

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Community Care Center of Hondo		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Ave E Hondo, TX 78861	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility or the resident through a means other than a postal service for 2 of 8 residents (confidential residents) reviewed for resident rights. The facility failed to ensure staff distributed mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. The findings included: During a confidential resident group meeting on 9/10/25 at 10:00 a.m., 2 of 8 members from the group meeting stated they did not receive mail on Saturdays because the Front Office Staff didn't work on Saturdays. The residents stated since the front office was locked, the mail delivered on Saturday was held in the front office and did not get delivered until the following Monday. Residents stated, the BOM collected the mail, sorted it, and then gave the mail to the Activity Director who then delivered the mail with the help of a resident. One resident stated, it bothers me a little bit that I don't get mail on Saturday, and I have a family member who lives out of town and there could be a chance I could get something but then I have to wait to get it. During an interview on 9/10/25 at 2:46 p.m., the BOM stated, she collected the mail from the box outside the facility entrance that was delivered by the postman. The BOM stated, the mail retrieved from the outside box was sorted with resident mail and separated from other mail. The BOM stated, she then took any personal mail addressed to the residents and placed them in a box marked Resident Mail that was left in the BOM's office. The BOM stated, then the Activity Director would come into the BOM's office and retrieve any mail that belonged to the residents from the Resident Mail box and delivered them to the residents with the help of a resident. The BOM stated, office hours are Monday to Friday, 8:00 a.m. to 5:00 p.m., but sometimes longer. The BOM stated she lived close to the facility and on most Saturdays would swing by the facility, collect the Saturday mail from the outside box and put the mail into the BOM's office and then lock it. The BOM stated the mail was not delivered to the Residents on Saturdays because the business office was closed. During an interview on 9/10/25 at 4:08 p.m., the Activities Director stated, mail was dropped off in a box outside the facility entry Monday to Saturday. The Activities Director stated, the BOM then took the mail from the outside box, took it to her office and sorted it. The Activities Director stated, any mail belonging to a resident was placed in a box marked, Resident Mail that was found in the BOM's office. The Activities Director stated she then retrieved mail placed in the Resident Mail box and she and a resident helped to distribute the mail to the residents. The Activities Director stated, mail delivery to the residents occurred from Monday to Friday and there was no Saturday delivery because the mail delivered on Saturday was locked in the BOM's office. The Activities Director stated, any mail that was delivered on Saturday, was picked up on Monday and delivered to the residents. The Activities Director stated, if I were waiting for something in the mail and had to wait until Monday to get it, I would want to get it when it came, including on Saturday. During an interview with the Administrator on 9/11/25 at 8:56 a.m. revealed he was not aware residents were not receiving the Saturday mail delivery. The Administrator stated he believed they had a good system in place for delivering the mail. The Administrator stated, the mail should be delivered on Saturday, but sometimes somebody must alert us that that was not happening. Record review of the facility document titled, Resident Rights with (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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revision date 6/10/25 revealed in part, .The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.i. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for ten of ten residents (Residents #4, #15, #19, #25, #27, #29, #33, #34, #36 and #37) reviewed for food and nutrition services. The facility failed to ensure the glazed lemon cake served for the lunch meal on 09/09/2025 was pureed to the correct consistency as required for Residents #4, #15, #19, #25, #27, #29, #33, #34, #36 and #37 who were ordered a pureed diet. This deficient practice could place residents at risk of choking, poor intake, and/or weight loss. The findings included: Record review of Resident #19's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #19 had diagnoses which included peripheral autonomic neuropathy (a condition that affects the nerves that control involuntary bodily functions, such as digestion, heart rate, sweating, and urination); vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain); anxiety disorder (excessive and persistent worry, fear, and nervousness that can interfere with daily functioning); cellulitis and abscess of mouth (an infection of the skin and underlying tissues and a localized collection of pus caused by bacteria); and dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). Record review of Resident #19's quarterly MDS assessment dated [DATE] revealed a BIMS score of 07/15, which indicated severe impaired cognition. Record review of the electronic health records for Residents #4, #15, #19, #25, #27, #29, #33, #34, #36 and #37 revealed all ten residents had orders for a pureed texture