STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175470	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quaker Hill Manor	8675 SE 72nd Terrace Baxter Springs, KS 66713

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 47 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility, and to prevent the potential for food borne bacteria in one of one kitchen. Findings included: - During an initial tour of the resident kitchenette, on 12/02/25 at 09:37 AM, the following areas of concern were noted in the facility kitchen:1. The vent on the front of the ice machine had a build-up of dust and debris.2. A cart holding clean, plastic trays for serving residents' food contained food debris.3. Eight plastic containers holding cold cereal had a sticky, dusty substance on the lids.4. Two large, white, rolling plastic containers containing sugar and potatoes had a sticky, dusty substance on the lids.5. Four reach-in freezer doors had dried-on food. The handles of the reach-in freezers had a build-up of food debris and a sticky substance.6. An electric blender base had a thick, dried-on food substance.On 12/03/25 at 08:51 AM, Dietary Staff BB confirmed the above areas of concern needed to be addressed.The facility's kitchen cleaning schedule documented counters and carts would be cleaned daily, and the ice machine, refrigerators, and freezers would be cleaned weekly.

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 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 reported a census of 47 residents with 12 residents sampled, including one resident reviewed for dignity. Based on observation, interview and record review, the facility failed to show respect and dignity to one Resident (R)30, when the resident sat with her bare legs, including her upper thighs, exposed. Findings included:- R30's Electronic Medical Record (EMR) revealed a diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R30's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She had limited range of motion (ROM) on one side of her upper and lower extremities (UE/LE) and was dependent on staff for lower body dressing. The Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 10/02/25, documented the resident required assistance from staff for activities of daily living (ADLs). R30's Quarterly MDS, dated [DATE], documented a BIMS score of 14, indicating intact cognition. She did not have any limitation in ROM and required substantial to maximal staff assistance with lower body dressing. R30's ADL Care Plan, revised 11/07/25, instructed staff the resident was dependent on staff for lower body dressing. R30's EMR under the Tasks tab, dated 11/03/25 through 12/01/25, revealed the resident required partial/moderate to dependent staff assistance for lower body dressing. On 12/01/25 at 10:03 AM, the resident sat in her room, with the door open, in her wheelchair. Her gown and blanket were pulled up to her waist, exposing her legs from her upper thighs to her feet. The resident was visible to any staff, visitors, or other residents in the hallway. On 12/02/25 at 09:15 AM, the resident sat in her room, with the door open, in her wheelchair. Her gown and blanket were pulled up to her waist, exposing her legs from her upper thighs to her feet. The resident was visible to any staff, visitors, or other residents in the hallway. On 12/01/25 at 10:03 AM, the resident stated she was unable to cover her legs with the blanket in her lap. On 12/03/25 at 09:40 AM, Certified Nurse Aide (CNA) N stated the resident was able to cover her legs with the blanket on her own, but at times would leave her legs uncovered. On 12/03/25 at 10:30 PM, Administrative Nurse D stated it was the expectation for staff to ensure residents were covered appropriately to ensure their dignity. The facility policy Resident Rights, implemented 01/01/25, included: The facility shall ensure all residents are treated with dignity, respect, and consideration.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 47 residents; the sample included 12 residents including two residents reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R)15 and R1, and/or their representative, a written notification explaining the purpose of the discharge.Findings included:-R15's Electronic Medical Record (EMR) documented a diagnosis of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). R15's admission Minimal Data Set (MDS), dated [DATE], documented the resident admitted to the facility from a short-term, acute hospital on [DATE]. He had a Brief Mental Status (BIMS) score of 15, indicating intact cognition. R15's Discharge MDS, dated [DATE], documented the resident discharged from the facility to a short-term, acute hospital on [DATE]. His BIMS was not assessed. R15's EMR lacked documentation of a written notification with the explanation of the purpose for the resident's transfer to the hospital. On 12/03/25 at 11:37 AM, Administrative Staff A stated that written notification of