STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phillips County Retirement Center	1300 State Street Phillipsburg, KS 67661

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility identified a census of 29 residents with 12 residents included in the sample and three residents reviewed for accident hazards. Based on observation, interview and record review, the facility failed to provide resident centered analysis after falls and interventions aimed to prevent falls for Resident (R)3, who had multiple falls with incomplete investigations of the causal factors and implementation of interventions to prevent further falls.Findings included:- R3's Electronic Health Record (EHR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).R3's 10/07/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) could not be completed because the resident was rarely or never understood. Per staff assessment, R3 had memory problems and moderately impaired cognition. R3 had physical, verbal and other behavioral symptoms directed towards others that occurred one to three days during the look-back period. R3 rejected care and wandered one to three days during the look-back period. R3 had one non-injury fall and one fall with major injury since the last MDS.R3's 01/07/26 Quarterly MDS documented a BIMS interview could not be completed because the resident was rarely or never understood. Per staff interview, R3 had memory problems and moderately impaired cognition. R3 had physical, verbal and other behavioral symptoms directed towards others that occurred four to six days during the look-back period. R3 rejected care and wandered four to six days during the look-back period. R3 required partial/moderate assistance for sit-to-stand repositioning and transfers and substantial/maximal assistance for walking. R3 self-propelled in a wheelchair. The MDS documented R3 had two or more falls since the previous assessment.The 10/07/25 Cognitive Loss / Dementia Care Area Assessment (CAA) triggered for further development but was not completed.The 10/07/25 Falls CAA triggered for further development but was not completed.R3's Care Plan initiated on 05/16/24 and revised on 01/14/26, documented R3 was at risk for falls and noted the following interventions:Staff would anticipate and meet R3's needs. Staff would be sure R3's call light was within reach and encourage her to use it for assistance as needed. R3 required a prompt response to all requests for assistance. Staff would encourage R3 to participate in activities that promote exercise, physical activity for strengthening and improved mobility.Staff would ensure R3 wore appropriate footwear when ambulating or mobilizing in a wheelchair. Staff would follow the facility fall protocol. Staff would initiate fall risk precautions such as ensure adequate lighting in the resident's room and bathroom at night, ensure the call light was within reach, ensure shoes were on during the day, and slipper socks were on the resident at night, ensure bed brakes were locked, minimize clutter in the room, keep floor surfaces dry during transfers and ambulation, and keep environment the same as much as possible. R3's Care Plan dated 08/09/24, documented R3 had an actual fall and noted staff would continue interventions, currently care planner for R3's at risk status. It further revealed the following interventions.Staff would provide assistance with two staff, a gait belt, and a four-wheeled walker (FWW), initiated on 10/25/24 and revised on 01/15/25.Staff would perform 15-minute visual checks, initiated 11/21/24 and revised on (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 0689 Level of Harm - Actual harm Residents Affected - Few	01/15/25.Staff would ambulate R3 between 09:30 AM and 10:30 AM every day shift, initiated on 11/21/24.Staff would take R3 to the toilet right after evening meal, initiated on 12/12/24Staff would place R3 in a recliner in front of the commons area, initiated on 01/27/25Staff would place Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in R3's wheelchair, initiated 01/20/25.Staff were re-educated regarding agitated behaviors, initiated on 07/07/25 and revised on 01/26/25.Staff would place a green mattress on the floor against R3's bed, initiated on 08/11/25.Staff would replace R3's bed with a Hi-Low bed, initiated on 08/11/25 and revised on 01/26/26.Staff would walk away and ask a different staff member to assist R3 if she remained agitated after staff approached her, initiated and revised on 08/11/25.Staff were educated to be mindful of floor conditions when plumbers were working where R3 was, initiated on 09/24/25 and revised on 11/03/25.Staff would place grip strips on the floor on the side of the bed to assist the green mattress to stay where it should, initiated and revised on 01/15/26.Staff was re-educated on not leaving R3 alone when she was restless, initiated