for food and thin or nectar/mildly thick textures for liquids. Record review of the resident menu for 09/09/2025 for residents whose diet order was a pureed diet was: Pureed lasagna with meat sauce, pureed broccoli and cauliflower blend, pureed garlic breadstick, pureed glazed lemon cake, and a beverage. Observation on 09/09/2025 at 11:45 AM in Resident #19's room revealed the resident was served her lunch tray. The pureed lasagna, pureed vegetables and pureed breadstick were served on one plate and were the appropriate consistency for a pureed diet: smooth, lump-free, and resembling mashed potatoes or pudding. Resident #19 fed herself the pureed lasagna and vegetables with a spoon from the plate on the tray. Observation on 09/09/2025 at 11:46 AM revealed the lemon cake was served in a cup and had a runny texture. When a fork was used to scoop up the cake, the cake dripped continuously through the fork prongs. During an interview on 09/09/2025 at 11:49 AM, Resident #19 stated the texture of the cake in the cup was too loose and not the same consistency as the pureed food on the plate. During an interview on 09/09/2025 at 11:55 AM, the MDS LVN stated the dessert served to Resident #19 was too runny and not the correct form for a pureed diet. During an interview on 09/09/2025 at 12:18 PM, the DM stated the pureed lemon cake was too runny to be served to residents on a pureed diet. She had been busy making copies and was not in the kitchen when the trays went out to the residents to see the consistency of the pureed cake. She believed there were eight residents who received a pureed diet. During an interview on 09/11/2025 at 10:30 AM, [NAME] A stated he pureed the cake for pureed diets, the cake was the proper consistency for pureed diets when it left the kitchen, but it was possible it had thinned out by the time it reached the residents. He knew the consistency of all pureed food should be similar to that of mashed potatoes, and residents who ordered a pureed diets could potentially choke if their food was not in the proper consistency. Record review of the recipe for Pureed Glazed Lemon Cake, 2025, revealed: Ingredients: Glazed Lemon cake (5 servings), *Milk (3/4 cup). Place cake servings in a washed and sanitized food processor; gradually add milk and blend until smooth. Portion with a #10 scoop. *Note: Any liquid specified in the recipe is a suggested amount of liquid (if needed). Some recipes items will require no liquid added to achieve the desired consistency. 1. If product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consistency. 2. If the product needs thickening, gradually add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency. 3. Follow any facility policies/procedures, such as the puree volume method procedure, to ensure a correct portion is served. IDDSI: Pureed (PU4) -Perform appropriate IDDSI testing to ensure texture standards are met. Record review of the facility's undated policy, Pureed Diet, undated, revealed, Indication for use: The Pureed Diet is designed for individuals who have difficulty in swallowing or who cannot chew foods of the Dental Soft (Mechanical soft) consistency. 2. The Pureed Diet follows the Regular Diet with alterations in the consistency of foods to a pureed consistency as needed. 3. All foods are prepared in a food processor or blender, with the exception of those foods which are normally in a soft, moist and smooth state (such as puddings, ice cream, mashed potatoes, oatmeal, etc.). 4. Additional liquid is added in the form of broth, gravy, vegetable or fruit Juices, or milk to achieve the appropriate consistency (puddings, smooth mashed potatoes). Record review of the IDDSI Pureed Adult Consumer Handout revealed: Level 4 - Pureed Foods: - Are usually eaten with a spoon; Do not require chewing; Have a smooth texture with no lumps; Hold shape on a spoon; Fall off a spoon in a single spoonful when tilted; are not sticky; Liquid (like sauces) must not separate from solids. IDDSI Fork Drip Test: Liquid does not dollop, or drip continuously through the fork prong.https://www.iddsi.org/images/Publications-Resources/PatientHandouts/English/Adults/4_pureed_adults		

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review the facility failed to ensure bedrooms measured at least 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in single resident rooms for 4 of 35 multiple occupancy resident rooms (#A5, #A6, #A9, and #A11) reviewed for physical environment. The facility failed to ensure rooms #A5, #A6, #A9, and #A11, which were multiple occupancy resident rooms, provided a minimum of 80 square feet per resident. This deficient practice could place residents at risk of inadequate space for activities of daily living in their rooms. The findings included: Observation on 9/10/25 at 4:55 p.m. revealed the measurement of rooms designated for three residents were as follows:- room #A5 measured 216.8 sq. ft. (72.6 sq. ft. per resident) with two residents residing in the room- room #A6 measured 220.4 sq. ft. (73.3 sq. ft. per resident) with no residents residing in the room- room #A9 measured 228.7 sq. ft. (76.2 sq. ft. per resident) with one resident residing in the room - room #A11 measured 226 sq. ft. (75.3 sq. ft. per resident) with one resident residing in the room During an interview on 9/11/25 at 11:22 a.m., the Administrator stated four of the facility's rooms, room #A5, #A6, #A9, and #A11 were below 80 square feet required per resident. The Administrator stated he wanted to continue the room waivers for these rooms. Record Review of the Bed Classification Form, dated 9/9/25, revealed resident rooms #A5, #A6, #A9, and #A11 were certified as rooms for 3 residents per room.