R15's emergency transport to the hospital had not been completed, as required. The facility policy for Emergency Transfer Notification Policy, dated 09/18, included: The resident and the resident representative shall be notified of hospital transfer in writing by the facility as soon as is practicable. - R1's Electronic Medical Record (EMR) revealed a diagnosis of lung cancer, respiratory failure, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R1's Nurse Note dated 11/20/25 at 02:16 AM documented R1was sitting on the side of the bed, wavering forward. R1's oxygen level was 79 percent (%) after breathing treatments were provided. R1 agreed to go to the hospital. The ambulance arrived and transported R1 to the hospital. R1's EMR lacked documentation of a written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital. On 12/03/2025 at 10:55 AM, Social Services X stated that she was the person who went over the bed hold with the resident's representative. Social Services X said she was unaware of the regulation to notify the resident in writing and notify the ombudsman. On 12/03/2025 at 11:07 AM, Administrative Nurse D said she was unaware of the regulation to notify the resident's representative in writing of a discharge or transfer, and the facility had not been notifying the ombudsman. On 12/03/2025 at 11:07 AM, Consultant HH stated that there needed to be a written notification of transfer to the resident and/or his representative, and that usually the social service designee sent this. The facility's undated Emergency Transfer Notification Policy documented that the resident and representative will be notified of transfer in writing by the SSD as soon as is practicable.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility identified a census of 47 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to revise Resident (R) 1's Care Plan with the interventions to address a diagnosis of cancer or the cancerous lesions.Findings Included:- R1's Electronic Medical Record (EMR) revealed the following diagnoses of lung cancer, respiratory failure, and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).R1's 10/09/2025 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R1 had dressing treatments. R1 had a diagnosis of cancer.R1's Care Plan dated 04/23/18 documented R1 was at risk for skin breakdown and documented that the nurse monitored skin daily and completed a monthly skin assessment. R1's Care Plan lacked documentation of cancerous skin lesions or lung cancer.R1's Physician's Orders documented an order to cleanse a wound to the thigh with Vashe (prescription wound cleanser), apply calcium alginate (highly absorbent dressing), then 4x4, cover with Xeroform (sterile non-adhering fine mesh gauze treated with a bacteriostatic agent), and apply ABD pad (large pad to absorb drainage). Wrap with ACE wrap. Change daily and as needed. Ordered 12/01/25.R1's telephone check-up on 09/03/25 with the pulmonologist (lung doctor) documented a diagnosis of squamous cell carcinoma (cancer) in R1's right lung.R1's Wound Care Plus Progress Note dated 10/23/25 documented the wound was six centimeters (cm) by 6.7cm. R1 went to an oncology appointment the previous day and was told the wound was cancerous.R1's Physician Progress Note dated 11/06/25 documented to start chemotherapy as soon as possible.R1's Physician Progress Note, dated 11/13/25, documented a port was placed. Keep the area clean and dry and watch for signs of infection. R1 was to carry a card at all times.R1's Physician Progress Note dated 11/18/25 documented metastatic squamous cell carcinoma (a type of advanced cancer where squamous cells-which are flat cells on the surface of the skin-have spread from their original location to other parts of the body) with ongoing bleeding from the left thigh, and severe anemia. Start Keytruda (an immunotherapy drug that works by blocking a protein, preventing cancer cells from hiding from the immune system, thereby empowering your body's T-cells to attack the cancer).R1's Nurses Note dated 11/29/2025 at 02:54 PM documented a dressing change to R1's left thigh with a copious amount of blood noted.On 12/01/2025 at 12:09 PM, R1 sat on her bed and stated she had cancer and she had a big cancer lesion on her left thigh. R1 reported she was going to have radiation on it.On 12/02/2025 at 8:53 AM, Licensed Nurse (LN) H stated she was going to dress the wound on R1's thigh, but she was waiting for another staff member to help due to the bleeding. During the dressing change, pressure was applied to keep the bleeding down.On 12/03/2025 at 10:52 AM, LN G stated that the MDS nurse updates the care plans.On 12/03/2025 at 11:07 AM, Administrative Nurse D stated that the wound and the cancer should have been documented in the care plan but were not documented in the care plan.The facility policy Care Plan Revisions Upon status Change, dated 01/01/25, documented the resident's care plan would be modified as needed.

