

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Ben Bolt Avenue Tazewell, VA 24651	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents receive treatment and care according to the medical provider orders for 2 of 19 sampled residents (Resident #3 and Resident #1).</p> <p>The findings included:</p> <p>1. For Resident #3, the facility staff failed to provide Bacitracin ointment to burns on the face, nares, and right hand.</p> <p>Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Schizoaffective Disorder Bipolar Type, Chronic Obstructive Pulmonary Disease, Asthma, and Generalized Muscle Weakness.</p> <p>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/18/25 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired.</p> <p>Resident #3 returned from the emergency department (ED) on 6/02/25 with a new medical provider order dated 6/02/25 for Bacitracin Ointment apply to face, nares, right hand topically every day and night shift for burns until healed. A review of Resident #3's June 2025 Medication Administration Record revealed Bacitracin was not administered on 6/03/25 day shift, the nurse documented a code of 9 indicating other/see progress notes.</p> <p>A 6/03/25 9:28 AM nursing progress note read in part Bacitracin External Ointment .waiting on arrival from pharmacy.</p> <p>On 6/11/25 at 10:10 AM, surveyor spoke with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) regarding the Bacitracin omission. The DON stated Bacitracin was house stock and they had spoken with the nurse working that night and the nurse did not know it was house stock. The RNC confirmed that the treatment was not administered on 6/03/25 day shift.</p> <p>Surveyor requested and received the facility policy titled Administering Medications which read in part .4. Medications are administered in accordance with prescriber orders .</p> <p>On 6/12/25 at 6:21 PM, the survey team met with the RNC, DON, and Regional [NAME] President of Clinical Services and discussed the concern of staff failing to administer Bacitracin as ordered for Resident #3.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/12/25.</p> <p>2. For resident # 1 (R1) the facility staff failed to follow physicians orders for a colonoscopy prep.</p> <p>R1's minimum data set (MDS) assessment with an assessment reference date of 4/9/25 assigned the resident a brief interview for mental status score (BIMS) of 15 out of 15 indicating intact cognition.</p> <p>On 6/10/25 this surveyor interviewed R1. They stated that the facility had sent them for a colonoscopy but had failed to follow orders and the procedure could not be done because, I wasn't cleaned out good, they didn't do things right, they were supposed to give me a clear liquid diet but they didn't. I had to go through it all over again. R1 could not recall the date but said they thought it was in December on 2024 and the second time was in February 2025.</p> <p>This surveyor was unable to find any documentation of a colonoscopy in December 2024. There was a report from February 14, 2025. The results read, Uncomplicated mild diverticulosis and the report stated that the prep was suboptimal. Under the heading Recommendations the document read, Repeat colonoscopy within one to two years with more extensive prep.</p> <p>The December 2024 medication administration record (MAR) for R1 was reviewed. On 12/5/24, R1 was started on dulcolax tablets give one tablet twice daily for seven days. There was only one dose administered on 12/5/25 according to the MAR.</p> <p>On 6/12/25 at 12:20 PM this surveyor interviewed the Director of Nursing. When asked about the first colonoscopy they stated, The first time they weren't able to do it because he wasn't clean out but that wasn't our fault, we followed the orders. (R1 name omitted) goes out to town and pretty much does his own thing so he may not have followed the orders for clear liquids and to be NPO (nothing by mouth) after midnight. The DON provided surveyor with a copy of the colonoscopy instructions provided to the facility for R1. The instructions included a clear liquid diet to start the day before the procedure on 12/10/24. There was a diet order in the record that indicated resident was ordered a clear liquid diet on 12/10/24. The instructions included an order that read, Patient will start taking Dulcolax laxative tablets 1 week prior to the procedure. Start taking 2 tablets daily on 12/5/24 and stop on 12/11/24.</p> <p>This surveyor showed the MAR to the DON indicating that resident only received one tablet on 12/5/24.</p> <p>The DON also provided the surveyor a copy of a consult note dated 12/18/24 that read in part, We recently sent him for a colonoscopy but unfortunately the prep was poor. He lives in a nursing home at this time and they failed to administer the proper prep according to the patient.