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with dignity and respect in a manner and environment that enhances his and her quality of life for 1 (Resident #2) of 8 residents reviewed, in that: CNA C referred to Resident #2's brief during catheter care as a diaper. The facility failed to ensure RN B provided privacy to Resident #1 when performing tracheostomy care (a surgical opening made through the front of the neck into the windpipe used to help a person breathe when the normal route through the mouth, nose, or throat is blocked or impaired). This deficient practice could affect residents at the facility who receive assistance with care and could place them at-risk for diminished quality of life, loss of dignity, and low self-esteem. The findings were: 1. Record review of Resident #2's admission record, dated 9/17/25, revealed an initial admission date of 11/24/23 and a readmission date of 11/25/24 with diagnoses that included pneumonia (an infection that inflames the air sacs in one or both lungs), epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures), and cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Record review of Resident #2's MDS, a Quarterly assessment dated [DATE], revealed under Section C her BIMS (Brief Interview for Mental Status) score was 10 out of 15, which indicated her cognition was moderately impaired. Section H revealed she had an indwelling catheter and was always incontinent of bowel. Record review of Resident #2's care plan, last revised on 9/2/25, revealed the resident had impaired urinary elimination related to neurogenic bladder secondary to neurological impairment as evidenced by use of indwelling foley catheter, post-void residuals (amount of urine left over in the bladder after urination), or urinary retention (holding urine) with intervention to perform catheter care per protocol. During an observation on 9/10/25 at 3:06 p.m. CNA C assisted with catheter care and incontinent care for Resident #2. Resident #2 was falling asleep during the care. CNA C helped to put a new clean brief on the resident. CNA C attempted to wake up the resident and stated, we are going to put on your diaper now. During an attempted interview on 9/11/25 at 2:45 p.m. Resident #2 was sleeping and did not wake up for an interview. During an interview on 9/12/25 at 12:31 p.m. CNA C stated she had used the word diaper instead of brief. CNA C stated she had training on words they were supposed to use instead but would forget when she was in a hurry sometimes. CNA C stated using diaper instead of brief could make the resident feel undignified. Record review of the facility's policy titled Resident Right, dated 6/10/25, stated .Policy Explanation and Compliance Guidelines:.11. The facility will ensure that all direct care and indirect care staff of the members, including properly contractors and volunteers, are educated on the rights of residents and the responsibility of the facility type of care for its residents. Training topics will be appropriate to the individual's role. Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 2. Record review of Resident #1's face sheet dated 9/11/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included major depressive disorder (mental health condition characterized by a persistent and intense feeling of sadness or loss of interest in activities), pneumonia (infection of the lungs that causes the air sacs to become inflamed and fill with fluid or pus), chronic obstructive pulmonary disease (long-term progressive lung disease that makes it hard to breathe), respiratory failure (medical condition in which the lungs cannot provide enough oxygen to the blood, cannot remove enough carbon dioxide from the blood or both), acute bronchitis (short-term inflammation of the bronchial tubes caused by a viral respiratory infection), and tracheostomy status. Record review of Resident #1's most recent quarterly MDS assessment, dated 6/25/25 revealed the resident was cognitively intact for daily decision-making skills and required oxygen and tracheostomy care. Record review of (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Order Summary Report dated 9/10/25 revealed the following:- Change inner tracheostomy cannula every day shift, with order date 10/10/24 and no end date. Record review of Resident #1's comprehensive care plan dated 6/9/25 revealed the resident was at risk of respiratory distress and infection related to having a tracheostomy and interventions that included to perform tracheostomy care every shift as ordered per the physician. Record review of Resident #1's comprehensive care plan revealed the resident had a tracheostomy and required routine monitoring and suctioning to maintain airway patency, to prevent infection, and support adequate oxygenation with interventions that included to ensure privacy and dignity during all procedures. Observation on 9/11/25 at 9:55 a.m. revealed RN B left Resident #1's bedroom door open during tracheostomy care. Resident #1's bed was placed nearest the bedroom door against the wall. Residents and staff were observed walking in the hallway. During an interview on 9/11/25 at 10:16 a.m., RN B stated she was nervous when performing tracheostomy care to Resident #1 and forgot to close the bedroom door. RN B stated, leaving the bedroom door open was not a dignified thing to do and the door should have been closed to provide privacy. During an interview on 9/11/25 at 10:37 a.m., Resident #1 stated, when nursing provided tracheostomy care they usually closed the bedroom door to provide privacy. Resident #1 stated, I guess she (RN B) forgot (to close the bedroom door) but it did not bother him. Resident #1 stated, I guess RN B was nervous. During an interview on 9/11/25 at 3:13 p.m., the DON stated it was her expectation that staff provided privacy to the residents when providing care because it was the resident's right to dignity. Record review of the facility document titled Resident Rights, with revision date 6/10/25 revealed in part, .The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality. Personal privacy includes accommodations, medical treatment.