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	175470	A. Building B. Wing	12/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 47 residents; there were 12 residents sampled, including one resident reviewed for activities of daily living (ADL). Based on observation, interview and record review, the facility failed to provide oral care for Resident (R)30, who was dependent on staff for oral hygiene.Findings included: - R30's Electronic Medical Record (EMR) revealed a diagnosis of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).R30's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She required setup and clean-up assistance with oral hygiene.The Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 10/02/25, documented the resident required assistance from staff for her ADLs.R30's Quarterly MDS, dated [DATE], documented a BIMS score of 14, indicating intact cognition. She required setup and clean-up assistance with oral hygiene.R30's ADL Care Plan, revised 11/07/25, instructed staff the resident was dependent on staff for oral hygiene.Review of R30's EMR under the Tasks tab, dated 11/03/25 through 12/01/25, revealed the resident required independent to dependent staff assistance with oral care.On 12/01/25 at 10:03 AM, the resident had dried-on food debris around her mouth. Her toothbrush and sink in her bathroom were dry.On 12/02/25 at 09:15 AM, the resident had dried-on food debris around her mouth. Her toothbrush and sink in her bathroom were dry.On 12/01/25 at 10:03 AM, the resident stated she was unable to brush her teeth on her own, and the staff did not assist her. She would like to have her teeth brushed every morning and before bed.On 12/02/25 at 09:17 AM, Consultant Staff GG stated the resident required staff assistance with oral hygiene.On 12/03/25 at 09:40 AM, Certified Nurse Aide (CNA) N stated the resident was able to brush her teeth on her own. CNA N confirmed she did not offer to brush the resident's teeth as part of her morning cares.On 12/03/25 at 10:30 PM, Administrative Nurse D stated it was the expectation for staff to assist residents with oral care when needed.The facility policy for Activities of Daily Living (ADL), implemented 01/01/25, included: Staff shall provide the necessary services to maintain oral hygiene for a resident who was unable to carry out ADLs independently.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 47 residents, with 12 residents sampled, including one resident reviewed for non-pressure skin issues, and one resident reviewed for constipation. Based on record review, interview and observation, the facility failed to monitor skin issues for Resident (R)30 and failed to administer as needed (PRN) medication and assess for constipation for R19.Findings included:- R30's Electronic Medical Record (EMR) revealed a diagnosis of cerebral infarction (CVA - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R30's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She was dependent on staff assistance with transfers. The Activity of Daily Living (ADL)/Functional Abilities Care Area Assessment (CAA), dated 10/02/25, documented the resident required assistance from staff for her ADLs. R30's Quarterly MDS, dated [DATE], documented a BIMS score of 14, indicating intact cognition. She required substantial/maximal staff assistance with transfers. R30's ADL Care Plan, revised 11/07/25, instructed staff the resident was dependent on staff for transfers and had a limited range of motion (ROM) on one side of her upper and lower extremities due to a history of a CVA. R30's EMR, dated 11/18/25, revealed documentation of a skin tear to the resident's left hand, measuring 1.0 X 0.1 centimeters (cm). The documentation lacked an explanation of which measurement was for the length (L) or the width (W) of the wound. The wound had minimal serosanguineous (semi-thick blood-tinged drainage) drainage. Staff were to cleanse the area with wound cleanser and apply a bordered gauze dressing. The resident reported no pain with the wound. R30's EMR, undated, revealed documentation of a skin tear to the resident's left hand, measuring 4.0 X 1.5 cm. The documentation lacked an explanation of which measurement was for the L or the W of the wound. The wound had minimal serosanguineous (semi-thick blood-tinged drainage) and serous (thin, clear) drainage. Staff were to cleanse the area with wound cleanser and apply a bordered gauze dressing. The resident reported no pain with the wound. R30's EMR lacked any further documentation of the wounds. On 12/01/25 at 10:03 AM, the resident had bandages, dated 12/01/25, on her left hand and forearm. On 12/01/25 at 10:03 AM, the resident stated she obtained skin tears to her left hand and wrist during transfers on two separate occasions. On 12/03/25 at 09:40 AM, Certified Nurse Aide (CNA) N stated the resident obtained skin tears to her left hand and wrist during transfers. On 12/02/25 at 11:09 AM, Licensed Nurse (LN) G stated that when a resident had a skin issue, staff would change the dressing, as ordered, and document the wound's appearance on a wound (continued on next page)

