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	12/18/2025

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

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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 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. Based on record review and interview, the facility failed to ensure a resident did not receive an antipsychotic medication for the diagnosis of dementia for 1 (#10) of 5 sampled residents reviewed for unnecessary medications.The DON identified 11 residents received antipsychotic medications.Findings:A facility policy titled Monitoring of Anti-Psychotics, dated 2025, showed residents were only to be prescribed antipsychotic medications if one of the listed diagnoses in the policy were used. The list in the policy did not include any form of dementia.A physician's order, dated 11/19/25, showed Resident #10 was to be administer quetiapine (an antipsychotic medication) one tablet of 25 mg once every morning for the diagnosis of vascular dementia, unspecified severity, with agitation.A physician's order, dated 11/19/25, showed Resident #10 was to be administer quetiapine (an antipsychotic medication) one tablet of 50 mg once every bedtime for the diagnosis of vascular dementia, unspecified severity, with agitation.A medication administration record for Resident #43, dated December 2025, showed Resident #43 was administered both the morning and bedtime doses of quetiapine on dates of 12/01/25, 12/02/25, 12/03/25, 12/04/25, 12/05/25, 12/06/25, 12/07/25, 12/08/25, 12/09/25, 12/10/25, and 12/11/25.On 12/12/25 at 11:20 a.m., the DON provided a copy of the facility's policy on antipsychotic medications. They were asked if antipsychotic medications were approved for the treatment of dementia. They stated they were not.On 12/12/25 at 12:01 p.m., LPN #1 was asked why Resident 43 had been administered quetiapine. They stated the resident had been given that medication for their aggression toward other residents. They were asked if they knew if the medication was approved for the treatment of dementia with aggression. They stated they did not know.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#5) of 14 sampled residents whose assessments were reviewed.The DON identified 39 residents resided in the facility. Findings: A medication administration record, dated July 2025, showed Resident #5 was ordered lorazepam (an anxiolytic medication) 1mg every four hours as needed for anxiety from 07/02/25 through 07/16/25. The medication administration record, showed Resident #5 had received lorazepam 1mg on 07/15/25 at 9:26 p.m. The medication administration record showed Resident #5 was ordered and received divalproex (an anticonvulsant medication) 125mg daily from 07/01/25 through 07/16/25. A quarterly assessment, dated 07/15/25, showed a staff assessment for cognition revealed Resident #5 was severely impaired in cognition for daily decision making, had not received an antianxiety medication or an anticonvulsant medication during the seven-day look back period. An annual assessment, dated 10/09/25, showed a staff assessment for cognition revealed Resident #5 was severely impaired in cognition for daily decision making, and had not received an anticonvulsant medication during the seven-day lookback period. A medication administration record, dated October 2025, showed Resident #5 was ordered and received divalproex 125mg daily. The medication administration record showed Resident #5 had received divalproex during the seven-day look back period on 10/03/25, 10/04/25, 10/05/25, 10/07/25, and 10/08/25. On 12/16/25 at 11:39 a.m., MDS coordinator #1 stated they reviewed the medication administration records when completing assessments and did not know why they had not accurately coded the assessment dated [DATE] for the lorazepam. On 12/16/25 at 12:01 p.m., MDS coordinator #1 stated since Resident #5 had not had a diagnosis of seizures they did not code the divalproex as an anticonvulsant medication the resident had received during the seven-day lookback period on the assessment dated [DATE] or the assessment dated [DATE].

