STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675748	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Trails Nursing and Rehabilitation Center	301 Lincoln Park Dr Cleburne, TX 76033

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on interview and record review, the facility failed to provide advance notice of change in services and charges not covered under Medicare for 1 of 3 residents (Residents #3) reviewed for Medicaid and Medicare Coverage Liability Notices. The facility failed to ensure Resident #3 was provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form CMS-10055 (SNF ABN) when she was discharged from Medicare Part A skilled nursing services. This failure placed residents, or their representatives, at risk of not being fully informed about services covered by Medicare Part A. Findings Included: Record review of Resident #3's AR, dated 7/11/2024, reflected a [AGE] year-old woman who admitted to the facility on [DATE]. She was diagnosed with congestive heart failure (which was a long-term condition that happened when the heart could not pump blood well enough to give your body a normal supply.) Record review of Resident #3's Quarterly MDS, dated [DATE], Section C., Cognitive Patterns indicated Resident #3 had a BIMS Score of 14. A BIMS Score of 14 indicated Resident #3 did not have cognitive impairment . Record review of Resident #3's census data, viewed 7-11-2024, indicated Resident #3 admitted to the facility on Medicare Part A on 2/13/2024 and discharged from Medicare Part A to private pay on 3/3/2024. Resident #3 was not taking part in skilled nursing services as of 3/3/2024. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/11/2024 at 9:01 AM with MDSC P revealed Resident #3 was admitted to the facility on [DATE] for skilled nursing services having utilized Medicare Part A. The resident initiated a move from skilled nursing services, Medicare Part A, to private pay because she did not want to pay the co-pay for skilled nursing services. Resident #3 stayed at the facility on private pay. Resident #3 did not utilize the full 100 days of Medicare Part A, so she had days remaining. She should have received a SNF ABN. The facility did not have SNF ABN on file with the resident's acknowledgement. Resident #3 did not receive the SNF ABN due to human error. The error did not place the resident in any harm or risk her ability to receive care. The error did not deny the resident the ability to have utilized Medicare Part A later. Interview on 7/11/2024 at 11:21 AM with the DON revealed SNF ABN forms were handled by the MDSC. Staff was supposed to follow the Medicare Part A guidelines for SNF ABN dispersal. The omission in dispersing a SNF ABN to Resident #3 fell upon human error and the unique situation that Resident #3 chose to drop Medicare Part A and stayed at the facility with private pay. Resident #3 was not placed in any harm and her opportunities to participate in Medicare Part A later were not altered. Interview on 7/11/2021 at 11:34 AM with the ADM revealed she expected her staff to follow the rules of Medicare Part A and the Medicare Claims Processing Manual for financial liability protections. The failure for the SNF ABN having not been provided was human error. Resident #3 was never placed in any harm. She was not placed at risk for denial to participate in Medicare Part A moving forward. Record review of the facility's guidelines for determination to issue a SNF ABN was the Medicare Claims Processing Manual, dated 12/20/2023. Section 70.4 of the Medicare Claims Processing Manual indicated : When completing and delivering the SNF ABN, skilled nursing facilities must meet the written notice standards of this chapter, unless otherwise specified. Failure to provide a proper SNF ABN in situations where a physician has ordered the extended care item or service may result in the skilled nursing facilities being held financially liable under the provisions, where such provisions apply. skilled nursing facilities may also be sanctioned for violating the conditions of participation regarding resident (beneficiary) rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 7 Residents (Resident #51) who were reviewed for accuracy of assessments. The facility incorrectly coded Resident #51 with weight loss on the quarterly MDS. This failure placed residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #51's AR, dated 7/9/2024, reflected an [AGE] year-old woman who admitted to the facility on [DATE]. She was diagnosed with encounter for removal of internal fixation device (which was admittance to remove a medical device post-surgical procedure.) Record review of Resident #51's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #51 had a BIMS Score of 12. A BIMS Score of 12 indicated the resident had moderate cognitive impairment. Record review of Resident #51's order summary report reflected an order, initiated on 6/13/2024, to weigh the resident upon admission, then monthly, if gain/loss greater than 3 pounds, reweigh, notify medical doctor. Record review of Resident #51's CP reflected a focus area for nutritional problem, initiated on 6/21/2024, evidenced by potential weight loss. The goal, initiated on 6/21/2024, was for the resident to maintain weight. The intervention, initiated 6/21/2024, was for nursing staff to monitor weight and report significant weight loss: 3 pounds loss in a week; greater than 5% in a month; greater than 7.5% in 3 months; and greater than 10% in 6 months. Record review of Resident #51's documented weights and