STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375322	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkhill North Nursing Home	319 North Owen Walters Blvd Salina, OK 74365

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46703 Based on record review and interview, the facility failed to ensure RN coverage for eight consecutive hours a day, seven days a week. The administrator reported 36 residents resided in the facility. Findings: A nursing schedule for April 2024 documented the facility did not have RN coverage for eight consecutive hours on 04/05/24, 04/08/24, 04/09/24, and 04/10/24. On 06/05/24 at 1:01 p.m., the DON was requested to provide documentation that an RN had worked eight consecutive hours in the facility on 04/05/24, 04/08/24, 04/09/24, and 04/10/24. On 06/05/24 at 1:30 p.m., the DON reported they did not have RN coverage in the facility on 04/05/24, 04/08/24, 04/09/24, and 04/10/24.

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