STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Blacksburg	3610 South Main Street Blacksburg, VA 24060

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, resident and staff interview, clinical record review, and facility document review, the facility staff failed to ensure electronic cigarettes (vapes) and/or illicit substances were stored in a manner to prevent misuse from other vulnerable residents and/or a fire hazard for four (4) of four (4) sampled residents, Resident #1, Resident #2, Resident #3, and Resident #4. The findings included:1. For Resident #1, the facility staff failed to ensure an electronic cigarette (vape) was securely stored. A facility policy titled, Resident Smoking, dated 2/21/24 specified, Smoking and/or vaping is not allowed inside the facility under any circumstances. The policy also specified, 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.An admission Record indicated the facility admitted Resident #1 on 5/22/23. According to the admission Record, Resident #1 had a medical history that included, but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, generalized muscle weakness, and chronic kidney disease stage 3. A quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/26/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated the resident had intact cognition. Resident #1's comprehensive person-centered care plan included a focus area revised on 11/19/24, that indicated Resident #1 was an active smoker with a history of non-compliance with the smoking policy and had lost smoking privileges in the past due to non-compliance. Interventions included Ensure smoking items are stored correctly per policy.Resident #1's Safe Smoking Assessment completed 2/18/26 did not address the use of an electronic cigarette or vape. During an interview on 2/23/26 at 3:10 PM, Resident #1 stated he vaped and kept his vape in his room and charged it without staff assistance. On 2/23/26 at 6:00 PM, the administrator was informed that Resident #1 reported having a vape in his room and charged it without staff assistance. The administrator provided a copy of a facility letter issued to and signed by Resident #1 dated 4/2/24 which indicated The intent of this letter is to reiterate the smoking policy. Residents are not allowed to keep any smoke materials (vapes, cigarettes, lighters, etc.). You have, again, been found with smoke materials on your person. Smoking is a privilege in this facility. Please know that if you are found to have any further smoke materials on your person or in your room your privilege to smoke at our facility will be rescinded. The letter also included a handwritten note dated 4/11/2024 indicating Found with another vape [no] smoking privileges now. On 2/24/26 at 8:58 AM, the administrator stated all vapes and chargers were to be kept secure by the activities department. The facility Activities Director (AD) was interviewed on 2/24/26 at 9:53 AM. The AD stated vapes are to be used at smoking times only and are kept in the activities department and locked. AD stated vapes were charged in the activities office while staff were working. AD stated they had heard residents have vapes, but she had never witnessed it, and they preached about the smoking policy. AD stated (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 attended smoke breaks and usually smoked one cigarette, but she had never seen him with a vape. The facility Social Worker (SW) was interviewed on 2/24/26 at 10:09 AM. The SW stated she had taken multiple marijuana, and nicotine vapes from Resident #1's room in the past that were out in plain sight. SW stated this most recently occurred in November 2025. SW stated Resident #1 had received warnings and write-ups and had lost smoking privileges in the past but got them back. On 2/24/26 at 2:10 PM, the administrator and Director of Nursing were informed of the concern of Resident #1 having a vape and charging it in their room without staff assistance. No further information was provided prior to the exit conference on 2/24/26. 2. For Resident #2, the facility staff failed to ensure an electronic cigarette (vape) was securely stored. A facility policy titled, Resident Smoking, dated 2/21/24 specified, Smoking and/or vaping is not allowed inside the facility under any circumstances. The policy also specified, 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.An admission Record indicated the facility admitted Resident #2 on 7/28/25. According to the admission Record, Resident #2 had a medical history that included, but not limited to dislocation of C6/C7 cervical vertebrae, chronic pain syndrome, generalized muscle weakness, and adult failure to thrive. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/09/25, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated the resident had intact cognition. Resident #2's comprehensive person-centered care plan included a focus area initiated on 7/29/25, which indicated the resident had a history of smoking with a goal that the resident will not smoke without supervision. Interventions included administering medications as ordered for smoking and notify charge nurse immediately if it is suspected that resident has violated facility smoking policy. Resident #2's Safe Smoking Assessment dated 12/09/25 indicated the resident was a non-smoker. During an interview on 2/23/26 at 3:13 PM, Resident #2 stated he had a vape in a tote bag on his bed and the facility lets him vape while in bed, but he hardly uses it. When asked if staff helped him charge the vape, he stated no he uses his phone charger. The resident's phone charger was on the bed beside the resident. On 2/23/26 at 6:00 PM, the administrator was informed that Resident #2 reported having a vape in his room and charged it without staff assistance. On 2/24/26 at 8:58 AM, the administrator stated Resident #2 gave her his vape last evening. The administrator further stated all vapes and chargers were to be kept secure by the activities department. The facility Activities Director (AD) was interviewed on 2/24/26 at 9:53 AM. The AD stated vapes are to be used at smoking times only and are kept in the activities department and locked. AD stated vapes were charged in the activities office while staff were working. AD stated they had heard residents have vapes, but she had never witnessed it, and they preached about the smoking policy. On 2/24/26 at 2:10 PM, the administrator and Director of Nursing were informed of the concern of Resident #2 having a vape and charging it in their room without staff assistance. 3. For Resident #3, the facility staff failed to ensure a drug substance was safely secured. A facility policy titled, Resident Smoking, dated 2/21/24 specified, Smoking and/or vaping is not allowed inside the facility under any circumstances. The policy also specified, 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.The Resident admission Agreement labeled VII: 01-01 2025 specified Facility will not permit the use or possession of, without Facility's permission and a physician's order, cannabis or marijuana products, or any controlled substance (except as prescribed) in violation of any law. Any resident who, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while on Facility premises, engages in the sale and/or unauthorized possession of cannabis or marijuana products, or any controlled substance may be subject to discharge and may be referred to local law enforcement. Upon suspicion of possession of cannabis or marijuana products, or a controlled substances violating this section and with consent of Resident, Facility may search the resident's room, personal locker, personal effects, and other personal spaces.An admission Record indicated the facility admitted Resident #3 on 3/28/25. According to the admission Record, Resident #3 had a medical history that included, but not limited to type 2 diabetes mellitus with diabetic neuropathy, need for continuous supervision, and generalized muscle weakness. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) summary score of 14 out of 15, which indicated the resident had intact cognition. Resident #3's comprehensive person-centered care plan included a focus area revised on 9/30/25, that indicated the resident was a smoker with a history of noncompliance with smoking policy despite education. Interventions included the resident requires a smoking apron while smoking and notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Resident #3's Safe Smoking Assessment completed 2/10/26 indicated the resident was a smoker and used a vape. On 2/23/26 at 5:53 PM, while walking by Resident #3's room, the door opened and another resident entered the room and quickly closed the door. An odor resembling marijuana was noted coming from inside the room. Surveyor knocked on Resident #3's door and was welcomed in, the odor was stronger in the room but there was no substance, vaping or smoking device visible in Resident #3's room. The administrator was notified of the observation on 2/23/26 at 5:55 PM. The administrator entered the room briefly, exited the room and agreed to noting an odor resembling marijuana. She stated a marijuana smell had previously been reported coming from Resident #3's room but this was the first time she had observed the odor herself. During an interview with the administrator and Regional Nurse Consultant (RNC) on 2/24/25 at 8:58 AM, the administrator stated they spoke with Resident #3 last evening and the resident admitted to having marijuana in his room and turned over a small baggie with a pinch size amount and a lighter but stated he did not smoke it in his room. Administrator stated Resident #3 was re-educated on the facility smoking policy. Resident #3's current medical provider orders did not include an order for marijuana products. The long-term care social worker (SW) was interviewed on 2/24/26 at 10:09 AM. SW denied having witnessed a resident using marijuana but stated it had been reported to her and each time she