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	175470	A. Building B. Wing	12/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment; if the wound was worsening, the facility would notify the resident's physician. On 12/02/25 at 01:18 PM, Administrative Nurse D stated the resident's left arm was completely flaccid due to a CVA. The skin tears occurred when staff transferred the resident from her wheelchair with a full-body lift, and her arm became caught between her body and the arm of the wheelchair. Administrative Nurse D confirmed documentation lacked weekly documentation of the wound's appearance, as required. The facility policy for Skin Tears, implemented 01/01/25, included: The facility shall utilize a systematic approach for the prevention and management of skin tears, including assessment, monitoring, and modification of interventions as appropriate. - R19's Electronic Medical Records (EMR) documented diagnoses, which included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R19's 10/07/25 Significant Change Minimum Data Set (MDS) documented R19 was rarely understood and had memory problems. The MDS noted R19 was frequently incontinent of bladder, but always continent of bowels. R1 did not have a toileting program, and/or constipation. R19's Care Plan dated 05/29/24, documented R19 was at risk for constipation related to medication use and directed staff to monitor and document bowel movements every shift. If R19 had no bowel movement in three days, the nurse was to perform a bowel assessment and initiate the bowel movement protocol. R19's Physician Orders in the EMR documented an order for Fleet Oil Enema rectally every 24 hours as needed for constipation, ordered 09/13/25. Review of R19's bowel movement frequency under the Tasks in the EMR dated 11/04/25 through 12/03/25 revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 11/21/25 at 11:57 AM through 11/29/25 at 12:15 PM (eight consecutive days) with no medication given for constipation and no assessment documented. On 12/03/25 at 11:07 AM, Administrative Nurse D said the nurse monitored the residents for bowel movements. The nurse follows the standing orders for the bowel movement protocol. If there is no bowel movement, the nurse assesses the resident. Administrative Nurse D said if the resident does not have kidney impairment, the nurse proceeds with medications, and assessments would be completed and documented. The facility's Constipation Management Policy documents that the facility will monitor bowel patterns daily and intervene promptly when abnormalities are noted. No bowel movements for 72 hours trigger an assessment and intervention per the standing orders.

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	175470	A. Building B. Wing	12/03/2025

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F 0689 Level of Harm - Minimal harm or potential for 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 reported a census of 47 residents; the sample included 12 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure Resident(R) 4's call light remained in reach to prevent falls for R4. The facility further failed to ensure R45 had wheelchair pedals when staff propelled him in the wheelchair. Findings included:- R4's Electronic Medical Records (EMR) documented the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R4's 09/23/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. R4 had no falls in the previous quarter.R4's 09/23/25 Falls Care Area Assessment (CAA) documented R4 had a history of falls prior to admission, used medications that may affect his level of alertness, and had weakness. R4 had a defect with balance, gait, strength, and endurance. R4's risk factors included falls and a potential for major or minor injuries related to falls.R4's Care Plan dated 10/30/19 documented R4 was at risk for falls related to having a catheter (a tube inserted into the bladder to drain urine), weakness, and decreased safety awareness. On 12/10/23, staff applied pink tape to R4's call light for a visual cue. An intervention dated 10/30/24 directed staff to encourage R4 to use the call light for assistance.On 12/01/2025 at 09:19 AM, observation revealed R4 laid in bed. There was a floor mat on the floor by his bed. The call light was on the floor along the wall at the head of the bed. There was a sign across the room on his wardrobe that read, Call us for help [R4].On 12/01/2025 at 10:03 AM, the call light remained on the floor.On 12/02/2025 at 8:57 AM, R4 was in bed, and the call light remained on the floor.On 12/02/2025 at 11:34 AM, R4 remained in bed with his call light on the floor. Certified Medication Aide (CMA) and Certified Nurse Aide (CNA) O entered the room and encouraged R4 to get up for lunch. R4 refused to get up but agreed to be changed. CMA R and CNA O changed R4's shirt and checked his brief. They covered him up and left the room with the call light still on the floor.During an interview on 12/02/2025 at 10:41 AM, CNA O stated that R4 calls for help using the call light and sometimes yells out for help when he wants to get up; staff check on him often.During an interview on 12/03/2025 at 11:07 AM, Administrative Nurse D stated that R4 should always have his call light within reach.The facility's Fall Prevention Program, dated 01/01/25, documented under the compliance guidelines that the call light and frequently used items will be placed within reach. - R45's Electronic Medical Records (EMR) documented the following diagnoses: traumatic brain injury (TBI- an injury to the brain caused by external forces) and epilepsy (brain disorder characterized by repeated seizures).R45's 09/17/2025 Quarterly Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score was not assessed; R45 had good memory per staff interview. R45 had no falls in the previous quarter.R45's Care Plan documented, on 12/21/2024, R45 had an actual self-care impairment related to a recent fall with fracture that resulted in a total left hip replacement. The plan documented R45 was dependent on staff assistance with wheelchair mobility.On 12/03/2025 at 08:45 AM, R45 sat in his wheelchair in the commons area. Licensed Nurse (LN) G talked to R45 and directed him to go to his room. R45 did not attempt to self-propel his wheelchair to his room. R45 remained leaning forward in his wheelchair with his eyes closed.On 12/03/2025 at 08:48 AM, Certified Medication Aide (CMA) S pushed R45 in his wheelchair to the room with no foot pedals. CMA S reminded R45 to raise his feet. R45 was able to hold his feet slightly above the floor. His feet were lightly touching the floor at times. Staff took R45 to the bathroom, then propelled him back to the common area without foot pedals.On 12/03/2025 at 9:14 AM, R45 still sat in the wheelchair with his head hung down and eyes closed. LN G approached R45 and placed the foot pedals on his wheelchair. LN G stated she looked, and R45 was not care planned to be pushed without wheelchair pedals.On 12/03/2025 at 09:04 AM, CMA S stated she thought it was care (continued on next page)