on 01/27/26.Staff would replace R3's mattress with a scoop mattress, initiated on 01/27/26.Staff were re-educated on the importance of checking on R3 according to her visual checks, initiated on 01/27/26 On 08/05/24 at 06:24 AM, a Post Fall Evaluation documented a noninjury fall at 06:45 AM. The facility's fall investigation report did not contain a root cause analysis (RCA) and Administrative Staff C documented on 08/05/24 an intervention for staff to place grip strips on the floor in front of both recliners.The facility was unable to provide fall investigations or interventions for falls dated 10/04/24, 11/01/24, and 12/23/24.The facility provided fall investigations for the following falls, however the facility investigations lacked casual factors of the falls and failed to implement interventions in a timely manner. The falls were dated as follows:10/03/24 at 03:30 PM with an intervention on 10/25/24 for staff to assist R3 with the use of a gait belt and walker, initiated 22 days after the fall.11/02/24 at 10:52 PM with an intervention on 11/21/24 for staff to assist R3 to the toilet after the evening meal, initiated 19 days after the fall.12/22/24 at 02:10 PM with an intervention on 01/09/25 to check R3 every 15 minutes, initiated 18 days after the fall.12/22/24 at 01:45 PM with intervention on 01/09/25 to place R3 in a recliner in the commons area and provide a different wheelchair.12/28/24 at 11:45 AM with an intervention on 01/09/25 to place R3 in a low bed. On 12/23/24 at 06:39 AM, a Post Fall Evaluation documented a noninjury fall at 06:40 AM. The facility did not provide a fall investigation.On 12/25/24 at 11:01 PM, a Communication - with Physician note documented R3 had increased pain to her pelvic area, right hip and lower back, and she walked with a mild limp. Staff documented there was no bruising or swelling to the pelvic area or shortening or rotation of either leg.R3's EHR, under the scanned documents tab, revealed an order dated 12/26/24 from R3's physician to obtain a pelvis and lumbar (lower back) spine x-rays. The document was signed off by an unknown staff member and Administrative Nurse D on 12/31/24.On 12/27/24 at 09:27 AM, a Nurse's Note documented the facility received a fax response, and it was sent to radiology (x-ray).On 12/27/24 at 10:59 AM, a Psychosocial Note documented R3 was transported to the hospital for x-rays accompanied by family.R3's EHR scanned documents dated 12/27/24 revealed radiology results for the pelvis x-ray exam performed on 12/27/24 at 11:16 AM, which documented a right greater trochanteric (hip) fracture. The document was signed by the radiologist on 12/24/24 at 11:30 PM. The document was signed by R3's physician on 12/30/24.On 12/27/24 at 12:47 PM, a Nurse's Note documented the facility received a telephone call from the hospital to inform them R3 needed to be sent to the Emergency Department (ED) due to a hip fracture. Staff informed R3's representative and transported R3 back to the hospital. Staff documented the reports indicated surgical intervention was likely needed and R3 had family members in the facility who would accompany staff and R3 to the ED.On 12/27/24 at 11:05 PM, a Nurse's Note documented R3 returned to the facility at 06:00 PM with instructions from the ED that the resident's hip fracture did not require surgical intervention and included instructions for R3 to utilize a walker/wheelchair for locomotion, take Tylenol (acetaminophen) as needed (PRN) for pain, and instruction to follow up with her physician in 10 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	days.On 12/28/24 at 01:44 PM, an Incident Note documented R3 had an unwitnessed fall in her room at approximately 11:45 AM and was assessed to have shortening and subluxation (rotation) of the right leg. R3 was unable to keep her leg straight and was transported to the ED for evaluation.On 12/28/24 at 02:16 PM, R3's EHR Nurse's Note documented the facility called the ED for a status update for R3 and was informed R3's fracture was worse, and the ED was working to transfer R3 to a different facility for additional treatment.On 12/28/24 at 05:17 PM, R3's EHR Nurse's Note documented the facility received a call from the ED and was notified R3 was transferred to a different hospital than originally planned because R3's fracture was complicated and further fractured and dislocated.On 12/31/24 at 01:42 PM, R3's EHR Nurse's Note documented R3 returned to the facility from the hospital in the facility van with assistance from two staff in a wheelchair. R3 had a surgical dressing on her right hip/thigh and knee with orders to monitor her daily for signs of infection and to keep the dressing intact.On 01/03/25 at 12:23 AM, the facility's fall report documented the resident had a fall with minor injury. The EHR progress notes did not contain an entry that documented the fall. The