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the residents had the right to formulate an advanced directive) for 1 (Resident #4) of 8 residents reviewed for right to formulate advance directive. 1. The facility failed to ensure Resident #4's OOH DNR was incomplete and not able to be used in emergency situations. This failure could affect any residents who have medical records and could result in misinformation about professional care provided. Findings included: 1. Record review of Resident #4's admission Record, dated [DATE], revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including hypo-osmolality (lower than normal concentration of solutes in the blood) and hyponatremia (low sodium levels), type 2 diabetes mellitus without complications, muscle wasting and atrophy (muscle loss), muscle weakness, wedge compression fracture of T7-T8 (thoracic region- part of the body surrounded by the ribs, located between the neck and the waist) vertebra (spinal injury where the front part of the vertebra collapses, creating a wedge-shaped deformity), subsequent encounter for fracture with routine healing, wedge compression fracture of first lumbar (lower back) vertebra, and wedge compression fracture of third lumbar vertebra. The admission record revealed the resident advance directive was a DNR. Record review of Resident #4's Medicare MDS assessment, dated [DATE], revealed the resident cognition was severely impaired for daily decision making. Record review of Resident #4's comprehensive care plan, initiated [DATE], revealed the resident and or RP/family had advanced directive of choice was to be DNR status, out of hospital DNR with interventions for social services to review residents advance directives and make changes to plan of care as requested by resident or RP. Record review of Resident #4's order summary, dated [DATE], revealed an order for DNR with a start date of [DATE], and no end date. Record review of Resident #4's OOH DNR revealed, the document was signed by the Resident's family member on [DATE]. The family member also signed on the bottom of the document. There was a notary seal stamp on the document from Indiana, [NAME] County. The notary signed the bottom of the DNR. There was no physicians signature, and the notary did not fill out the portion of the document above in the area for the witness or notary to print, date, and sign. Record review of a 2nd OOH DNR for Resident #4's revealed, the document was the same DNR document Resident #4's family member and an out of state notary signed on [DATE]. The document also contained a physician's signature dated [DATE]. The document contained two witness signatures, one from cook D and one from housekeeper E. The dates for the witness signatures were written over and were not legible. During an interview on [DATE] 3:19 p.m. the DON stated all resident's DNRs were in their EMR. The DON stated they did not have physical copies of the DNRs because medical records upload them all in the EMR. The DON stated Medical Records helped complete OOH DNRs and checked to make sure they were valid before she uploaded them into resident's medical record. During an interview on [DATE] at 9:11 a.m. The MDS coordinator stated she had worked for the facility for at least 2 1/2 years and during that time the facility did not have a SW. She stated she had helped with DNR paperwork, but the SW responsibilities were done collaboratively with the DON and the BOM. During an interview on [DATE] 12:20 p.m. CNA C/Medical Records stated she had recently been tasked with direct patient care and occasionally helped with medical records. CNA C stated she had assisted with completing DNR paperwork for residents in the past. CNA C stated she had no formal training on how to complete DNR paperwork and did not think it required a physician's signature to be valid. CNA C stated on the morning of [DATE] she went into the facility and was told by the DON that she had not filled out the DNR paperwork for Resident #4 correctly. CNA C stated normally the DON would review the DNRs before she uploaded them. CNA C stated she thought the DON reviewed Resident #4's OOH DNR paperwork before she uploaded it. CNA C stated if the DNR paperwork was not valid the resident would require life saving measures in an (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency. CNA C stated if the DNR was not filled out correctly it would not be valid, and they would not be honoring the residents wishes. During a follow-up interview on [DATE] at 12:30 p.m. the DON stated she noticed Resident #4's DNR paperwork was missing a physician's signature and had the DNR paperwork signed by a physician on [DATE]. The DON stated they had a physical copy of the DNR, and it was not in the EMR. The DON