</p> <p>The survey team met with the DON, Assistant Director of Nursing, Regional Nurse Consultant and the Regional [NAME] President of Clinical Services on 6/12/25. This concern was discussed with then at that time.</p> <p>No further information was provided to the survey team prior to the exit conference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident and staff interview and clinical record review the facility staff failed to provide wound care as ordered to one of 19 residents in the survey sample, resident #1 (R1).</p> <p>The findings included:</p> <p>R1's minimum data set (MDS) assessment with an assessment reference date of 4/9/25 assigned the resident a brief interview for mental status score of 15/15 indicating intact cognition.</p> <p>On 6/10/25 at 2:15 PM this surveyor interviewed R1. They stated that the former wound nurse refused to take care of him and he had to, Chase different ones down to get my dressings changed. She said I supposedly said something dirty to her but that isn't true, she just doesn't like me. When asked if the wound is improving R1 stated, Oh yeah, it's much better than it was. R1 stated that it used to go up his leg and showed this surveyor a scar that ended at the back of the knee.</p> <p>The treatment administration record (TAR) was reviewed for the past year. Wound is chronic in nature. In June of 2024 the order read, Arterial ulcer right lower leg cleanse with wound cleanser, pat dry, apply [NAME] boot, applying calamine [NAME] boot followed by coban wrap twice weekly and PRN (as needed). There were holes of the TAR for 6/10/24, 6/13/24 and 6/17/24. The orders for March 2025 were reviewed. The order read, Santyl apply to right heel topically every shift. There were blanks noted for the day shift on 3/22/25, 3/23/25 and 3/26/25. Another order on the March TAR read, Clean DTI left heel with wound cleanser, pat dry, apply santyl and cover with ABD (abdominal pad) wrap with kerlix and secure with tape. There were holes for 3/3/25 and 3/26/25. The TAR for May 2025 was reviewed with an order that read, May clean stage IV pressure right heel with wound cleanser, pat dry, apply collagen sheet and cover with ABD pad wrap with kerlix and secure with tape daily and as needed. There were holes noted 5/7/25, 5/9/25, 5/10/25, and 5/11/25.</p> <p>On 6/11/25 at 1:16 PM this surveyor interviewed the Director of Nursing (DON) regarding R1's wound to the right heel. They stated the wound started out as arterial and extended from the heel up the calf to almost the bend of the knee. The DON stated, Where now it's just on the heel and he is constantly walking on it and wearing shoes, it is considered pressure now. The DON went on to say, Those days last June, the 10th and 13th, he was out of the facility. He sometimes leaves in the morning and stays gone all day. Surveyor asked if the next shift should have done the wound care and they stated, I feel like they probably did but since it was scheduled for day shift, they couldn't see it to sign it off. He won't let anybody not take care of what he needs. He would have ranted and raved until it got done. Surveyor asked if it should have been documented in the notes or on a PRN order and they agreed that it should.</p> <p>The survey team met with the DON, Assistant Don, Regional Nurse Consultant and Regional [NAME] President of Clinical Services on 6/11/25 at 4:00 PM. This concern was discussed with them at that time.</p> <p>No further information was provided to the survey team prior to the exit conference.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to: (a) ensure a resident identified as a smoker was assessed for capability and safety needs regarding smoking, (b) provide adequate monitoring and supervision of residents who smoke, ensure lighters, cigarettes, and/or electronic cigarettes (vapes) were stored in a manner to prevent misuse from other vulnerable residents and/or a fire hazard, and/or (c) ensure smoking safety precautions were in place for the resident's individual safety, as well as the safety of others for five (5) of 19 sampled residents (Resident #3, Resident #7, Resident #8, Resident #9, and Resident #10).</p> <p>The survey team informed the facility on 6/12/25 at 11:26 AM of the Immediate Jeopardy situation for Resident #3, Resident #7, Resident #8, and Resident #9. The scope and severity were originally cited at a Level IV, pattern. On 6/12/25 at 6:15 PM, the Immediate Jeopardy was abated and lowered to a Level III, isolated.</p> <p>The findings included:</p> <p>For Resident #3, the facility staff failed to assess the resident for safe smoking capability and safety needs regarding smoking and failed to provide adequate monitoring and supervision following knowledge that the resident had a history of smoking unsupervised and attempting to go outside to smoke with an oxygen tank on his wheelchair.