received a report she met with the resident and asked to search their room. SW stated Resident #3 was the main one that she had received reports concerning the smell of marijuana from their room. SW stated Resident #3 had never consented to a search. A review of Resident #3's clinical record failed to reveal any conversations regarding marijuana or facility requests to search the resident's room. During an interview with the SW on 2/24/26 at 1:41 PM, SW stated she failed to document the conversations. Throughout the course of the survey, during interviews with Licensed Practical Nurse (LPN) #1, LPN #4, Certified Nursing Assistant (CNA) #1, CNA #4, Housekeeper #1, Housekeeper #2, Unit Manager (UM) #2, each reported noting the smell of marijuana in or near the vicinity of Resident #3's room. On 2/24/26 at 2:13 PM, the administrator and Director of Nursing were notified of the concern regarding Resident #3 having an unsecured drug substance in their room with an odor resembling marijuana and failing to provide documentation of having addressed staff reports of marijuana use in the facility. No further information was provided prior to the exit conference on 2/24/26. 4. For Resident #4, the facility staff failed to ensure an electronic cigarette (vape) was securely stored. A facility policy titled, Resident Smoking, dated 2/21/24 specified, Smoking and/or vaping is not allowed inside the facility under any circumstances. The policy also specified, All (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.An admission Record indicated the facility admitted Resident #4 on 9/17/25. According to the admission Record, Resident #4 had a medical history that included, but not limited to Alzheimer's Disease, major depressive disorder, generalized arthritis, and generalized muscle weakness. A significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/09/26, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) summary score of 14 out of 15, which indicated the resident had intact cognition. Resident #4's comprehensive person-centered care plan did not address their smoking status. Resident #4's Safe Smoking Assessment completed 12/18/25 indicated the resident was a nonsmoker. Resident #4's clinical record included a physician's progress note dated 1/06/26 which revealed Patient reports THC (the main active ingredient of cannabis) vape use which is helping with pain management. During an interview in their room on 2/23/26 at 3:23 PM, Resident #4 stated she did not smoke cigarettes but did have a vape in her room but did not use it. Resident #4 stated she was able to charge the vape without staff assistance. No odor of cigarette smoke, marijuana, or vape use noted in Resident #4's room during the interview. On 2/23/26 at 5:35 PM, Certified Nursing Assistant (CNA) #2 stated they had noticed the smell of marijuana in the facility before. CNA #2 pointed down the hall to the general vicinity of Resident #4's room and stated it started down there just a week or two ago. CNA #2 stated residents are not supposed to have vapes in their room and when staff see them, they take them and then the resident will have another one. On 2/23/26 at 6:00 PM, the administrator was informed that Resident #4 reported having a vape in her room and charged it without staff assistance. On 2/24/26 at 8:58 AM, the administrator stated they met with Resident #4 last evening and she admitted to having a tobacco vape but declined to turn it in but did surrender a lighter. Administrator stated she had received the first report of a marijuana smell coming from Resident #4's room on 2/23/26. The facility Activities Director (AD) was interviewed on 2/24/26 at 9:53 AM. The AD stated vapes are to be used at smoking times only and are kept in the activities department and locked. AD stated vapes were charged in the activities office while staff were working. AD stated they had heard residents had vapes, but she had never witnessed it, and they preached about the smoking policy. During an interview on 2/24/26 at 11:11 AM, CNA #4 stated she had noticed the smell of marijuana in the hall near Resident #4's door but did not report it because she did not know exactly where it was coming from. During an interview on 2/24/26 at 11:26 AM, Housekeeper #2 stated she smells marijuana in the facility probably twice a week. She stated had never seen Resident #4 using it but had noticed the smell from that particular room. Housekeeper #2 stated she had never reported the smell of marijuana to administration because she did not know. On 2/24/26 at 12:33 PM, Resident #4's physician (MD) stated the resident reported using THC for pain control and he did not know she was using it in the facility. MD further stated he had no knowledge the resident was using THC in the facility. On 2/24/26 at 2:13 PM, the Administrator and Director of Nursing were informed of the concern regarding Resident #4 having a vape in her room. No further information was provided prior to the exit conference on 2/24/26.