stated she would go get a copy of the DNR. During an observation and interview on [DATE] at 12:40 p.m. the ADON stated she was unsure where the DON was and would look for a copy of Resident #4's DNR. On the table where the DON had been sitting was a binder with all active resident's DNRs. The binder was open and Resident #4's DNR was removed from the binder. During a follow-up interview and observation on [DATE] at 2:25 p.m. the DON provided the 2nd copy of Resident #4's OOH DNR with witness signatures and a physician signature. The DON stated the 2nd copy had not been uploaded into the resident's record. During an interview on [DATE] at 2:44 p.m. Resident #4's family member stated they were the person who had obtained the OOH DNR paperwork from the facility. The family member stated they did not want Resident #4 to receive CPR due to her age, condition, and statute her bones would most likely break. The family member stated they lived in a different state. The family member stated sometime in June of 2025 the facility mailed them OOH DNR paperwork. The family member stated they took this paperwork to a local notary in their state and signed the OOH DNR. The family member stated they did not fill out the paperwork in front of [NAME] D or Housekeeper E. The family member stated they had not been to the facility since February of 2025. During a phone interview on [DATE] at 2:54 p.m. [NAME] D stated he does assist with DNR paperwork. When this surveyor asked how he assist with DNR paperwork the call was disconnected. During a follow-up phone interview on [DATE] at 3:01 p.m. [NAME] D stated he was in the emergency room, and the call was disconnected. [NAME] D stated he had witnessed Resident #4's family member sign the OOH DNR at the facility. Housekeeper E had no phone number available on the employee roster and was not scheduled to work the day interview attempted. Record review of the facility's policy titled Residents' Rights Regarding Treatment and Advance Directives, dated [DATE], stated Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives. Definitions: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to the staff. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Community Care Center of Hondo		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Ave E Hondo, TX 78861	
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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** Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 13 residents (Residents #1 and #19) reviewed for accuracy.1. The facility failed to ensure Resident #1's quarterly MDS assessment, dated 6/25/25 accurately reflected the resident's use of insulin.2. The facility failed to accurately document Resident #19's dental status on the resident's annual assessment dated [DATE].These failures could place residents at risk for inadequate care due to inaccurate assessments. The findings included: 1. Record review of Resident #1's face sheet dated 9/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included morbid obesity (extremely overweight), hyperlipidemia (abnormally high levels of fat in the blood), hypertension (high blood pressure), heart failure, and chronic kidney failure (long term condition in which the kidneys gradually lose their ability to filter waste products, toxins, and excess fluids from the blood). Record review of Resident #1's most current quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, and under Section N &ndash; Medications, N0300 Injections reflected the resident was given insulin injections. During an interview on 9/9/25 at 3:40 p.m. Resident #1 stated he did not take insulin. During an interview on 9/11/25 at 11:00 a.m., RN B stated she had worked for the facility for the past 3 years and was &ldquo;very&rdquo; familiar with Resident #1. RN B stated Resident #1 was not a diabetic and could not recall the resident ever receiving insulin while in the facility. During an interview on 9/11/25 at 1:44 p.m., the MDS Coordinator stated she had accidentally marked Resident #1 had received insulin on the quarterly MDS assessment dated [DATE]. The MDS Coordinator stated, Resident #1 was not treated with insulin and the error on the MDS assessment could affect reimbursement to the facility. The MDS Coordinator stated she followed the RAI to help develop the MDS. During an interview on 9/11/25 at 3:13 p.m., the DON stated the MDS assessment was important for reimbursement purposes and drives the care plan. The DON stated, an accurate MDS ensured the resident was getting the proper care. 2. Record review of Resident #19's face sheet revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: peripheral autonomic neuropathy (a condition that affects the nerves that control involuntary bodily functions, such as digestion, heart rate, sweating, and urination); vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain); anxiety disorder (excessive and persistent worry, fear, and nervousness that can interfere with daily functioning); cellulitis and abscess of mouth (an infection of the skin and underlying tissues and a localized collection of pus caused by bacteria); and dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). Record review of Resident #19's quarterly MDS assessment dated [DATE] revealed a BIMS score of 07/15, indicating severely impaired cognition. (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 19's annual MDS assessment dated [DATE] noted in Section L0200.B that the resident was not edentulous (no natural teeth). Record review of a dental