</p> <p>Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Schizoaffective Disorder Bipolar Type, Chronic Obstructive Pulmonary Disease, Asthma, and Generalized Muscle Weakness.</p> <p>The admission minimum data set (MDS) with an assessment reference date (ARD) of 4/18/25 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired.</p> <p>Resident #3's After Visit Summary at admission stated the resident was a former one (1) pack per day smoker for 47 years.</p> <p>Resident #3's clinical record included a Safe Smoking Assessment dated 4/09/25 which documented the resident stated he does not smoke, and the assessment was not completed.</p> <p>A review of Resident #3's comprehensive person-centered care plan revealed a focus area dated 4/28/25 stating The resident has a behavior problem r/t [related to] resident places oxygen tank in his bed or tries to go outside to smoke with tank on his wheelchair. Attempts made to redirect behavior. Education on safety and oxygen use has been provided. An additional focus area dated 4/28/25 stated The resident is a smoker. He is often noncompliant with smoking policy and procedures. He has been educated on the risks associated with non-compliance and has voiced understanding. This care plan documentation indicated the facility was aware of the resident's smoking and non-compliance with smoking safety as early as 4/28/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #3's clinical record included nursing progress notes dated 5/25/25 9:43 AM and 5/25/25 1:22 PM indicating the resident was outside smoking at these times.</p> <p>A nursing progress note dated 6/02/25 at 6:42 AM read in part Approximately 0610 [6:10 AM] resident brought self up to station behind his wheelchair. Noted resident to have black soot to his face and right hand. Upon asking resident what happened he stated he had took [sic] himself outside to smoke and forgot his oxygen was on and it just 'went up'. Resident was unsupervised when event happened, no staff present outside at the time of event. Resident was assisted into his wheelchair. Both eyebrows, eyelashes, front of hair and some of beard are all singed, both eyelids appear red and burnt. Both nares burnt, some blood noted to left mucous membrane. Right hand appears to have blisters forming, area cleaned as best possible. Resident complaining of pain. Face cleaned with wound cleaner to best of availability [sic] due to pain. DON [Director of Nursing] notified at 0615 [6:15 AM]. MD notified at 0635 [6:35 AM] with orders given to send resident to ER for eval [evaluation] .EMS in facility at 0650 [6:50 AM] to transfer resident .</p> <p>On 6/12/25 at 6:15 AM, surveyor spoke with Licensed Practical Nurse (LPN) #4, the writer of the 6/02/25 6:42 AM nursing progress note. LPN #4 stated she had stepped over to another station and when she came back around the corner the resident told her what had happened. LPN #4 stated Resident #3 had a lighter and he smoked all the time and he knew about the facility smoking rules, but he did not follow them. LPN #4 stated for a while he followed the rules and then saw other residents not following the rules and he followed suit. She stated Resident #3 had previously cussed one of the CNAs [certified nursing assistants] who tried to redirect him from going out to smoke telling the CNA they were not his boss and to mind their own business. LPN #4 stated everyone knew the resident went out whenever he wanted to smoke. LPN #4 stated most of the time the resident did not wear oxygen while in facility. When asked if it was known that residents went out unsupervised to smoke, LPN #4 stated yes.</p> <p>According to Resident #3's clinical record, at the time of the incident, he had a medical provider order for oxygen at 2 liters per minute as needed for shortness of breath.</p> <p>Resident #3 returned from the emergency department (ED) on 6/02/25 with a provider order for Bacitracin Ointment to face, nares, and right hand topically every day and night shift until healed.</p> <p>After returning from the ED, a 6/02/25 10:30 AM nursing progress note read in part Resident outside smoking unsupervised at this time after just returning from ED for burns to face and right hand from smoking with oxygen on . According to nursing documentation the resident was not wearing oxygen at that time.