fall report did not contain a root cause analysis and Administrative Staff C documented on 01/09/25 an intervention was initiated to educate staff regarding the resident's skin integrity and transfer protocols.On 02/12/25 at 07:23 PM, R3's EHR Nurse's Note documented the resident had a fall with major injury at 05:10 PM. R3 was assisted to her wheelchair and transported back to her room, where she was assessed for injury, had left leg pain, and was identified with outward rotation. Facility staff contacted Emergency Medical Services (EMS) for transport to the ED for evaluation. The facility's fall investigation did not contain a root cause analysis and Administrative Staff C documented a 02/13/25 intervention for staff to know R3 was sent to the hospital for surgery and then would be released to swing bed (a type of hospital setting that allows persons to transition from hospital treatment to recovery). The care plan team would assess R3 upon return to the facility for any applicable interventions.Review of the Post Fall Evaluations revealed R3 also had falls on 07/10/25, 09/23/25, 10/25/25, 12/05/25, 12/14/25 and 01/08/26.On 03/09/26 at 10:40 AM, R3 rested in a recliner in the common area with her eyes closed.On 03/09/26 at 02:00 PM, R3 sat in her wheelchair and self-propelled herself in the common area with peers and staff present.On 03/10/26 at 06:24 AM, R3 rested in her bed with her eyes closed. Her bed was in the lowest position with the mattress beside the bed on the floor.On 03/10/26 at 11:02 AM, R3 rested in a recliner in the common area with her eyes closed.On 03/10/26 at 09:48 AM, Certified Medication Aide (CMA) R stated after a fall was over and the resident was taken care of, fall interventions were added by Administrative Staff C and Administrative Nurse D. CMA R stated some interventions were communicated to staff on the Treatment Administration Record (TAR) such as the 15-minute visual checks, or the interventions would be passed on in shift report for a couple of days. CMA R said she did not have access to the care plan in the EHR and could only look in the EHR at the TAR.On 03/10/25 at 09:51 AM, Licensed Nurse (LN) G stated fall reports were routed to Administrative Staff C, and interventions to implement to prevent additional falls were created by Administrative Staff C and Administrative Nurse D. LN G stated the nurses working the floor did not create any interventions to prevent falls and did not have access to the resident's care plan. LN G stated there was an intervention book kept in the nurses' station for each resident and stated that staff did not know what the interventions for falls were until Administrative Nurse D and Administrative Staff C let the staff know, and then passed it on in shift change report.On 03/10/26 at 10:01 AM, Certified Nurse Aide (CNA) M stated staff did not have access to the care plan book most of the time since it was stored in Administrative Staff C's office. CNA M stated that after a fall, when staff filled out the paperwork, they documented what they thought an intervention could be, but the decision was ultimately up to Administrative Nurse D and Administrative Staff C. CNA M stated CNA staff do not have access to the care plan in the EHR.On 03/10/26 at 10:12 AM, Administrative Nurse D stated staff would have a meeting and develop an intervention (to prevent further falls) until the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	maintenance, therapy, etc.) could meet and develop an intervention to be placed on the care plan in the EHR. After a fall, the facility's IDT team which was composed of Administrative Staff C, Administrative Nurse D and Consultant GG would hold a meeting and develop a care plan intervention. Administrative Nurse D stated Administrative Staff C was responsible to update the care plan and communicate any changes to staff, who would then transmit the information via shift change report. Administrative Nurse D stated the care delivered by the staff was driven by the care plan and was unsure of the licensure/certification of Administrative Staff C and that this process was in place prior to her being hired by the facility. Administrative Nurse D stated that she was currently in school and was not able to regularly hold or attend IDT meetings to discuss falls in the facility. Administrative Nurse D stated prior to 08/2025 when she started school, IDT meetings were held once per week, but currently they were held whenever possible due to work/school scheduling conflicts. Administrative Nurse D stated that after a fall, the IDT team should meet within 24 to 48 hours to investigate the fall and develop care plan interventions and communicate that with staff.On 03/10/26 at 12:45 PM, Administrative Staff C stated she was a CNA and was in charge of the care plan interventions with Administrative Nurse D related to falls with