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was developed for 1 (#19) of 14 sampled residents whose care plans were reviewed. The DON identified 39 residents resided in the facility.Findings:The admission assessment, dated 06/20/25, showed Resident #19 had been admitted to the facility on [DATE] and had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making.Review of the clinical record did not show a baseline care plan had been completed for Resident #19. On 12/18/25 at 11:02 a.m., MDS coordinator #1 stated they or the ADON completed baseline care plans. They reviewed the electronic clinical record and the paper chart and stated the ADON may know where the baseline care plan was located for Resident #19. On 12/18/25 at 11:09 a.m., the ADON stated they completed baseline care plans for residents. The ADON reviewed the electronic clinical record and stated they had not completed a baseline care plan for Resident #19 within 48 hours of admission for Resident #19 because they had been off work on those days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a resident assessed to be at risk for wandering and elopement had a problem, goals, and interventions in their care plan for wandering and elopement for 1 (#43) of 2 sampled residents reviewed for accident hazards.The DON identified two residents were at risk of wandering.Findings:An MDS admission assessment, dated 12/01/24, showed in Section C under staff assessment, Resident #43's cognition was moderately impaired. In Section E of the assessment, it showed the resident experienced delusions and wandered one to three days in the previous seven days.A quarterly wandering/elopement assessment, performed by LPN #4 on 09/02/25, showed the answers to the questions: Is the resident resistant to being placed in facility, does the resident have a history of wandering, is the resident confused and disoriented, and are there any indications of dementia, were answered yes. According to the instructions printed on the assessment, one yes answer to any of the questions required the resident be put on wandering / elopement precautions.An MDS admission assessment, dated 12/04/25, showed in Section C staff assessment, Resident #43's cognition was severely impaired. In Section E of the assessment, it showed the resident experienced delusions and wandered one to three days in the previous seven days.A care plan for Resident #43, revised 12/06/25, showed no problem, goals, or interventions for wandering or elopement risk.On 12/18/25 at 10:45 a.m., the ADON was asked who at the facility had the responsibility to create the resident care plans. They stated they did. They were asked to review Resident #43's care plan for entries regarding wandering or elopement. After reviewing the document, the ADON stated there was nothing care planned for wandering or elopement risk in the care plan. The ADON was asked what they knew about resident #43 should there be problems, goals, and interventions related to wandering and elopement risk. They stated since the resident did wander and had dementia the problems should have been included in the care plan.

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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. Based on observation, record review, and interview, the facility failed to ensure a resident who had been assessed as an elopement risk was unable to exit the building and enter the facility parking lot unseen for 1 (#43) of 2 sampled residents reviewed for accident hazards.The DON identified two residents that wandered.Findings:On 12/09/25 at 10:00 a.m., Resident #43 was observed attempting to open the front door of the facility when they observed the surveyors waiting to enter. The resident repeatedly pushed on the door latch until a staff member intervened.A facility policy titled Elopement, dated 2008, read in part, Staff shall investigate and report all cases of missing residents,An MDS admission assessment, dated 12/01/24, showed in Section C staff assessment, Resident #43's cognition was moderately impaired. In Section E of the assessment, it showed the resident experienced delusions and wandered one to three days in the previous seven days.A quarterly wandering/elopement assessment, performed by LPN #4 on 09/02/25, showed the answers to the questions: Is the resident resistant to being placed in facility, does the resident have a history of wandering, is the resident confused and disoriented, and are there any indications of dementia, were answered yes. According to the instructions printed on the assessment one yes answer to any of the questions required the resident be put on wandering / elopement precautions.An MDS admission assessment, dated 12/04/25, showed in Section C staff assessment, Resident #43's cognition was severely impaired. In Section E of the assessment, it showed the resident experienced delusions and wandered one to three days in the previous seven days.On 12/17/25 