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	175470	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planned for him to be assisted in the wheelchair without foot pedals, but CMA S would check the care plan.During an interview on 12/03/2025 at 11:07 AM, Administrative Nurse D stated that staff should use wheelchair pedals when they pushed a resident in a wheelchair.On 12/03/25 at 03:56 PM, Administrative Staff A stated that staff know they are expected to use wheelchair pedals whenever a staff member pushed a resident in a wheelchair.The facility's Fall Prevention Program dated 01/01/25, documented each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.The facility's undated Safe Transport of Residents in Wheelchairs documented leg rests must be attached and positioned appropriately whenever staff are pushing a resident in a wheelchair.

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	175470	A. Building B. Wing	12/03/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 47 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on interview and record review, the facility failed to follow physician orders regarding blood pressure monitoring for Resident (R) 5's blood pressure medication when staff administered the medication despite R5's blood pressure being lower than the ordered parameters. Findings included:- R5's Electronic Medical Record (EMR) revealed a diagnosis of hypertension (HTN-elevated blood pressure).R5's Significant Change Minimal Data Set (MDS), dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She had a diagnosis of HTN.The Psychotropic Medication Use Care Area Assessment (CAA), dated 02/23/25, documented the resident took multiple medications.R5's Quarterly MDS, dated [DATE], documented she had a BIMS score of 15, indicating intact cognition. She had a diagnosis of HTN.R5's HTN Care Plan, revised 11/07/25, instructed staff the resident received hypertensive medication (medication used to lower blood pressure). Staff were to hold the medication if the resident's systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 110.R5's EMR included the following physician's order:Metoprolol (a hypertensive medication) 50 milligrams (mg), by mouth (po), twice daily (BID), for a diagnosis of HTN, hold if the SBP was less than 110, ordered 07/01/25.Review of R5's Medication Administration Record, dated 11/01/25 through 11/30/25, revealed staff administered the medication on seven occasions with the resident's SBP less than 110.On 12/03/25 at 09:47 AM, Certified Medication Aide (CMA) R confirmed the medication had been given when the resident's SBP had been out of the ordered parameters.On 12/03/25 at 10:13 AM, Administrative Nurse D stated it was the expectation for staff to hold medications when the SBP was out of parameters.The facility policy for Medication Administration, implemented 01/01/25, included: The facility shall administer medications as ordered by the physician and in accordance with professional standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175470	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quaker Hill Manor	8675 SE 72nd Terrace Baxter Springs, KS 66713