consultation with Consultant GG. Administrative Staff C said she was in charge of the care plans and she would generate the focus, and Administrative Nurse D would input the interventions to generate the cares. Administrative Staff C said she and Administrative Nurse D would perform the root cause analysis of a fall investigation. Administrative staff attempted to have an IDT meeting every morning when Administrative Nurse D was in the building, but a resident could go two to four weeks between the fall and an intervention being developed and added to the care plan. Administrative Staff C stated floor nurses had the ability to add interventions to the care plan, but not the authority to perform this action. Administrative Staff C said that staff knew what interventions to implement after Administrative Staff C and Administrative Nurse D figured it out and it was communicated to all the staff via shift report. Administrative Staff C said she had the ability and authority to make care plan revisions without the knowledge or approval of the DON. Administrative Staff C said that after a fall, an intervention log was generated and a copy was placed in the red intervention book in the nurses' station and also placed in the falls tab on the care plan. This list was discussed with Consultant GG when she came to visit. Administrative Staff C said fall reports were routed to her and she assessed the situation to determine an appropriate intervention.On 03/10/26 at 01:51 PM, Administrative Nurse D recognized the fall investigations were incomplete and/or missing and did not contain a root cause analysis of why the fall occurred. Further, Administrative Nurse D identified the notes documented on the last page of each fall investigation were the intervention that was developed and should have been added to the care plan. Administrative Nurse D stated she expected fall investigations to be completed and written in such a manner that the reader would be able to visualize what happened without going to the area where the fall occurred. Administrative Nurse D stated floor nurses had the authority to create care plan interventions, however she was unsure if floor nurses had the authority to create interventions on the care plan. Additionally, Administrative Nurse D stated the facility did not have a fall packet to prompt staff on duty on what to document and where to document in the EHR to correctly and completely document a fall.The facility's undated admission Fall Prevention Protocol policy documented that each resident in the facility would be provided services and care that ensured the environment remained as free from accident hazards as possible and that each resident received adequate supervision and assistive devices to prevent accidents.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility reported a census of 29 residents. Based on observation, interview and record review, the facility failed to have Registered Nurse (RN) coverage for at least eight continuous hours daily as required. Additionally, the facility failed to employ a full-time RN to serve in the role of Director of Nurses (DON). Findings included:- Observation of the daily staffing posting sheet in the facility on 03/09/26 at 08:00 AM, 03/10/26 at 09:00 AM and 03/11/26 at 10:00 AM revealed no RN hours documented. Review of the Payroll Based Journal Staffing Data Report for fiscal year (FY) Quarter 4 2025 (July 1 to September 30) documented no RN hours on the following dates:07/01 Tuesday (TU); 07/02 Wednesday (WE); 07/04 Friday (FR); 07/05 Saturday (SA); 07/06 Sunday (SU); 07/07 Monday (MO); 07/08 (TU); 07/09 (WE); 07/10 (TH); 07/11 (FR); 07/12 (SA); 07/13 (SU); 07/14 (MO); 07/15 (TU); 07/16 (WE); 07/17 (TH); 07/20 (SU); 07/21 (MO); 07/22 (TU); 07/23 (WE); 07/24 (TH); 07/25 (FR); 07/26 (SA); 07/27 (SU); 07/28 (MO); 07/29 (TU); 07/31 (TH) 08/01 (FR); 08/02 (SA); 08/03 (SU); 08/04 (MO); 08/05 (TU); 08/06 (WE); 08/07 (TH); 08/09 (SA); 08/10 (SU); 08/11 (MO); 08/14 (TH); 08/17 (SU); 08/18 (MO); 08/19 (TU); 08/20 (WE); 08/21 (TH); 08/22 (FR); 08/23 (SA); 08/24 (SU); 08/25 (MO); 08/26 (TU); 08/27 (WE); 08/28 (TH); 08/29 (FR); 08/30 (SA); 08/31 (SU) 09/01 (MO); 09/02 (TU); 09/03 (WE); 09/04 (TH); 09/07 (SU); 09/08 (MO); 09/09 (TU); 09/10 (WE); 09/14 (SU); 09/15 (MO); 09/16 (TU); 09/17 (WE); 09/18 (TH); 09/21 (SU); 09/22 (MO); 09/23 (TU); 09/24 (WE); 09/25 (TH); 09/28 (SU); 09/29 (MO); 09/30 (TU) On 03/09/26 at 02:34 PM, Administrative Staff A stated the facility has not had an RN to serve in the roll of DON since 2023. Administrative Staff A stated the facility does not provide any skilled services since those services are provided by the hospital next door. Administrative Staff A confirmed the PBJ report to be accurate for dates with no RN coverage and declined to review the dates with the survey team. Administrative Staff A reported that the Licensed Nurse (LN) currently serving in the role of DON is a Licensed Practical Nurse (LPN) and is in a RN program with estimated completion date of 05/2026. Administrative Staff A stated the facility was actively recruiting RN staff but has been unsuccessful. On 03/11/26 at 12:07 PM, Administrative Staff A provided a document Job Description - Director of Nursing that did not specify the incumbent of the role of DON was required to hold an active and unincumbered license as an RN. The facility's undated Registered Nurse policy documented the facility would employ the services of an RN for at least eight consecutive hours, seven days per week.