at 2:56 p.m., LPN #3 was asked if Resident #43 had ever gotten out of the facility without anyone knowing. They stated the resident had done that once. They were asked when that occurred. LPN #3 stated they could not recall when it occurred. They were asked if they were on duty when it occurred. LPN #3 stated they had been on duty at the time but had not witnessed the resident leave the building. They stated the resident had been found outside the front door of the facility. On 12/17/25 at 2:59 p.m., LPN #1 was asked if they knew of an instance when Resident #43 had exited the building without anyone knowing. They stated it had happened once, but they could not recall when it occurred. On 12/17/25 at 3:27 p.m., LPN #3 was asked if they had informed anyone in administration about Resident #43 getting out of the building. They stated they did not since the resident had just walked around the building.On 12/18/25 at 8:32 a.m., LPN #4 was asked if they knew of an incident where Resident #43 had left the faciity on their own. They stated they were aware, but had not seen it. They stated they were at the facility and recalled nurse aides going toward the front door and returning with Resident #43. They were asked if they had reported the incident to anyone in administration. They stated they had not.On 12/18/25 at 8:36 a.m., CNA #3 was asked if they knew of an incident where Resident #43 had exited the facility without anyone knowing. They stated they could not recall exactly when it occurred, but thought it was on a Friday during the summer. They stated CNA #2, LPN #2, and certified medication aide #3 had been in the building when it occurred. They stated they had observed Resident #43 in the front parking lot and went outside to get them.On 12/18/25 at 9:23 a.m., the DON was asked when they had become aware Resident #43 had previously exited the facility. They stated when this surveyor had told them about what the other staff members had said on 12/17/25. They were asked if there was a system in place at the facility regarding the reporting of such incidents. They stated yes and the staff were supposed to report to them when that occurs.On 12/18/25 at 9:32 a.m., CNA #2 was asked if they knew of an instance when Resident #43 had left the building without staff knowing. They stated it had occurred once, but they could not recall when. They stated CNA #4 had said the resident was outside and that they went with CNA #4 to get the resident. On 12/18/25 at 9:41 a.m., CNA #4 was asked if they knew of a time when (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43 had been found outside the building without anyone knowing. They stated they did recall that had occurred but not when. They stated they were the first person to go out to get the resident.On 12/18/25 at 9:59 a.m., the DON made the statement that they believed what occurred with Resident #43 was not elopement as a staff member CNA #5 had never lost sight of the resident. The DON stated they were attempting to contact CNA #5 to get them to contact this surveyor. On 12/18/25 at 10:18 a.m., CNA #3 was asked who the first person was to reach Resident #43 on the date they went outside the building. They stated it was CNA #4. They were asked if CNA #5 had assisted during the incident. They stated CNA #5 was not there when it occurred.On 12/18/25 at 10:21 a.m., CNA #2 was asked who the first person was to reach Resident #43 on the date they went outside the building. They stated it was CNA #4. They were asked if CNA #5 had assisted during the incident.On 12/18/25 at 10:24 a.m., CNA #4 was asked if CNA #5 had been present when they had found Resident #43 outside the building. They stated no and the incident occurred during the day shift and CNA #5 worked the evening shift.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure indwelling urinary catheters were changed when ordered by the physician for 1 (#19) of 1 sampled resident reviewed for indwelling urinary catheters.The DON identified four residents with indwelling urinary catheters.Findings: On 12/17/25 at 9:31 a.m., Resident #19 was observed in bed with an indwelling urinary catheter. A physician order, dated 06/10/25, showed the indwelling urinary catheter was to be changed every month on the 9th and as needed. A quarterly assessment, dated 12/04/25, showed Resident #19 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, had an indwelling urinary catheter, and had obstructive uropathy. A care plan, revised 12/04/25, showed Resident #19 had an indwelling urinary catheter. The care plan showed the indwelling urinary catheter was to be changed every month and as needed. The medication administration record, dated 12/01/25 through 12/17/25, showed the indwelling urinary catheter was to be changed on 12/09/25, but was not documented as completed. On 12/17/25 at 9:31 a.m., Resident #19 stated they had received catheter care as indicated but their catheter had not yet been changed