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility reported a census of 47 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to use adequate hand hygiene when caring for residents. Findings included:- Observation on 12/03/2025 at 12:56 PM, Certified Medication Aide (CMA) S and Licensed Nurse (LN) G, entered Resident (R) 2's room and donned gloves and gowns. CMA S placed the walker in front of R2 and performed a two-person stand-pivot transfer with the walker. R2 pivoted, sat on the edge of the bed, then laid down on the bed with assistance. LN G grabbed the trash at the top of the trash can and moved the trash to the other side of the bed. LN G did not change gloves after touching the trash can. CMA S removed R2's pants, and LN G obtained a brief and wipes from the bedside stand, wearing the same soiled gloves. CMA S removed her gloves and washed her hands, then CMA S applied clean gloves. Both staff members unattached the brief from their side of R2. LN G obtained wipes and wiped the front of R2's peri area, still wearing the soiled glove, and then applied cream to R2's peri area. CMA S opened the clean brief and handed it to LN G. LN G placed the brief under R2 and removed the dirty brief. CMA S washed her hands and applied clean gloves. LN G then removed the soiled gloves and applied clean gloves without performing hand hygiene. LN G cleaned the opening and the catheter tubing, cleaning away from the body. LN G dried the area and applied petroleum jelly to the opening of the urethra (tube by which urine is carried from the bladder out of the body). They attached the brief and made R2 comfortable. Both staff washed their hands and left the room.On 12/03/2025 at 01:19 PM, LN G verified she did not wash her hands when removing her gloves, prior to putting new gloves on, and confirmed that she had not completed hand hygiene between dirty and clean areas while assisting with R2's peri care.During an interview on 12/03/2025 at 01:36 PM, Administrative Nurse D stated she expected staff to perform adequate hand hygiene, which included completing hand hygiene when removing gloves prior to applying clean gloves.The facility's undated Infection Control Policy documented the facility will follow Standard Precautions for Infection Control and Prevention, including but not limited to hand hygiene, which referred to both washing with plain or anti-microbial soap and water and use of alcohol gel (when hands are not visibly soiled, alcohol gel is the preferred method of hand hygiene). Staff would perform hand hygiene before and after contact with a resident, immediately after touching blood, body fluids, non-intact skin, mucous membranes, or contaminated items (even when gloves are worn during contact), after removing gloves, and when moving from contaminated body sites to clean body sites during resident care.

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	175470	A. Building B. Wing	12/03/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 47 residents. Based on observation, record review and interview, the facility failed to display posted staffing information which contained the required data including the actual nursing hours worked for the 47 residents who resided in the facility. Findings included:- Review of the facility's Daily Staffing Sheets, from 11/03/25 through 12/03/25, revealed the actual hours worked had not been completed on the daily staffing sheets.On 12/03/25 at 10:30 AM, Administrative Nurse D confirmed the facility had not completed the actual hours on the nurse staffing sheets, as required.The facility policy Nurse Staffing Posting Information, implemented 12/03/25, included: The Nurse Staffing Sheet will be posted daily and will contain the total number and the actual hours worked by nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175470	A. Building B. Wing	12/03/2025

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. The facility reported a census of 47 residents. The sample included 12 residents. Based on interviews, record reviews and observation, the facility failed to ensure a safe, homelike environment in all areas of the facility including those used by visitors and staff and the floor in one of one kitchen. This deficient practice created a risk for impaired safety and cleanliness.Findings included:- Observed on 12/02/25 at 09:20 AM, numerous ceiling tiles in the east residential hall had flaked areas and/or cracked or broken areas. Two ceiling tiles outside R12's room were damaged, and there was a ceiling tile track that was hanging down. Several ceiling tiles outside R13's room were damaged and required replacement or repair. Also observed were cracks from the top of the resident door frame to the ceiling of R12, R37, R25, R10, R5, and R30.Observed on 12/02/25 at 09:25 AM, numerous ceiling tiles were broken, cracked, and/or stained in the facility entrance common area and the south resident hall, and there were numerous ceiling tile tracks that were damaged and/or hanging down.An initial tour of the kitchen on 12/02/25 at 09:37 AM revealed the parameter of the kitchen floor had a build-up of food debris.On 12/02/25 at 09:45 AM, Maintenance U stated he observed and monitored he ceiling tiles throughout the building frequently; if they were damaged, looked bad, or had stains, he replaced them. On 12/02/25 at 10:23 AM, Administrative Staff A stated she expected the facility to be fresh and clean, and if anything was damaged, she expected it to get addressed and a plan made to repair whatever it was. She further stated that all staff were expected to be vigilant and identify any maintenance or environmental concerns and to turn in work orders. She said that if ceiling tiles or ceiling tracks were damaged, they should be replaced.On 12/03/25 at 08:51 AM, Dietary staff BB confirmed the kitchen floor was in poor condition and said it needed to be replaced.The facility policy Safe and Homelike Environment, dated 01/01/25, documented that the facility would provide a safe, clean, comfortable, and homelike environment. The policy further documented that housekeeping and maintenance services would be provided as necessary to maintain a sanitary, orderly, and comfortable environment.