vitals in PCC (the facility documentation platform,) taken on 6/13/2024, reflected her weight of 174.6 pounds. Weight taken and recorded by LVN M. Record review of Resident #51's documented weights and vitals in PCC, taken on 6/18/2024, reflected her weight of 157 pounds. Weight taken and recorded by the RD. (Having utilized the LTCSP software: On 06/13/2024, the resident weighed 174.6 lbs. On 06/18/2024, the resident weighed 157 pounds which was a -10.08 % loss.) Record review of the facility's monthly weight report (loose paper copy; not in PCC,) dated 7/1/2024, reflected Resident #51 weighed 171 pounds. Weight taken and recorded by the AAD. (Having utilized the LTCSP software: On 06/13/2024, the resident weighed 174.6 lbs . On 07/01/2024, the resident weighed 171 pounds which was a -2.06 % loss.) (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #51's documented weights and vitals in PCC, taken on 7/4/2024, reflected her weight of 146 pounds. Weight taken and recorded by LVN N. (Having utilized the LTCSP software: (Having Utilized the LTCSP software: On 06/13/2024, the resident weighed 174.6 lbs . On 07/04/2024, the resident weighed 146 pounds which is a -16.38 % Loss.) Record review of Resident #51's Quarterly MDS, dated [DATE], reflected Section K., Swallowing/Nutritional Status: Resident #51 weighed 146 pounds. Resident #51's weight of 146 pounds reflected a loss of 5% or more in the last month, or more than 10% in the last 6 months, and was not on a physician-prescribed weight loss regimen. Record review of Resident #51's documented weights and vitals in PCC, taken on 7/8/2024, reflected her weight of 157 pounds. Weight taken and recorded by LVN O. (Having Utilized the LTCSP software: (Having Utilized the LTCSP software: On 06/13/2024, the resident weighed 174.6 lbs . On 07/08/2024, the resident weighed 157 pounds which was a -10.08 % Loss.) Interview and record review on 7/10/2024 at 11:10 AM with the KM revealed she was unaware that Resident #51 was flagged for weight loss on her most recent MDS assessment, dated 7/5/2024. The KM stated she and the RD had weights taken on 7/1/2024 and Resident #51 weighed 171 pounds, which did not result in any significant weight loss. The KM produced a loose paper copy of residents' weights of indicated the weights taken on 7/1/2024 was the weight information used for dietary management and the weight of 171 pounds did not reflect the need for weight loss intervention for Resident #51. The weights recorded from 7/1/2024 had not been uploaded in the facility weights and vitals summary in PCC. Interview on 07/10/24 at 11:28 AM with Resident #51 revealed she had been at the facility for a few weeks. She claimed she felt good and that she hoped to go home soon. She was at a healthy body weight and did not feel she had any significant weight loss. Interview on 07/11/24 at 9:01 AM with MDSC P revealed Resident #51's Quarterly MDS, dated [DATE], was documented with the most recent weights on the weights and vitals summary in PCC, which was 146 pounds taken on 7/4/2024. If the weights were incorrect on the weights and vitals summary in PCC, it would have been incorrect on the MDS also. The MDS identifier for weight loss was triggered incorrectly based on inaccurate weights on the weights and vitals summary in PCC. Interview and observation on 7/11/2024 at 9:45 AM with the AAD revealed he was the staff member who weighed residents listed the 7/1/2024 monthly weight report. He, along with other staff who weighed Resident #51, had access to two distinct types of scales at the facility. One was a wheelchair scale, which weighed residents while seated in a wheelchair, and the other was a mechanical chair, which weighed residents from on a cushioned seat (not in a wheelchair.) He stated he wanted to be the only staff member to weigh the residents so they would be weighed using the same scale in the same body position, which would reflect the most accurate weight. He stated sometimes residents rested their foot/feet on a small bar under the seat of the mechanical scale, which resulted in inaccurate weights. If a different staff member weighed the resident on a different scale than before or did not notice the resident having rested their foot on the bar under the seat, the weights would have been inaccurate. Observations reflected the wheelchair scale accurate. Observations reflected the mechanical scale 5 pounds greater. A second weight was taken with the mechanical scale with a foot placed on the bar under the seat. The second weight taken, with a foot on the bar, was 100 pounds lighter and did not reflect an accurate weight. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/11/2024 at 11:21 AM with the DON revealed Resident #51 had been coded for weight loss in her most recent Quarterly MDS, dated [DATE]. The DON was not aware of any significant weight loss because she participated in the facility's monthly weight loss meetings, where Resident #51 had not been discussed with the KM or RD. When the DON reviewed Resident #51 weights recorded in the weights and vitals summary in PCC, she remarked how the weights fluctuated and how she would have liked for one person to weight the residents, so the same scales were used and weights more accurate. Interview and record review on 7/11/2024 at 1:00 PM with the ADM revealed she expected her staff to follow the facility policies for Weight Assessment and Interventions as well as Resident Assessments. Record review of Resident #51's documented weights and vitals in PCC, taken on 7/11/2024 at 12:14 