in December 2025. On 12/17/25 3:11 p.m., LPN #3 stated they thought the hospice nurse had changed the catheter for Resident #19 on 12/09/25. On 12/18/25 at 10:39 a.m., the DON stated the hospice nurse had not changed the indwelling urinary catheter for Resident #19 on 12/09/25. The DON stated the charge nurse was responsible to complete indwelling urinary catheter changes. They stated they did not have monitoring in place to ensure indwelling urinary catheters were changed as ordered by the physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interview, the facility failed to ensure communication between the facility and a resident's dialysis provider was conducted routinely for 1 (#3) of 1 sampled resident reviewed for dialysis care.The DON identified one resident received dialysis care.Findings:On 12/17/25 at 10:08 a.m., LPN #1 was observed conducting a pre-dialysis assessment of Resident #3.A facility policy titled Dialysis-General Guidelines and Management, dated 01/2008, was reviewed. The policy did not address the continued communication between the dialysis center and the facility.A physician's order, dated 01/30/25, showed Resident #3 was to be sent to a contracted dialysis provided every Monday, Wednesday, and Friday.On 12/17/25 at 10:20 a.m., LPN #1 was asked if they had used the facility's dialysis communicating form to document Resident #3's assessment results. They stated they had not since they had been a nurse at the facility. They were asked how long they had been a nurse at the facility. They stated it had been two years. They were asked again if they had used the facility's dialysis communication form to document their pre and post dialysis assessments and had they sent the form with the pre-dialysis assessment results to the dialysis center. They stated they had not. They were asked if they had ever sent pre-dialysis assessment information to the personnel at the dialysis center. They stated they had not and that they believed the reason was that in the past the dialysis center would never fill out their section of the form or send the form back at all.On 12/17/25 at 10:45 a.m., DON was asked about the use of the facility's dialysis communication form. They stated they did have that form, but it had not been filled out and sent to the dialysis center in years. They were asked how they received information from a session of dialysis from the dialysis center. They stated they had not received routine communication back from the dialysis about Resident #3 during the time they had been going to the dialysis center for care. They stated the only exception was that the dialysis center nutritionist did send regular documentation about nutrition.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for 2 (#33 and #5) of 5 sampled residents whose labs were reviewed.The DON identified 37 residents had lab orders.Findings:1.A policy titled Lab and Diagnostic Test Results-Clinical Protocol, dated November 2018, read in part, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests.A physician order, dated 04/11/25, showed Resident #33 was to have a CBC and CMP every six months in April and October.A quarterly assessment, dated 10/31/25, showed Resident #33 had a BIMS score of 2, which indicated the resident was severely impaired in cognition for daily decision making, and did not have any pressure ulcers.A care plan, revised 10/31/25, showed the resident was at risk for pressure ulcers, did not currently have any pressure ulcers, and to monitor labs as ordered by the physician.Review of the clinical record did not show labs had been completed as ordered by the physician in April or October 2025.On 12/17/25 at 11:09 a.m., the DON stated the ordered labs for Resident #33 had not been completed. They stated they did not know why labs were not completed as ordered by the physician.2. A physician order, dated 03/12/24, showed Resident #5 was to receive a CBC, CMP, LFT, and Valproic Acid level every six months in April and October.An annual assessment, dated 10/09/25, showed a staff assessment that Resident #5 was severely impaired in cognition for daily decision making and had hypertension (high blood pressure).A care plan, revised 10/09/25, showed Resident #5 had hypertension and staff were to monitor labs as ordered.Review of the clinical record did not show the ordered labs had been completed in October 2025.On 12/17/25 at 11:09 a.m., the DON stated the CBC, CMP, LFT, and Valproic Acid labs had not been completed in October 2025. They stated they were supposed to monitor the lab reports monthly, but did not know why that was not being done.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation and interview, the facility failed to employ a full-time dietary manager and have competent kitchen staff assigned to perform the duties of cook and/or dietary aide. The DON identified 39 residents received meals prepared in the kitchen. Findings: On 12/09/25 at 10:50 a.m., there was no dietary manager observed in the kitchen.On 12/09/25 at 1:30 p.m., there was no dietary manager observed in the kitchen.On 12/10/25 at 10:30 a.m., there was no dietary manager observed in the kitchen. A hospice aide entered the kitchen without a hair net or hair cover and scooped ice from a cooler located in the center of the kitchen. [NAME] #1 and cook #2 were present, but neither corrected the hospice aide nor offered them a hair net. On 12/10/25 at 4:40 p.m., there was no dietary manager observed in the kitchen. Dietary Ade #1 stepped onto the top of an open box of russet potatoes located on the bottom shelf of the food preparation table in the center of the kitchen. The dietary aide tied their shoe before returning their foot/shoe to the floor. On 12/15/25 at 9:20 a.m., there was no dietary manager observed in the kitchen. [NAME] #1 pureed canned carrots. They slid a butter knife back and forth between the blender housing and the cover until the safety engaged and the blender started. On 12/15/25 at 11:50 a.m., there was no dietary manager observed in the kitchen. [NAME] #1 plated a pureed diet plate with pureed lasagna, carrots, and a whipped dessert. There was no bread served.On 12/15/25 at 5:55 p.m., there was no dietary manager observed in the kitchen. [NAME] #2 was observed touching multiple kitchen counter surfaces and the food preparation table with their bare hands. [NAME] #2 picked up a gallon size can of pears, pushed the metal lid down into the can, and placed the can in the refrigerator. Without washing their hands, cook #2 grabbed a small plate, covered the surface area where food would go with their palm and four fingers. [NAME] #2 placed the plate on the counter and immediately reached over with their other bare hand and picked up and placed a grilled cheese sandwich on the plate. [NAME] #2 exited the kitchen with the grilled cheese and delivered it to a resident's room. [NAME] #2 was in the room for a few seconds before exiting and returning to the kitchen which they entered without washing their hands. [NAME] #2 began storing leftovers and disposing of packaging in the trash can.On 12/15/25 at 6:20 p.m., there was no dietary manager observed in the kitchen. Dietary Aide #1 was in the kitchen. A 44-ounce Styrofoam cup with lid and straw was present on the top shelf above the counter top. There was a gallon sized can of pears in the refrigerator. Dietary aide #1 was shown the canned pears stored inside the refrigerator. Dietary Aide #1 moved the pears to a plastic storage container with lid and labeled the lid. An unidentified CNA requested a pureed tray and received a plate of mashed potatoes, apple sauce, and chicken broth. There were no noodles or meat in the broth. Another unidentified CNA requested a regular diet tray and received half of a grilled cheese sandwich, a ladle full of diced peaches, and a Styrofoam bowl of chicken noodle soup. There was a half a loaf of white bread in a package sitting on top of the toaster. On 12/10/25 at 10:40 a.m., cook #1 stated the facility did not have a dietary manager and were told they did not need a dietary manager since the registered dietician visited once a month. On 12/15/25 at 9:20 a.m., cook #1 stated the top cover to the commercial blender the staff used to make puree meals was broken and required a butter knife to engage the lock before the blender would work. [NAME] #1 stated they had a new top for the blender on order. [NAME] #1 stated they would not puree the bread sticks that were on the menu for residents. On 12/15/25 at 5:15 p.m., cook #2 was asked to provide a copy of the extended menus for the week. [NAME] #2 stated they did not know of an extended menu. The extended menu was described to cook #2 as the menu approved by the registered dietician, which detailed what each person received based on their ordered diet (For example: what was fixed for residents who (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received a pureed diet, or renal diet) and which gave the serving size for each menu item. [NAME] #2 stated they were never shown an extended menu. On 12/15/25 at 5:55 p.m., cook #2 stated they were the evening cook two days a week. [NAME] #2 stated they did not know the requirements for storing leftover foods. [NAME] #2 stated they were not taught how to properly cool leftover food and did not know what the temperature danger zone was for foods. When asked what the holding temperature for cold food and for food stored on the steam table, cook #2 only shrugged. When asked what did the staff do to reduce the risk of foodborne illness in residents, cook #2 initially shrugged and then stated they only received two days of training and never heard of a temperature danger zone for food, did not know what an extended menu was, and did not know what the proper holding temperatures for hot and cold foods were to be. [NAME] #2 stated they did not know what the dietary requirements were for residents who received a pureed diet and served what the daytime cook wrote for them to fix for the evening meal. On 12/15/25 at 6:20 p.m., dietary aide #1 stated they did not know about an extended menu, the temperature danger zone for foods, or the holding temperatures for hot/cold foods. Dietary Aide #2 stated they did not cook or plate food, but common sense would tell you not to touch the surface area of the plate where the food would lay or to touch the food with bare hands. With a smile on their face, dietary aide #1 stated the open drink in the kitchen was theirs. Dietary Aide #1 stated it was unsanitary to have personal drinks in the kitchen or to use the open top box of stored baking potatoes as a raised step to tie your shoes. Dietary Aide #1 stated cook #2 must have placed the gallon size can of pears in the refrigerator and this was not the way to store foods in the refrigerator. Dietary Aide #1 stated cook #2 said they ran out of bread and the activities director stated to cut the grilled cheese sandwiches in half and service half servings to the residents. Dietary Aide #1 stated they did not know why the cook served mashed potatoes and apple sauce for the pureed evening meal. Dietary Aide #1 stated the biggest problem they saw with the kitchen was a lack of management and training. On 12/15/25 at 6:35 p.m., the DON stated the facility did not have a dietary manager and cook #1 was like an interim dietary manager because they had been there the longest. On 12/18/25 at 4:30 p.m., cook #1 stated they were not filling in as the dietary manager. [NAME] #1 stated they did not puree the bread sticks because residents who received pureed diet would not eat pureed bread. [NAME] #1 stated the activities director was responsible for ordering the food and based the order off what was needed to prepare the scheduled meals from the menu. [NAME] #1 stated the facility did not require a food handler's permit to work in the kitchen and the registered dietician told them if anything needed to change. On 12/18/25 at 4:40 p.m., the DON stated the residents who received pureed meals should have received what was on the menu. The DON stated the activities director reviewed the menu and ordered the food, but if they ran out of something, they went to the local grocery store to purchase it. The DON stated they gave the kitchen staff a week or two of training with the main cook and the registered dietician in-serviced the kitchen staff. The DON was asked who was responsible to ensure the kitchen staff were competent/trained in their duties. The DON stated it was the activities director and cook #1 who monitored the kitchen duties and dietary staff. The DON stated cook #2 was untrainable. The DON stated it was hard to get someone to apply because the pay was so low for the dietary department, but they set them to train with kitchen staff who worked in the facility for a while.

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	375322	A. Building B. Wing	12/18/2025

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to provide meals according to the menu approved by the registered dietician for two of two observed meal services. The DON identified 39 residents ate meals prepared in the kitchen and cook #1 identified six residents received pureed diets.Findings:On 12/15/25 at 9:20 a.m., cook #1 was observed pureeing canned carrots. [NAME] #1 slid a butter knife back and forth between the blender housing and the cover until the safety engaged and the blender started. On 12/15/25 at 11:10 a.m., cook #1 was observed pureeing prepared lasagna. [NAME] #1 slid a butter knife back and forth between the blender housing and the cover until the safety engaged and the blender started. On 12/15/25 at 11:50 a.m., cook #1 was observed plating a pureed diet plate with pureed lasagna, carrots, and a whipped dessert. There was no breadstick/bread served. On 12/15/25 at 6:20 p.m., there was a half a loaf of white bread observed in a package sitting on top of the toaster. Dietary Aide #1 was in the kitchen. An unidentified CNA requested a pureed tray and received a plate of mashed potatoes, apple sauce, and chicken broth. There were no noodles or meat in the broth. Another unidentified CNA requested a regular diet tray and received half of a grilled cheese sandwich, a ladle full of diced peaches, and a Styrofoam bowl of chicken noodle soup. The extended menu for the noon meal, dated for week three, day 16 (12/15/25), showed the pureed meal consisted of: a #6 scoop (6 ounces) of pureed lasagna, a #8 scoop (4 to 5 ounces) of pureed vegetable blend, a #16 scoop (2 to 2.25 ounces) of pureed garlic bread, and a #10 (3 to 4 ounces) scoop of pureed brownie. The extended menu for the evening meal, dated for week three, day 16 (12/15/25), showed the regular textured meal was to consist of: three quarters cup chicken noodle soup, 2 ounces of pimento cheese sandwich, half of a cup of cucumber onion salad, six saltine crackers, and half of a cup of emerald pears. The pureed textured meal was to consist of: #6 scoop of pureed chicken noodle soup, two #8 scoops of pureed pimento cheese sandwich, a #8 scoop of pureed vegetable blend, a #16 scoop of pureed bread, and a #12 scoop of pureed emerald pear. On 12/15/25 at 9:20 a.m., cook #1 stated they would not puree the bread sticks. [NAME] #1 stated they wrote their substitutions on a paper on the wall for the registered dietician to review. On 12/15/25 at 5:15 p.m., cook #2 was asked to provide a copy of the extended menus for the week. [NAME] #2 stated they did not know of an extended menu. The extended menu was described to cook #2 as the menu approved by the registered dietician, which detailed what each person received based on their ordered diet (i.e. what was fixed for residents who received a pureed diet, or renal diet, etc.) and what the serving size was for each menu item. [NAME] #2 stated they were never shown an extended menu and served what the daytime cook wrote on the board for the day. [NAME] #2 stated they did not know what the dietary requirements were for residents who received a pureed diet and served what the daytime cook wrote for them to fix for the evening meal. On 12/15/25 at 6:20 p.m., dietary aide #1 stated they did not know about an extended menu. Dietary Aide #1 stated cook #2 said they ran out of bread and the activities director stated to cut the grilled cheese sandwiches in half and serve half servings to the residents. Dietary Aide #1 stated they did not know why cook #2 served mashed potatoes and apple sauce instead of what was on the menu for the pureed evening meal. Dietary Aide #2 stated the biggest problem they saw with the kitchen was a lack of management and training. On 12/15/25 at 6:35 p.m., the DON stated the facility did not have a dietary manager and cook #1 was like an interim dietary manager because they had been there the longest. On 12/18/25 at 4:30 p.m., cook #1 stated the residents would not eat the pureed bread sticks so they quit pureeing the bread sticks. [NAME] #1 was asked why the dietary staff did not follow the menu or serving sizes, especially with the puree diets. [NAME] #1 repeated the residents just would not (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eat the pureed bread. [NAME] #1 stated it was the activities director who reviewed the menu and ordered the food. [NAME] #1 was asked about the training the facility provided to the dietary staff. [NAME] #1 stated the registered dietician told them if something changed. On 12/18/25 at 4:40 p.m., the DON was asked why the kitchen staff did not follow the menu. The DON stated the residents were supposed to get the missing menu items, but they have found the evening cook was not trainable. The DON stated the activities director was responsible for ordering food and if anything was missing, they went to the local grocery store to purchase the missing items. The DON stated the kitchen staff was provided a week or two of training with the main cook, the registered dietician performed in-services, and they were certain the facility required a food handler's permit to work in the kitchen.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to:a. ensure hair restraints were used by individuals entering the kitchen;b. ensure the integrity of the kitchen environment was free of breaks/holes; c. ensure leftover foods were stored according to standards of practice;d. ensure the kitchen staff followed infection control standards of practice;e. ensure the ice machine was kept clean; andf. ensure food was served according to standards of practice.The DON identified 39 residents ate meals prepared in the kitchen. Findings: On 12/09/25 at 10:50 a.m., the following observations were made in the kitchen: a. a metal pipe of a type used as an electrical conduit, exited the ceiling through a hole which was not sealed around the metal. There was also another quarter size hole in the ceiling six inches from the pipe. The hole had two white wires hanging through the quarter size hole. The hole was not sealed around the two wires,b. a partially painted over bell was hanging loosely from the ceiling. There was electrical wiring and a screw exposed between the base of the bell and the ceiling. There were two screw holes in the ceiling and another quarter sized hole which appeared to have wires coming through the hole and to the bell. None of the holes were sealed,c. the crown molding in the corner of the kitchen appeared separated from the ceiling and wall, andd. there was an unsealed dime sized hole in the ceiling, adjacent to the ceiling rack for pots/pans which hung from the ceiling over one end of the center food preparation table. On 12/09/25 at 1:30 p.m., the ice machine was observed with the maintenance supervisor. There was a black and brown mucous looking substance along the edges of the drip pan and a dark substance covering the inside and outside of the