</p> <p>Despite the facility staff's awareness of Resident #3 being a smoker as early as 4/28/25, a safe smoking assessment was not completed until 6/04/25, two days following the injury. This assessment indicated the Resident #3's decision-making was moderately impaired, he was non-compliant with smoking policy consistently/frequently, had a history of skin burns from smoking material, demonstrated unsafe smoking in the past 3 months, had highly/severely impaired vision, used continuous oxygen with recommendations for a smoking apron/protector, cigarette holder, and assistance with smoking. A care plan intervention to remove oxygen prior to taking smoke breaks was added to the resident's care plan on 6/05/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>According to Resident #3's clinical record, on 6/05/25, Resident #3 began having difficulty breathing and stridor which progressed to respiratory distress despite treatment with Duo Neb and Solumedrol and resident was transferred to the ED where he was intubated and transferred to [hospital name omitted] intensive care unit for further treatment. Resident #3 remained hospitalized at the time of the investigation.</p> <p>Resident #3's clinical record included a Risk Management Department Smoking Consent and Release dated 4/09/25 and signed by the resident and facility admission Director. This document read in part .unsupervised smoking is not allowed .The designated times for supervised smoking times are: 9:00am, 1:00pm, 3:00pm, 7:30pm, 8:30pm. By signing below, the resident and their responsible party .2-Consent and agree to abide by the smoking policy and procedures .6-Understand that violation of the contract will be considered a breach of the contract. 7-Understand that if the resident violates the agreement, he/she will lose the privilege of supervised smoking and the continued or serious violations may also result in our facilitating alternative placement.</p> <p>Surveyor requested and received the facility policy titled Resident Smoking Policy and Procedure with an effective date of 2/21/2024 which read in part .3. Oxygen use is prohibited in smoking areas .6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: the level of assistance and the type of equipment needed to smoke safely. All residents that smoke traditional cigarettes, cigars, etc. will be required to wear a smoking apron and are encouraged to utilize a cigarette holder both to be provided by the facility .8. A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff .11. All residents that smoke will do so only while being supervised during scheduled smoke breaks. Failure to adhere will result in the suspension of smoking privileges. 12. All smoking paraphernalia cigarettes, cigars, e cigs, vapes, etc. will not be left in the possession of any resident at any time. These items must be kept at the nurse's station or locked inside the med room or additional locked safe area designated by the facility .17. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies, to include a safety search of the resident's room upon resident permission .</p> <p>Surveyor spoke with Resident #7 outside in the rear courtyard on 6/10/25 at 12:57 PM. Resident #7 stated the smoking policy recently changed and now residents can not keep their own cigarettes or lighters, and they must be supervised. At 1:08 PM, surveyor observed Resident #7 take a cigarette from his shirt pocket and a lighter from his pants pocket and light his own cigarette and begin smoking. A staff member was present in the courtyard but did not intervene or appear to notice the resident had a lighter and lit his own cigarette. Resident #7's BIMS summary score was documented as 15 out of 15 indicating the resident was cognitively intact. Resident #7's safe smoking assessment dated [DATE] recommended the use of a smoking apron/protector, cigarette holder and supervision while smoking.</p> <p>The survey team spoke with Resident #7 again on 6/11/25 at 5:38 PM, at this time the resident stated prior to the current Administrator, the smoking rules were strict. The resident stated the current Administrator began to allow two residents to smoke out of the posted smoking times and that started something.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 6/11/25 at 5:59 PM surveyors observed Resident #8 sitting alone in his room using an electronic cigarette/vape. Resident #8's BIMS summary score was documented as a 15 out of 15 indicating the resident was cognitively intact. Resident #8's safe smoking assessment dated [DATE] indicated the resident has had combative behavior, was non-compliant with the smoking policy and recommended the use of a smoking apron/protector, cigarette holder and assistance while smoking. Surveyor was unable to locate evidence of assessment and safety education regarding vape use.</p> <p>On 6/11/25 at 6:00 PM, surveyors noted the smell of cigarette smoke in the hall outside of the rear courtyard and observed Resident #9 in his wheelchair smoking unsupervised in the courtyard near the doors. The resident was actively smoking a cigarette with a blue lighter visible in the wheelchair seat. The resident was not wearing an apron or using a cigarette holder. After finishing his cigarette, the resident returned inside, and surveyors observed ashes present in his wheelchair seat. Observation was immediately reported to the Director of Nursing (DON). The DON approached the resident and asked if he had cigarettes or a lighter and he stated no and proceeded down the hall out of sight. Resident #9's BIMS summary score was documented as a 14 out of 15 indicating the resident was cognitively intact. Resident #9's safe smoking assessment dated [DATE] indicated the resident was non-compliant with the smoking policy and recommended a smoking apron/protector, cigarette holder and supervision while smoking.