PM by LVN O, reflected Resident #51's weight of 169.8 pounds. The inaccurate weights in the weights and vitals summary in PCC was a failure for staff having been consistent with the scale used, the resident's body position at the time of being weighed and making corrections to observable weight errors. The failure of the accurate MDS Assessment fell upon the use of inaccurate weights documented in the weights and vitals summary in PCC. Resident #51 had not suffered any significant weight loss and was never at risk of harm due to weight loss. Record review of the facility's Weight Assessment and Intervention Policy, dated March 2022, reflected weights were supposed to be recorded in each unit's weight record chart and in the individual's medical record. Any weight change of 5% or more since the last weight assessment was supposed to be retaken the next day for confirmation. If the weights were verified, nursing would immediately notify the dietitian in writing. Unless notified of significant weight change, the dietician would review the unit weight record monthly to follow individual weight trends over time. Record review of the facility's Resident Assessment Policy, dated March 2022, reflected the resident assessment coordinator was responsible for ensuring the IDT team conducts timely and appropriate resident assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 2 of 7 Resident (Resident #64 and Resident #24) reviewed for quality of care. 1. The facility failed to ensure Resident #64 had a clean air filter in his CPCP Machine and the facility towel dried Resident #64's CPAP mask versus allowing to air dry. 2. The facility failed to ensure Resident #24 had an air filter in his CPAP Machine and the facility failed to allow Resident #64's CPAP mask, along with the head strap, to air dry. The failures placed residents who use CPAP treatment at risk of respiratory infection. Findings included: 1. Record review of Resident #64's AR, dated 7/9/2024, reflected a [AGE] year-old-male who admitted to the facility on [DATE]. He was diagnosed with critical illness myopathy (which was a disease having involved muscles of the extremities, trunk, and respiration) and obstructive sleep apnea (which was a medical condition marked by throat muscles having relaxed and having blocked the person's airway while sleeping.) Record review of Resident #64's Admission MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #64 had a BIMS Score of 13. A BIMS Score of 13 indicated the resident had no cognitive impairment. Section O., Special Treatments, Procedures, and Programs reflected Resident #64 utilized Non-invasive Mechanical Ventilator while a resident. Record review of Resident #64's CP reflected a focus area for sleep apnea support, initiated 6/27/2024, evidenced by resident having sleep apnea. The goal, initiated on 6/27/2024, was for resident to be free from complications. The intervention, initiated on 6/27/2024, was for the resident to utilize a CPAP machine. Record review of Resident #64's order summary report reflected an order, initiated on 6/25/2024, to cleanse CPAP mask and tubing with soap and water daily after use in the morning. Record review on 7/11/2024 of Resident #64's CPAP Machine manufacturer guidelines , issued June 2021, which was a Resvent Model, reflected the machine required an undamaged filter for proper operation. Dirty inlet filters may have caused high operating temperatures that may have affected the CPAP device's performance. Regular examination was required for the inlet filters as needed for integrity and cleanliness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 07/09/24 at 10:29 AM with Resident #64's revealed he utilized a CPAP machine for his sleep apnea every night. Interview reflected he was not able to recall the last time his filter was changed in his CPAP machine, when the last time his CPAP mask was washed, or the last time his CPAP tubing was changed. Observations of Resident #64's CPAP machine revealed the filter, utilized to keep contaminates out of his CPAP machine, was dirty. The filter, which was originally white, was approximately 1.5 inches long x .75 inches wide x .125 inches deep. The filter was no longer white. It was grey from dust and the filter had a larger accumulation of dust in a circle. The heavier concentration of dust was in the shape of a circle was where the filter fit directly over the air inlet vent on the back side of the CPAP Machine. There were no date markings to signify the last date the CPAP machine was cleaned or serviced . Interview and observation on 07/10/24 at 9:12 AM Resident #64 stated staff cleaned his CPAP mask today. Observation of the filter in the CPAP machine filter revealed a grey filter with a darker collection of dirt in the shape of a circle where the filter covered the inlet vent. It had not been cleaned or changed since yesterday's observation. The resident's mask was on the resident's lap; he complained that there was water in the mask, left from when staff washed it, and that he needed it to be dry because water leaked into his mouth. Interview and observation on 07/10/24 at 9:14 AM with LVN O revealed she cleaned Resident #64's mask this morning and had done so every morning. The TAR notified the nurse team to clean his mask daily. She stated she cleaned his air inlet filter yesterday and was about to clean it again today. She was observed removing the filter from the CPAP machine and entered the bathroom; she said to wash the filter out. When she emerged from the restroom, she stated she