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility identified a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility.Findings included:- Review of the Infection Control Log for tracking and trending infections from March 2025 through February 2026, lacked evidence of organism identification, duration of prescribed antibiotics, and the infections treated. The facility was unable to provide this upon request. On 03/10/26 at 10:39 AM, Administrative Nurse D confirmed she was also the facility's Infection Preventionist. She said she tracked who was taking an antibiotic in the Electronic Medical Record (EMR). She stated she was unable to provide tracking and trending for antibiotics. Administrative Nurse D stated the floor nurses would open the infection document for tracking, but the nurses would not fill out the form. She stated the only documents she had were the antibiotics the residents had taken for infections.The facility's Infection Preventionist policy undated, documented The Infection Preventionist is responsible for the effective direction, management and operation of the infection prevention program, including education of facility staff members and independent practitioners, and consulting with County and State Department of Health and Environment. The Infection Preventionist utilizes evidence-based practices such as those published by the Centers for Disease Control (CDC). Additionally, the Infection Preventionist ensures compliance with regulations and requirements from the Centers for Medicare and Medicaid Services (CMS) and other accrediting healthcare organizations and State regulatory agencies.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility identified a census of 29 residents. Based on record review and interviews, the facility failed to designate a staff member with the required qualification and certification as the Infection Preventionist, responsible for the facility's Infection Prevention and Control Program.Findings included: - During the entrance conference Administrative Staff A stated Administrative Nurse D was the Infection Preventionist for the facility. He stated she was a Licensed Nurse (LN) and had been continuing education for infection prevention.The facility provided documentation of continuing education topic for Enhanced Barrier Precautions (EHB) and how to implement a surveillance plan for antibiotic stewardship.On 03/10/26 at 10:36 AM, Administrative Nurse D stated she had been doing the Infection Preventionist duties for the facility. She stated she had been doing continuing education hours but did not have her certificate as an Infection Preventionist. Administrative Nurse D stated the facilities plan was for her to take the course and get her Infection Preventionist certificate.The facility's Administration of Antibiotic undated, documented antibiotics were essential treatments for serious infections and remain one of the most significant treatment options for control of microbials. The purpose of this policy is to provide guidance for staff on appropriate administration and follow-up of administration of antibiotics. Following the facility antibiotic stewardship policy, the facility and the practitioners ordering antibiotics would order antibiotic therapy only when indicated by laboratory testing and would be ordered for the shortest amount of time.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. The facility identified a census of 29 residents with 12 residents sampled. Based on interview and record review, the facility did not ensure completion of four residents comprehensive Minimum Data Set (MDS) assessments related to completion of the Care Area Assessments (CAA). Findings included:- R1's 09/28/25 Annual MDS triggered the following CAA areas, but were not completed:Activity of Daily Living (ADL) Functional / Rehabilitation PotentialUrinary Incontinence and Indwelling CatheterFallsNutritional StatusDehydration/Fluid MaintenanceDental CarePressure Ulcer/InjuryPsychotropic Drug Use R3's 10/07/25 Annual MDS triggered the following CAA areas, but were not completed:Cognitive Loss / DementiaCommunicationUrinary Incontinence and Indwelling CatheterBehavioral SymptomsFallsPressure Ulcer/InjuryPsychotropic