</p> <p>On 6/11/25 at 6:05 PM, the survey team met with the DON, Regional [NAME] President of Clinical Services (RVPCS), and the Regional Nurse Consultant (RNC) and discussed the observations of Resident #8 and Resident #9.</p> <p>On 6/12/25 at 10:47 AM, surveyors spoke with Ancillary Aide (AA) #1 who stated she was currently assigned to rotate out with another staff member every 30 minutes to be outside and monitor the rear courtyard. When asked when this began, she stated a couple days ago. The surveyors entered the facility on the morning of 6/10/25. AA #1 stated prior to the incident, residents were allowed to come out to the courtyard and smoke unsupervised anytime they wanted as long as they wore an apron. Surveyors were unable to locate a fire blanket in the smoking area and AA #1 stated she had never seen a fire blanket.</p> <p>Surveyors spoke with Resident #10 on 6/12/25 at 10:50 AM regarding resident smoking. Resident #10 stated up until a week ago they could keep their own lighters and cigarettes and smoke anytime they wanted.</p> <p>On 6/12/25 at 10:57 AM, the DON confirmed the facility did not have a fire blanket available.</p> <p>On 6/12/25 at 11:26 AM, the survey team notified the DON, Assistant DON, RVPCS, and RNC of the Immediate Jeopardy situation regarding Resident #3, Resident #7, Resident #8, Resident #9 and the on-going concerns regarding residents smoking unsupervised, having lighters and smoking supplies.</p> <p>On 6/12/25 at 12:00 PM, surveyors again observed Resident #9 smoking unsupervised. The resident was outside on the sidewalk in the front of the building smoking without an apron. Surveyors immediately notified facility staff.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 6/12/25 at 1:30 PM, surveyors observed Resident #10 outside unsupervised on the sidewalk in the front of the building with a cigarette. The resident pulled out a lighter from the back pocket of his wheelchair and lit the cigarette and began smoking. Resident #10 did not have an apron on and was wearing a surgical mask that was pulled down under his chin. Surveyors immediately notified facility staff. Resident #10's BIMS summary score was documented as a 15 out of 15 indicating the resident was cognitively intact. The resident's safe smoking assessment dated [DATE] indicated the resident was non-compliant with the smoking policy and recommended use of a smoking apron/protector, cigarette holder, and supervision while smoking.</p> <p>On 6/12/25 at 3:27 PM, the RVPCS presented the following immediate jeopardy abatement plan:</p> <p>Corrective Action:</p> <p>Courtyard doors are locked and will require a staff member to open and assist residents out. - Maintenance</p> <p>Reviewed all Smoking assessments and care plans for accuracy. - MDS Coordinator</p> <p>Letter and copy of safe smoking policy given to residents that smoke regarding them following the safe smoking policy and 30-day discharge if not in compliance. - DON and/or designee</p> <p>Letter being sent to all residents' representatives asking them to not provide smoking items to residents and to give them to the staff of (facility name omitted). - DON and/or Designee</p> <p>Sign posted on front entrance to hallway for visitors: For the safety of all residents no smoking items are to be given to residents. Items are to be given to staff to be used at designated supervised times. - DON</p> <p>Fire Blanket has been ordered. - Maintenance</p> <p>Residents that smoke have been asked to search their rooms/personal self for smoking items/electronic devices (vapes) and items collected then placed on smoking cart.</p> <p>ADHOC Meeting held with Medical Director to discuss IJ F689 - facility resident being non-compliant with safe smoking policy. Discussed corrective actions taken and monitoring measures. Medical Director (name omitted) in agreeance to POC.</p> <p>Identification of Deficient Practice(s) and Corrective Action(s):</p> <p>All other residents who smoke may have potentially been affected.