA DEPARTMENT OF SOCIAL SERVICES



ABUSE & NEGLECT

ASSISTANCE

CHILD SUPPORT

COMMUNITY SUPPORT

FOSTER CARE & ADOPTION

LICENSING

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#### Commonwealth Senior Living at King's Grant House

440 North Lynnhaven Road  
Va. beach, VA 23452  
(757) 431-8825

**Current Inspector:** Lanesha Allen (757) 715-1499

**Inspection Date:** April 23, 2021 and April 26, 2021

**Complaint Related:** Yes

#### Areas Reviewed:

22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS  
22VAC40-73 RESIDENT CARE AND RELATED SERVICES

#### Comments:

This inspection was conducted by licensing staff using an alternate remote protocol, necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A complaint investigation was initiated on 04-23-2021 and concluded on 04-26-2021. A complaint was received by the department regarding allegations in the areas of Personal Care Services and General Supervision of Care and Restorative, Habilitative, and Rehabilitative Services. The Administrator was contacted by telephone to conduct the investigation. The licensing inspector emailed the Administrator a list of documentation required to complete the investigation.

The evidence gathered during the investigation did not support the allegations of non-compliance with standards or law. Any violations not related to the complaint but identified during the course of the investigation can be found on the violation notice.

#### Violations:

Standard #: 22VAC40-73-325-C

Complaint related: No

Description: Based on record review and interview, the facility failed to document an analysis of the circumstances of the fall and interventions initiated to prevent or reduce risk of subsequent falls for residents who meet the criteria for assisted living care.

##### Evidence:

1. Resident #1's Uniform Assessment Instrument ([UAI](#)) dated 12-14-2020, resident #2's [UAI](#) dated 02-11-2021, and resident #4's [UAI](#) dated 03-12-2021 documented the residents? meet criteria for assisted living level of care.

2. Staff ?Progress Notes? indicated the following falls:

A. 02-10-2021, resident #1 was observed on the bathroom floor, with evidence of head injury and skin tear to right shoulder;

B. 02-28-2021, resident #2 fell in room and c/o [complained of] pain; and

C. 04-06-2021, resident #3 was found on the floor; and on 04-16-2021 resident was found on the floor with injury on forehead.

3. Staff #1 stated ?On the documentation for analysis and interventions you requested for each of the 3 residents [residents #1, #2, and #3 listed above, we do not have.]?

4. Staff #1 and staff #2 acknowledged the facility did not document an analysis of the circumstances of the falls or interventions for residents? #1, #2, or #3.

**Plan of Correction:** What Has Been Done to Correct? Updated Fall Analysis report and implemented Interventions as indicated for residents 1, 2, and 3

How Will Recurrence Be Prevented? Utilize Fall Analysis report post fall for all residents

Person Responsible: Resident Care Director, Assistant Resident Care Director or designee

#### Disclaimer:

*This information is provided by the Virginia Department of Social Services, which neither endorses any facility nor guarantees that the information is complete. It should not be used as the sole source in evaluating and/or selecting a facility.*