Drug UsePain R4's 08/25/25 Annual MDS triggered the following CAA areas, but were not completed:Activity of Daily Living (ADL) Functional / Rehabilitation PotentialUrinary Incontinence and Indwelling CatheterNutritional StatusPressure Ulcer/InjuryPhysical RestraintsPain R20's 04/16/25 Annual MDS triggered the following CAA areas, but were not completed:Cognitive Loss / DementiaCommunicationUrinary Incontinence and Indwelling CatheterMood StateFallsNutritional StatusDental CarePressure Ulcer/InjuryPsychotropic Drug UsePain On 03/10/26 at 04:06 PM, Administrative Nurse D acknowledged the above findings and stated the CAA should be filled out to more accurately trigger care plan interventions. Administrative Nurse D said she was still learning how to complete MDS assessments and missed the CAAs on the residents listed. Additionally, Administrative Nurse D stated she expected MDS assessments to accurately reflect each resident's status. The facility's undated Minimum Data Set (MDS) Accuracy Audits policy documented the facility was committed to ensuring the accuracy, timeliness and completeness of all MDS assessments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. The facility identified a census of 29 residents, with 12 residents sampled. Based on interview and record review, the facility did not ensure accurate completion of five residents' Minimum Data Set (MDS) assessments related to the utilization of bedrails as restraints. Findings included:- R2's 01/20/25 Quarterly MDS documented bed rails were utilized as physical restraints daily during the look-back period. R4's 11/25/25 Quarterly MDS documented bed rails were utilized as physical restraints daily during the look-back period. R10's 01/16/26 Quarterly MDS documented bed rails were utilized as physical restraints daily during the look-back period. R11's 02/15/26 Quarterly MDS documented bed rails were utilized as physical restraints daily during the look-back period. R24's 12/20/25 Quarterly MDS documented bed rails were utilized as physical restraints daily during the look-back period. On 03/10/26 at 04:06 PM, Administrative Nurse D confirmed she had indicated bed rails as restraints on the MDS assessments of residents in the facility whose beds had bed rails installed on them, regardless of whether or not the resident used them. Administrative Nurse D confirmed the bed rails did not restrict the above-mentioned residents mobility and therefore did not meet the definition of a restraint. Administrative Nurse D stated she expected MDS assessments to accurately reflect each resident's status. The facility's undated Minimum Data Set (MDS) Accuracy Audits policy documented the facility was committed to ensuring the accuracy, timeliness and completeness of all MDS assessments.

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	17E658	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Phillips County Retirement Center	1300 State Street Phillipsburg, KS 67661

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. The facility reported a census of 29 residents, with one medication room, three medication carts, and one treatment cart. Based on observation, interview, and record review, the facility failed to ensure safe and secure medication storage for unauthorized staff and residents when licensed nursing staff left a medication cart unlocked and unsupervised. Findings included:- During an observation on 03/09/26, at 02:08 PM, Licensed Nurse (LN) H approached a medication cart parked directly outside of the nurse's station. She prepared medications in a small cup, locked her computer screen, and walked away from the medication cart that remained unlocked. LN H then walked down the hall into a resident's room, leaving the unlocked medication cart unattended by staff. The medication cart's lock remained outward, indicating the lock was not engaged, which left the cart accessible to anyone who attempted to access it. When the LN returned to the cart, she logged into her computer, prepared medications for another resident, locked her monitor screen and after closing the medication drawer she walked down the same hall into another resident's room and out of visual range. The medication cart remained unlocked and unsupervised during this time. When LN H returned to the medication cart, she logged back into her computer and noted her medication cart remained locked at this time. During an interview with LN H at 02:15 PM, on 03/09/26, she verified the medication cart and computer monitor should be locked every time it is left unattended. An interview with Administrative Nurse D on 03/11/26 at 12:46 PM revealed she expected staff to lock the medication cart before walking away. The Medication Labeling and Storage policy, dated 06/05/24, states all medications must be stored in a secure, locked location, accessible only to designated staff.