dropped it, the filter, down the drain. She stated she was going to get another filter for Resident #64's CPAP machine. She did not know where to get new filters and said she was going to find out. Observations revealed the CPAP air filter in the drainpipe in Resident #64's bathroom. LVN O was observed returning to Resident #64's room where she was observed having towel-dried Resident #64's CPAP mask. 2. Record review of Resident #24's AR, dated 7/9/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with a fracture to the thoracic vertebrae (breaks in the discs that composed the spine) and obstructive sleep apnea (which was a medical condition marked by throat muscles having relaxed and having blocked the person's airway while sleeping.) Record review of Resident #24's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident #24 had a BIMS Score of 12. A BIMS Score of 12 indicated the resident had moderate cognitive impairment. Section O., Special Treatments, Procedures, and Programs reflected Resident #24 utilized Non-invasive Mechanical Ventilator while a resident. Record review of Resident #24's CP reflected a focus area for sleep patterns, initiated 9/29/2023, evidenced by resident having sleep apnea. The goal, initiated on 9/29/2023, was for resident to have adequate sleep. The intervention, initiated on 5/10/2024, was for the resident to utilize a CPAP machine. Record review of Resident #24's order summary report reflected an order, initiated on 5/10/2024, to cleanse mask and tubing with soap and water daily after use in the morning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review, on 7/11/2024 of Resident #24's CPAP Machine manufacturer guidelines , undated, which was a ResMed Model, reflected the filter was supposed to be regularly checked for any damage; replaced every 6 months or earlier if there was any sign of holes of blockage. The filter was supposed to be in place at all times to prevent water and dust from entering the device. Interview and observation on 07/09/24 at 10:14 AM with Resident #24 revealed he was diagnosed with sleep apnea and utilized a CPAP machine to help him breathe every night when he slept. He was unable to recall the last time he observed staff clean his CPAP mask, change his filter, or change the tubing. He denied respiratory illnesses. Observation of his CPAP machine revealed his mask was contained in a plastic bag while not in use. The compartment on the CPAP machine, which was supposed to have a filter for clean air intake, was empty. There were no dates on any of the tubing or CPAP machine. Interview and observation on 07/10/24 at 9:33 AM with Resident #24 revealed staff cleaned his CPAP mask this morning. He denied respiratory distress. Observation reflected the mask was tucked away in a closed plastic bag. The CPAP mask and the headband for the mask were damp to the touch. Observation of the chamber for the air filter reflected an empty chamber; there was no filter. Interview and observation on 07/10/24 at 9:34 AM with LVN O revealed she cleaned Resident #24's mask with soap and water this morning under the water in the bathroom sink and the placed the mask back into the plastic bag. She did not clean his filter and did not recall the last time it was changed. She was observed checking the resident's filter and discovered the resident did not have a filter in its machine. LVN O stated she told the ADON B, who got the filters . LVN O stated the TAR prompted masks to be washed daily, but the orders and the TAR did not indicate anything about the filter . Interview on 07/10/24 at 9:44 AM with the DON reflected replacement filters, and parts, for CPAP Machines were not kept at the facility. The facility coordinated with either the resident's family, or with a third-party vendor, for CPAP supplies . Interview on 7/10/24 at 11:15 AM ADON B revealed the facility contacted the third-party vendor for Resident #64's CPAP supplies and a responsible party for Resident #24's CPAP supplies. ADON B stated the facility had initiated contact for the supplies needed. Interview on 7/11/2024 at 10:40 AM with LVN P revealed staff were trained in caring for CPAP machines. LVN P stated staff was trained to wash the CPAP mask with soap and water and let them air dry. She stated the training did not cover filters. She stated a dirty air filter on a CPAP machine, or uncleaned CPAP components, placed the resident at risk for respiratory illness. She stated the failure to have clean filters, or to know to check for dirty ones fell on education, no changes specified as an order, or notifications prompted in the TAR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 7/11/2024 at 11:21 AM with the DON revealed nursing staff had been trained on how to care for CPCP machines. Training entailed CPAP masks were washed daily and placed on a towel to air dry. The filter was supposed to be checked weekly and changed, as necessary. Per policy, it was the facility's responsibility to provide routine supplies and routine cleaning for residents' CPAP machines. Per policy, the facility was also responsible to follow specific cleaning instruction obtained from the manufacturer of the CPAP device. If a CPCP machine was not maintained per policy and manufacturer recommendations, the resident was placed at risk of respiratory infection. The failure for proper care for the CPAP fell upon general knowledge, not being specified in the orders, or listed on the TAR. Interview on 7/11/2024 at 11:30 AM with the ADM revealed she expected the staff to clean resident's