STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455602	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Healthcare Residence	400 Old Sidney Rd Comanche, TX 76442

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure the facility assessment development and inform of staffing decisions, inform of specific staffing needs, and plan to maximize recruitment and retention of direct care staff for 1 of 1 facility to care for its residents.1.The facility failed to outline in their Facility Assessment the informed staffing decisions to ensure that there were enough staff with the appropriate competencies and skill sets. 2.The facility failed to outline in their Facility Assessment the specific staff needs for each resident unit in the facility, specific staffing needs for each shift and adjust as necessary.3.The facility failed to develop and maintain a plan to maximize recruitment and retention of direct care staff. These failures placed residents at risk of not having corporate oversite and insufficient staff with appropriate competencies and skill sets necessary to care for their resident's needs based on changes to its resident population.Findings Included:Record Review of the facility's document titled Facility Assessment, dated 01/05/2026, reflected on the assessment no evidence of facility resources needed to provide competent resident support and care daily and during emergencies, staff training/education and competencies, staff assignment needs, or a plan to maximize recruitment and retention of direct care staff. Further review reflected the facility assessment tool was reviewed by QAPI on 01/23/2026 with no governing body member present.Record review of the document titled Resident Matrix, dated 06/29/2026, reflected the facility had a census of 59 residents. Further review of the Facility Matrix reflected 17 residents had fallen, 3 residents had pressure ulcers, 3 residents had infections, and 1 resident who utilized an enteral tube (a tube that enters the body from the skin on the abdomen and ends in the stomach for nutrition and medication administration).During an interview on 06/29/2026 at 4:13 p.m., the ADMN stated it was her expectation for the Facility Assessment to have all areas that were required filled out. She stated she was responsible for filling out the Facility Assessment and had piggybacked off the Facility Assessment from the previous Administrator. She stated she was unaware the Facility Assessment needed information about the staffing decisions including how it arrived at the staffing needs and how the facility planned to retain their staff. She stated the governing body was available to her for questions, but they were not at the QAPI meeting when the Facility Assessment was discussed. She stated the facility management was always discussing staffing needs to care for the residents during morning meetings and she would come up to the facility during off hours when needed to see how the staff were doing. She did not feel any negative impact had occurred to the residents who resided in the facility from the Facility Assessment not having those items completed. She stated the facility did not have a policy regarding the Facility Assessment.

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