</p> <p>All residents who smoke have been educated and given a copy of the safe smoking policy and signed a letter saying they will comply with the policy. - DON and/or Designee</p> <p>Systematic Change(s):</p> <p>The facility's smoking policy and procedure has been reviewed no changes are warranted at this time. - DON</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Re-educated staff on the safe smoking policy, residents are not allowed to be outside in courtyard without supervision. Staff will not return to work until education completed. - DON and/or Designee</p> <p>Corrective action will be taken if staff allow residents outside without supervision in courtyard and safety items needed. - DON and/or Designee</p> <p>Monitoring:</p> <p>The Administrator is responsible for maintaining compliance.</p> <p>The Administrator +/- designee will observe resident smoking period activities three [sic] weekly to monitor for compliance.</p> <p>Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken.</p> <p>Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in the facility policy, procedure, and/or practice.</p> <p>Completion Date:</p> <p>6/12/25 4:00 PM</p> <p>On 6/12/25 at 3:28 PM, the survey team informed the RVPCS that the facility's immediate jeopardy abatement plan was accepted.</p> <p>The facility presented credible evidence that the abatement plan had been implemented, including evidence of staff education as outlined in the plan, locks installed to front and rear courtyard doors, review of all safe smoking assessments and care plans of residents who smoke, safe smoking guidelines reviewed with all residents who smoke, letters sent to all residents or resident representatives regarding smoking guidelines, signs posted on front entrance regarding no smoking items are to be given directly to residents, fire blanket was ordered, and residents who smoke were asked to allow staff to search their rooms/personal self for smoking items and items were collected and placed on smoking cart.</p> <p>Interviews were conducted with Registered Nurse (RN) #1, RN #2, LPN #2, LPN #5, LPN #6, CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6.</p> <p>On 6/12/25 at 6:21 PM, the survey team met with the RNC, RVPCS, and DON and notified them that as of 6:15 PM the immediate jeopardy was abated.</p> <p>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/12/25.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medical provider ordered medication was available for administration for 1 of 19 sampled residents (Resident #2).</p> <p>The findings included:</p> <p>For Resident #2, the facility staff failed to ensure the narcotic pain medication, Oxycontin was available for administration on six (6) separate occasions.</p> <p>Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Generalized Muscle Weakness, Chronic Kidney Disease, Conversion Disorder with Seizures, Irritable Bowel Syndrome, and Constipation.</p> <p>The resident's most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/29/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.</p> <p>On 6/10/25 at 2:09 PM, surveyor spoke with Resident #2 who stated staff have previously let their scheduled pain medication run out.</p> <p>Resident #2's current comprehensive person-centered care plan included a focus area stating The resident is at risk for pain r/t [related to] mobility. Ordered Oxycodone and Oxycontin.</p> <p>Resident #2's current medical provider orders included an order dated 11/30/24 for Oxycontin Oral Tablet Extended Release 12 Hour Abuse-Deterrent 10 mg give 1 tablet by mouth two times a day.</p> <p>Surveyor reviewed Resident #2's clinical record which revealed Oxycontin 10 mg was not administered on 4/05/25 5:34 PM, 4/06/25 5:04 AM, 4/06/25 6:49 PM, 4/15/25 6:33 PM, 5/08/25 6:01 PM, and 5/30/25 6:40 PM.</p> <p>Corresponding nursing progress notes documentation indicated:</p> <p>4/05/25 5:34 PM - not available</p> <p>4/06/25 5:04 AM - pending arrival, unavailable in Pyxis</p> <p>4/06/25 6:49 PM - held pending arrival</p> <p>4/15/25 6:33 PM - unavailable from pharmacy</p> <p>5/08/25 6:01 PM - not available</p> <p>5/30/25 6:40 PM - awaiting pharmacy</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Ben Bolt Avenue Tazewell, VA 24651	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 10:15 AM, surveyor spoke with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) who verified Resident #2 did not receive Oxycontin at these times because it was not sent by the pharmacy and Oxycontin was not available in the Pyxis (onsite medication supply system). RNC stated they did not know why the medication was not sent.</p> <p>Surveyor requested and received the facility policy titled Administering Medications which read in part .4. Medications are administered in accordance with prescriber orders .</p> <p>On 6/11/25 at 4:00 PM, the survey team met with the DON, Assistant DON, RNC, and the Regional [NAME] President of Clinical Services and discussed the concern of staff failing to ensure Resident #2's Oxycontin was available for administration.</p> <p>No further information regarding this concern was presented to the survey team prior to the exit conference on 6/12/25.</p>