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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. The facility identified a census of 29 residents. The facility identified two residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure Resident (R)1's continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and R9, R7, and R6's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) masks were stored in a sanitary manner when not in use. The facility failed to ensure staff were wearing proper personal protective equipment (PPE) for EBP when doing direct care. The facility failed to transport dirty laundry using acceptable infection control practices. Findings included:- On 03/09/26 at 07:48 AM, during the initial walk-through of the facility, R1's CPAP mask laid directly on her bedside table. R1's CPAP mask was not stored in a sanitary container. R9's nebulizer mask laid on her bedside tablet. R9's nebulizer mask was not stored in a sanitary container.R7's nebulizer mask laid on her bedside table. R7's nebulizer mask was not stored in a sanitary container.R6's nebulizer mask hung over her side table and laid in her magazine rack. R6's nebulizer mask was not stored in a sanitary container.On 03/09/26 at 08:12 AM, Certified Nurses Aide (CNA) M carried unbagged dirty laundry from the bottom of Hall 2 holding the dirty clothing next to their uniform. CNA M was carrying the dirty laundry to a dirty laundry barrel in the middle Of Hall 2.On 03/10/26 at 07:36 AM, CNA 0 held a graduated cylinder (cylindrical vessel made of transparent plastic or glass, marked with precise, horizontal lines to measure liquid volumes), that contained dark amber colored urine. CNA 0 was wearing gloves only. CNA O was not wearing appropriate PPE for a resident with a urinary catheter.On 03/10/26 at 07:44 AM, CNA O stated she should have been wearing the proper PPE for EBP. CNA 0 stated all CNAs were trained on EBP. She stated there was a sign on the door to inform staff of the proper PPE to wear when taking care of residents with urinary catheters.On 03/11/26 at 09:55 AM, Licensed Nurse (LN) H stated all respiratory equipment should be rinsed and laid to dry, and the equipment should be covered while drying. LN H stated the equipment should be placed in a marked bag when not in use. She stated all staff were trained on proper PPE to wear when doing resident personal care for residents on EBP. She stated a gown and gloves should be worn when doing personal cares with a resident who had a urinary catheter.On 01/10/26 at 12:49 AM, Administrative Nurse D stated all respiratory equipment that was not in use should be placed in a bag labeled with the resident's name and date. She stated she expected staff to place respiratory equipment in a bag when the equipment was not in use. Administrative Nurse D stated all staff were trained on EHB precautions, each staff know when PPE was required when doing cares for residents. She stated staff should never carry dirty laundry next to their clothing; staff were to move the laundry tub next to the resident's door.The facility's Respiratory Care policy undated, documented the facility was committed to providing high-quality respiratory care to residents in accordance with evidence-based best practices, regulatory requirements, and physician orders. Nursing staff are responsible for ensuring proper assessment, intervention and monitoring of residents with respiratory conditions, whether acute or chronic. The purpose of this policy is to establish guidelines for the assessment, management, and monitoring of residents with any respiratory condition to ensure optimal respiratory function, prevent complications, and promote overall resident well-being. This policy applies to all nursing staff, respiratory therapists, physicians, and other healthcare professionals involved in the care of residents with respiratory conditions.The facility's Laundry Protocols policy undated, documented it was the policy of this facility to prevent the spread of infection by appropriate separation, collection, laundry and storage of laundry. Facility staff will handle, store, process, and transport linens in a method to prevent the spread of infectionThe facility was unable to provide a policy for EHB as requested on 03/11/26.

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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** The facility identified a census of 29 residents. The sample included 12 residents, with one resident reviewed for dignity. Based on observation and interviews, the facility failed to ensure dependent Resident (R)20 was clothed appropriately when sitting in the TV area with her peers.Findings Included:- R20's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), pain, major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (condition with disordered or absent language function), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R20 was dependent on staff for all activities for daily living (ADLs). R20's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) lacked analysis.R20's Care Plan dated 03/19/22 documented R20 was at risk for impaired communication and directed staff to allow adequate time for R20 to respond and to provide clear instructions while doing care.On 03/09/26 at 10:37 AM R20 sat in her Broda (special wheelchair with the ability to tilt and recline) chair in the TV room. R20 wore a green hospital gown and had a white sheet over her lap. R20 was moving her hands in an up and down motion and raised her sheet and gown. R20's white incontinence brief was visible to the two male peers who sat in the TV room with her.On 03/11/26 at 10:04 AM, Certified Nurse's Aide (CNA) O stated R20 should be dressed or completely covered. She stated residents should not be exposed to other residents.On 03/11/26 at 09:54 AM, Licensed Nurses (LN) H stated residents should not be in the TV room wearing only a gown and sheet. She stated residents should be left in their rooms until the bath aide was ready for them.On 03/10/26 at 12:49 PM, Administrative Nurse D stated the facility protocol was for residents to be dressed and groomed before leaving their room. She stated she expected residents to be fully dressed when out in the TV area and said their incontinence brief should never be exposed.The facility's Residents Rights Policy undated documented each resident