exam note dated 10/11/2024 in Resident #19's electronic health record revealed an X mark in the box next to the number of every tooth, indicating the resident was missing all her natural teeth. Observation on 09/09/2025 at 2:42 PM of Resident #19's mouth revealed Resident #19 was edentulous. During an interview on 09/09/2025 at 2:43 PM, the MDS Coordinator stated Resident #19 was edentulous. During an interview on 09/11/2025 at 1:30 PM, the DON stated if Resident #19 had no natural teeth, her MDS should have indicated this status. During an interview on 09/11/2025 at 1:45 PM, the MDS LVN stated she incorrectly coded Resident #19's annual MDS because she mistakenly believed if a resident had a full set of dentures, the resident was not considered edentulous. The MDS LVN stated it was important to code the assessment correctly to ensure residents received the appropriate care for their conditions. Record review of the facility policy Conducting an Accurate Resident Assessment, revised 06/30/2025, revealed, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e., comprehensive, quarterly, significantly change in status). 6. The physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals, and preferences for 1 of 2 residents (Resident #1) reviewed for oxygen therapy:Resident #1's oxygen concentrator filter was covered in a thick white/gray substance.This failure could affect residents who received respiratory therapy and put them at risk for inadequate or inappropriate amounts of oxygen delivery. The findings included:Record review of Resident #1's face sheet dated 9/11/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included major depressive disorder (mental health condition characterized by a persistent and intense feeling of sadness or loss of interest in activities), pneumonia (infection of the lungs that causes the air sacs to become inflamed and fill with fluid or pus), chronic obstructive pulmonary disease (long-term progressive lung disease that makes it hard to breath), respiratory failure (medical condition in which the lungs cannot provide enough oxygen to the blood, cannot remove enough carbon dioxide from the blood or both), acute bronchitis (short-term inflammation of the bronchial tubes caused by a viral respiratory infection), and tracheostomy status.Record review of Resident #1's most recent quarterly MDS assessment, dated 6/25/25 revealed the resident was cognitively intact for daily decision-making skills and required oxygen and tracheostomy care.Record review of Resident #1's comprehensive care plan with revision date 8/19/25 revealed the resident required oxygen therapy related to hypoxemia via (medical condition where there is an abnormally low level of oxygen in the blood) nasal cannula and at times tracheostomy collar with interventions that included to administer oxygen as ordered, and change cannula or mask and tubing as per facility protocol and as needed.Record review of Resident #1's Order Summary Report dated 9/10/25 revealed the following:- Oxygen: Tubing and Humidifier Change every Sunday night every night shift related to pulmonary hypertension with order date 4/27/25 and no end date.During an observation and interview on 9/11/25 at 9:55 a.m. revealed during tracheostomy care, Resident #1's bedside oxygen concentrator was inspected with RN B. Observation of RN B removing the oxygen concentrator for inspection revealed the filter on the back of the concentrator was covered with a thick white/gray substance. RN B stated the filter on Resident #1's oxygen concentrator was filled with dust and was supposed to be cleaned once a week every Sunday by the night shift. RN B stated she did not routinely check the oxygen concentrator but did change the humidifier container when needed. RN B stated the filter on the oxygen concentrator should be clean because the dirty filter could impact the oxygen being used by the resident and could make them sick and become hypoxic (when the body does not get enough oxygen to meet its needs).During an interview on 9/11/25 at 10:37 a.m., Resident #1 stated the nurses checked the oxygen concentrator every Sunday, including the filter but was not sure if it was done the past Sunday (9/7/25).During an interview on 9/11/25 at 3:13 p.m., the DON stated the oxygen filters should be checked every week by the night shift at the same time the oxygen tubing was changed. The DON stated, if the oxygen filters were dirty, it could affect the quality of oxygen the resident was receiving and could result in an infection.A policy was requested for the maintenance of oxygen concentrators and filters on 9/11/25 at 3:13 p.m. but was not provided at the time of exit.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (A wing medication cart) and 1 of 2 medication (B wing) storage rooms reviewed for medication storage. 1. The facility failed to ensure Resident #1's metolazone (diuretic that treats fluid retention) had a change direction sticker placed on the package. 