CPAP machines according to the policy and manufacturer guidelines. The failure of staff to maintain the CPAP machines, items such as air filters and air drying the masks, full upon education, vague written orders, and the lack of instructions on the TAR. Residents with poorly maintained CPAP machines were placed at risk for respiratory illnesses. Record review on 7/15/2024 of URL: Sleepfoundation.org (2024); CPAP machines were a form of positive airway pressure therapy, which used compressed air to open and support the upper airway during sleep. A portable machine generated the pressurized air and directed it to the user's airway via a hose and mask system. The machines were humid and often warm, having made them the perfect home for mold, bacteria, viruses, and other harmful microbes. Having cleaned your machine components regularly washed these microbes away and prevented them from reaching dangerous levels, but having neglected your machine's hygiene could have led to both acute and chronic respiratory illnesses. Record review of the Facility's CPAP Support Policy, dated March 2015, reflected CPAP therapy's purpose was to provide spontaneous breathing residents with continuous positive airway pressure to improve obstructive sleep, resident comfort, and resident safety. The policy indicated directed nursing staff to rinse washable filters under running water once a week to remove dust and debris and replace at least once a year. Disposable filters were supposed to be replaced monthly. CPAP masks were supposed to be cleaned by placing them in warm soapy water and soaking/agitating for 5 minutes. Then, rinse with warm water and allowed to air dry between uses. The CPCP mask head strap was supposed to be washed with warm soap and water and allowed to air dry. Per policy, the facility was also responsible to follow specific cleaning instruction obtained from the manufacturer of the CPAP device.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49065 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 1 of 1 laundry. The facility failed to ensure laundry staff handled and transported linens in a manner to ensure cleanliness and protect from dust and soil to prevent cross-contamination and the spread of infections. This failure could place residents at risk for development of communicable diseases and infections that could diminish a residents' quality of life. Findings were: Observation on 07/09/24 at 02:05 pm revealed the LS walking down the hall delivering linens to residents on an uncovered linen cart. Clothing for multiple residents was hanging openly on the cart. There were other residents, staff, and visitors in the hall when she was delivering the linens. In an interview on 07/09/24 at 02:05 pm the LS stated that staff normally covered laundry from the laundry building to the residents building. She stated once inside the residents building, they took= the cover off to deliver the clothes to the resident's room. The LS stated the linen/clothing was not kept covered as it went down the halls. In an interview on 07/10/24 at 11:55 am the LM stated that laundry was taken from the laundry to the residents building covered and left covered as they go down the hall. She stated they moved the cover enough to remove a single resident's clothing then recovered the cart. The LM stated the LS delivered the laundry yesterday and she was kind of new. The LM stated the policy was that laundry should be covered at all times to prevent contamination and cross-contamination. The LM stated the outcome of laundry not being covered could be infections for residents. In an interview on 07/11/24 at 08:57 am the DON stated the policy for transporting clean linens to residents was to bring the linen into the building covered with plastic or a sheet. She stated the purpose of covering the linen is to keep stuff from getting all over the clean linen and that they want it to be as clean as possible for the residents. The DON stated the outcome if the linen is not covered, is that you could introduce bacteria to a resident and make them sick. In an interview done on 07/11/24 at 09:22 am ADM stated the policy for transporting clean linens to residents was to bring the linen from laundry to the linen closet covered and resident clothing should be bagged or covered during transport. She stated the purpose of covering the linen is to prevent cross contamination. The ADM stated if linen was not covered, the staff would need reeducation and the laundry would need to be rewashed. The ADM stated the outcome if linen is not covered is that residents could get germs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675748	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Trails Nursing and Rehabilitation Center	301 Lincoln Park Dr Cleburne, TX 76033

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview done on 07/11/24 at 09:26 am ADON-A stated the policy for transporting clean linens to residents was to bring the linen from laundry in a bag. She stated the purpose of covering the linen was to prevent the linen from touching our clothing and keep it clean for residents. ADON-A stated the outcome if linen was not covered. is that it could spread infection to residents if it touches something else. On 7/11/24 a Record review of the facility's undated policy titled, Laundry and Bedding, Soiled-Transport Section reflected, Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. The policy also reflected for storing clean linens that the use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination.