DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495320	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/05/2025

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 CLINTWOOD, VA 24228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS

 Description of structure: One Story, Type II (000) Sprinkler status: Fully Sprinklered, NFPA 13

A paper revisit to a recertification Life Safety Code survey was conducted on 02-05-2025 of an initial survey conducted 01-20-25 in accordance with 42 Code of Federal Regulation, Part 483:90(a) Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 EXISTING regulations.
The findings that follow demonstrate compliance with Title 42 Code of Regulations, 483.90(a) et seq (Life Safety from Fire.) | {K 000} | | |

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