2. The facility failed to ensure the B wing emergency cart did not contain expired supplies. These deficient practice could place residents at risk of medication misuse and diversion.1. Record review of Resident #1's physician orders, dated [DATE], revealed an order for metolazone oral tablet 5 mg, give 1 tablet by mouth one time a day every Thursday related to heart failure, with an order date of [DATE], a start date of [DATE], and no end date.Observation and interview on [DATE] at 9:52 a.m. revealed Medication Aide G dispensed a 5mg tablet of metolazone with directions to give 1 tablet by mouth daily on Fridays. It was Thursday and MA G stated they must have just changed the order. MA G then took out a change of direction sticker and placed it on the medication package. MA G stated they should place a change of direction sticker on the medication to alert staff, the order had changed. MA G stated once the sticker was placed on the package, they would compare the MAR order and the package and know they were giving the medication on the correct date. During an interview on [DATE] at 3:20 p.m., the DON stated staff should place a change of direction sticker on a package with an order change. The DON stated nursing staff would have to communicate to the aides if there was a change in directions for a medication. The DON stated since the order was last changed in May of 2025 the pharmacy should have updated the directions on the package by then. The DON stated the resident could possibly miss a dose of the medication if there is no sticker to alert staff the order was changed. 2. During an observation on [DATE] at 11:08 a.m., revealed the B hallway emergency medical cart contained 2 non-rebreather masks (a type of breathing apparatus that includes soft plastic reservoir bag attached to it) with expiration dates of [DATE].During an interview on [DATE] at 11:20 a.m., the DON stated the night shift was responsible for checking the crash cart and removing/replacing expired supplies.Record review of the facility's policy titled Medication Storage, dated [DATE], documented Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevent and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 of 4 residents (Resident #21 and Resident #41) reviewed for infection control. The facility failed to ensure RN B wore gloves when picking up Resident #21's urostomy tube (surgical procedure that creates an opening, stoma, in the abdominal wall to divert urine away from the bladder and drains into a collection bag) off the floor. The facility failed to ensure RN B wore proper PPE while providing wound care to Resident #41. These deficient practices could place residents at risk for cross contamination and infection. The findings included: 1. Record review of Resident #21's face sheet dated 9/9/25 revealed a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included gross hematuria (visible blood in urine), chronic kidney disease stage 3 (moderate reduction in kidney function), diabetes (chronic medical condition in which the body either does not produce enough insulin or cannot effectively use the insulin it produces leading to elevated blood sugar levels), elevated white blood cell count (refers to the number of white blood cells in the blood is higher than the normal range usually caused from infection), and sepsis (the body's response to an infection that triggers widespread inflammation, leading to tissue damage, organ dysfunction, and potentially death). Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and had a urostomy. Record review of Resident #21's Order Summary Report dated 9/9/25 revealed the following:- Change urostomy bag and wafer every Thursday. Monitor stoma for irritation, signs and symptoms of infection, every day. Prefers [family member] to change, with order date 5/18/25 and no end date. Record review of Resident #21's comprehensive care plan initiated on 12/10/24 revealed the resident was at risk of developing and/or spreading infection related to urostomy and interventions that included to utilize enhanced barrier precautions as ordered. Resident #21's comprehensive care plan revealed the urostomy was used to divert urine related to incontinence after childbirth and interventions included to allow the resident's [family member] to change the bag and to provide ostomy care when preferred and to provide ostomy/catheter/diversion care as ordered or as needed. Observation on 9/9/25 at 10:24 a.m. revealed Resident #21 sitting up in a recliner and the urostomy tubing was on the left side of the resident attached to a urostomy bag which was placed inside of a bin. The resident's urostomy tubing was touching the floor. During an observation and interview on 9/10/25 at 4:18 p.m. revealed Resident #21 sitting up in a recliner and the urostomy tubing was on the left side of the resident attached to the urostomy bag that was placed inside of a bin. The resident's urostomy tubing was touching the floor. Resident #21 stated the CNA staff, or the nursing staff emptied the urine bag. During an observation and interview on 9/10/25 at 4:21 p.m., RN B confirmed the urostomy tubing touched the floor and should have been clipped to the resident's clothing to keep it off the floor. Resident #21 stated, CNA D placed the urostomy bag in the bin. RN B took the tubing from the floor and clipped it to the resident's gown without wearing gloves. RN B stated she should have been using gloves because the urostomy tube on the floor was considered cross contamination and because the floor was dirty, and it could also result in a tripping hazard. RN B stated, the urostomy tube touching the floor could cause germs to travel upward from the urostomy tube. RN B stated the use of gloves were to protect herself and the resident from infection. During an interview on 9/11/25 at 11:03 a.m., CNA D stated Resident #21 had a urostomy and the tubing attached to the drainage bag were not supposed to be touching the floor because it was considered an infection control issue and the tubing on the floor could also be considered a trip hazard. CNA D