

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

PRINTED: 10/22/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                          |  |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255284</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/25/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HERITAGE HOUSE NURSING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3103 WISCONSIN AVENUE</b><br><b>VICKSBURG, MS 39180</b>                      |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 000                                                                    | <p>INITIAL COMMENTS</p> <p>Initial Comments:</p> <p>CI MS #25959</p> <p>On September 25, 2024 the State Agency (SA) conducted an onsite complaint investigation, CI MS #25959, which alleged that the facility had neglected to use proper infection control procedures while a resident with an infection was in isolation. The complaint alleged that the neglect of the staff to follow proper infection control procedures had hastened the death of the resident. The SA determined that the facility was in compliance with the Standards for Participation in Medicare and Medicaid and no deficiencies were cited.</p> <p>The census on 09/25/24 was 57 and the facility was licensed for 60 beds.</p> | F 000                                                                      |                                                                                                                          |  |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/21/2024

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.