residing in this facility had the right and would be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility without interference, coercion, discrimination or reprisal. No staff member or contracted provider of care would hamper, compel, treat differently or retaliate against a resident for exercising Resident Rights. It was the responsibility of all who work in this facility, including employees of the facility and any others who provided services to the residents of the facility, to advocate and protect the rights of each resident. All staff members are trained in this Resident Right Policy at the time of employment, prior to providing care to residents, and at least annually to ensure full understanding and competency related to ensuring each resident's Resident Rights. Each resident would have the opportunity to exercise his/her rights as a citizen, or a resident of the United States and staff members will assist with exercise of those rights as needed by any/all residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 29 residents. The sample included 12 residents, with five residents reviewed for unnecessary medication. Based on record review and interviews, the facility failed to ensure Resident (R)21's as-needed lorazepam (antianxiety medications that calm and relax people) cream had a 14-day stop date, or a specified duration with a physician's rationale for extended use.Findings included:- R21's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (elevated blood pressure), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin),R21's Quarterly Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R21 needed substantial/maximal assistance for all activities of daily living except eating. The MDS documented R21 received an antidepressant (a class of medications used to treat mood disorder), hypnotic (a class of medications used to induce sleep), and an antianxiety medication during the observation period.R21's Psychotropic Use Care Area Assessment (CAA) dated 09/28/25 documented R21 had no adverse reactions noted related to her antidepressant treatment.R21's Care Plan documented:03/05/25 R21 would be free from medication side effects.03/05/25 Consult Pharmacist was to review R21's medication.03/05/25 R21 would be free from symptoms and side effects related to Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). Education would be provided to durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) and R21.R21's EMR under Orders documented the following physician's order:Lorazepam cream 0.5 milligrams (mg), apply every eight hours and as needed related to dementia. The order lacked a 14-day stop date or specified duration,R21's EMR lacked a physician's rationale for the extended use of as needed lorazepam.On 03/11/26 at 09:54 AM, License Nurse (LN)H stated the nurse taking the order should inform the physician the medication required a stop date. She stated the Director of Nursing was the second check for all orders.On 03/10/26 at 12:49 PM, Administrative Nurse D stated the facility's policy was to follow the regulations for as needed psychotropic medication. She stated all nurses taking orders would let the physician know as needed lorazepam required a stop date.The facility did not provide an unnecessary psychotropic drug policy as requested on 03/11/26.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	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. The facility identified a census of 29 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to conduct a thorough facility wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. Findings included:- On 03/09/26 at 10:45 AM, Administrative Staff A provided an undated Long-Term Care Self-Assessment.Review of the assessment revealed the following:The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends.The assessment failed to fully document the condition reports of the residents in the facility or document any potential extenuating circumstances that would make the condition report unusual.The assessment failed to document staff competencies and skill sets necessary to provide the level and types of care needed for specific resident populations.The assessment failed to fully document contractual agreements to outside providers for services available to residents in the facility for laboratory, radiology, therapy, hospital or transportation. Additionally, the facility failed to document contracts for lawn care and/or snow removal. On 03/11/26 at 09:11 AM, Administrative Staff A stated he reviewed the assessment annually and this was last performed on 10/23/25. Administrative Staff A reviewed the assessment and stated the facility does not have a vision or mission statement. He said he was unaware that the orange boxes on the assessment should be filled in per the assessment's instructions. Administrative Staff A stated staffing breakdown per unit should be completed and confirmed the assessment did not contain this information. Administrative Staff A confirmed the competencies that were unchecked indicated the listed staff were not responsible for the competency after he observed Safety and Missing Resident for All Staff were unchecked. Administrative Staff A stated he expected the facility assessment to be accurate. The facility's Facility Assessment Policy documented the assessment is the foundation to determine staffing levels and competencies and the facility would evaluate the resident population and identify the resources needed to provide the necessary care and services the residents require on an annual basis and any time significant changes are made to the care or service provided by the facility. The purpose included to consider specific staffing needs for each shift and adjust as necessary based on the resident population. The assessment would address the care required by the resident population as well as the staff competencies and skill sets necessary to provide the level and types of care required. The assessment would also address the facility's resources such as equipment, services provided, contracts and personnel (including education and/or training and competencies related to resident care). The assessment would include evaluations of any contracts or understandings that included third party agreements to provide goods, services and equipment to the facility during normal operations and emergencies.