stated, if the urostomy tubing or the drainage bag were touching the floor it could results in the resident getting an infection because the floor was dirty. CNA D stated she made rounds of the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents at least every two hours and it was the responsibility of the nurse aides and the nurses to ensure the drainage bag and tubing were kept off the floor. During an interview on 9/11/25 at 2:46 p.m., the DON stated, Resident #21's urostomy tube should not be on the floor because it was cross contamination and an infection control problem. The DON stated, the urostomy tube touching the floor increased the resident's risk of infection. The DON stated, whichever staff assisted the resident into the recliner was responsible for ensuring the urostomy tube was clipped to the chair and the drainage bag placed in the bin, so it was off the floor. The DON stated, when staff touched the urostomy tube gloves should be worn to prevent cross contamination and to prevent the chance of encountering bodily fluids. The DON stated a resident with a urostomy did not require EBP. 2. Record review of Resident #41's face sheet dated 9/10/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included diabetes (chronic medical condition in which the body either does not produce enough insulin or cannot effectively use the insulin it produces leading to elevated blood sugar levels), lack of coordination, irritable bowel syndrome (chronic functional gastrointestinal disorder characterized by abdominal pain or discomfort that is associated with changes in bowel habits) with diarrhea, and dementia (general term for a decline in cognitive function severe enough to interfere with daily life and independence). Record review of Resident #41's quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and was at risk for developing pressure ulcers/injuries. Record review of Resident #41's Order Summary Report dated 9/11/25 revealed the following:- Weekly skin assessment on Monday due to wound care services every day shift for wound to left buttock, with order date 6/30/25 and no end date.-Wound to coccyx, cleanse area with normal saline or wound cleanser, pat dry, apply Collagen Powder followed by Medi-Honey to wound bed, cover with dry dressing every Monday, Wednesday, Friday day shift and at bedtime Tuesday, Thursday, Saturday (shower days) for pressure ulcer, with order date 8/11/25 and no end date. Record review of Resident #41's comprehensive care plan initiated on 8/12/25 revealed the resident was at risk for infection related to an open pressure injury to the coccyx and chronic illness with interventions that included to continue wound care services throughout the healing process, educate on infection prevention measures, follow facility infection control policy during dressing change, and maintain strict hand hygiene before and after wound care. Record review of Resident #41's Wound Evaluation and Management Summary document dated 9/8/25 revealed the resident had a Stage 3 pressure wound (full-thickness tissue loss) to the coccyx with moderate serous exudate (type of fluid that can come from a wound; is thin and watery in appearance). Record review of Resident #41's Weekly Skin Assessment/Review document dated 9/8/25 revealed the resident had a wound to the coccyx that had moderate serous drainage. During an interview on 9/10/25 at 1:54 p.m., the DON confirmed Resident #41 had a pressure wound to the buttock area that required daily treatment, and the wound was identified on 6/30/25. Observation on 9/11/25 at 2:11 p.m. revealed RN B performed wound care to Resident #41's wound to the coccyx but did not wear a gown. Resident #41's wound to the coccyx appeared clean and pink, with an opening the size of a quarter. RN B was observed leaning on the resident's bed and placed her forearms on the resident's mattress while obtaining the measurements to the wound. During an interview on 9/11/25 at 2:24 p.m., RN B stated Resident #41 was not on enhanced barrier precautions even though the resident had a wound. RN B stated a resident who had a urinary catheter would be on EBP because the use of an indwelling catheter was long term and more susceptible to infection, whereas as with Resident #41's wound there was less risk of infection because the wound itself was kept covered. During an interview on 9/11/25 at 2:51 p.m., the DON stated there was confusion about the rules for EBP and believed the use of PPE was for chronic infections. The DON stated, the nurse probably should have worn a gown because Resident #41 had an open wound. The DON stated, EBP was utilized to protect the staff and the residents from spread of infection. Record review of RN B's Nursing Orientation/Annual Skills/Competency Checklist dated 8/19/25 revealed she had satisfied the requirements for proper infection control practices including (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the use of PPE, and standard precautions. Record review of the facility document titled Infection Prevention and Control Program with revision date 4/2/25 revealed in part, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. All staff are responsible for following all policies and procedures related to the program. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. Record review of the facility document titled Enhanced Barrier Precautions with revision date 4/10/25 revealed in part, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers.). Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.		