opaque tubing used to move water throughout the ice machine for the creation of ice. On 12/10/25 at 10:30 a.m., a hospice aide entered the kitchen without a hair net or hair cover and scooped ice from a cooler located in the center of the kitchen. [NAME] #1 and cook #2 were present, but neither corrected the hospice aide nor offered the aide a hair net. On 12/10/25 at 4:40 p.m., dietary aide #1 stepped onto the top of an open box of russet potatoes located on the bottom shelf of the food preparation table in the center of the kitchen. The dietary aide tied their shoe. On 12/15/25 at 5:55 p.m., cook #2 was observed touching multiple kitchen counter surfaces and the food preparation table with their bare hands. [NAME] #2 picked up a gallon size can of pears, pushed the metal lid down into the can, and placed the can in the refrigerator. Without washing their hands, cook #2 grabbed a small plate, covered the surface area where food would go with their palm and four fingers. [NAME] #2 placed the plate on the counter and immediately reached over with their other bare hand and picked up and placed a grilled cheese sandwich on the plate. [NAME] #2 exited the kitchen with the grilled cheese and delivered it to a resident's room located near the kitchen. [NAME] #2 was in the room only a few seconds before exiting and returning to the kitchen which they entered without washing their hands. [NAME] #2 began storing leftovers and disposing of packaging in the trash can. On 12/15/25 at 6:20 p.m., dietary aide #1 was in the kitchen. A 44-ounce Styrofoam cup with lid and straw was present on the top shelf above the corner countertop of the kitchen. There was an open gallon sized can of pears in the refrigerator. Dietary Aide #1 was shown the canned pears stored inside the refrigerator. Dietary Aide #1 transferred the pears to a plastic storage container with lid and labeled the lid. There was an unsealed plastic bag of white bread on top of the toaster. On 12/09/25 at 1:35 p.m., the maintenance supervisor stated they used to clean the ice machine one to two times a month, but the facility recently hired an outside company to clean the ice machine. The maintenance supervisor stated the ice machine needed to be cleaned and they would be in contact with the contracted company. On 12/10/25 at 10:40 a.m., cook #1 stated the facility did not have a dietary manager and were told they did not need a dietary (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manager since the registered dietician visited once a month. On 12/15/25 at 5:55 p.m., cook #2 stated they were the evening cook two days a week. [NAME] #2 stated they did not know the requirements for storing leftover foods. [NAME] #2 stated they were not taught how to properly cool leftover food and did not know what the temperature danger zone was for foods. When asked what the holding temperature for cold food and for food stored on the steam table, cook #2 only shrugged. When asked what did the staff do to reduce the risk of foodborne illness in residents, cook #2 initially shrugged and then stated they only received two days of training and never heard of a temperature danger zone for food, did not know what an extended menu was, and did not know what the proper holding temperatures for hot and cold foods were to be. [NAME] #2 stated they did not know what the dietary requirements were for residents who received a pureed diet and served what the daytime cook wrote for them to fix for the evening meal. On 12/15/25 at 6:20 p.m., dietary aide #1 stated they did not know about an extended menu, the temperature danger zone for foods, or the holding temperatures for hot/cold foods. Dietary Aide #1 stated they did not cook or plate food, but common sense would tell them not to touch the surface area of the plate where the food would lay or to touch the food with bare hands. With a smile on their face, dietary aide #1 stated the Styrofoam cup and straw was their open drink in the kitchen. Dietary Aide #1 stated it was unsanitary to have personal drinks in the kitchen or to use the open top box of stored baking potatoes as a raised step in which to tie their shoes. Dietary Aide #1 stated cook #2 must have placed the open gallon size can of pears in the refrigerator and this was not the way to store foods in the refrigerator. Dietary Aide #1 stated cook #2 said they ran out of bread and the activities director instructed them to cut the grilled cheese sandwiches they served for dinner in half and give half servings to the residents. Dietary Aide #1 stated they did not know why the cook served mashed potatoes and apple sauce for the pureed evening meal. Dietary Aide #1 stated the biggest problem they saw with the kitchen was a lack of management and training. On 12/15/25 at 6:35 p.m., the DON stated the facility did not have a dietary manager and cook #1 was like an interim dietary manager because they had been employed in the kitchen the longest. On 12/18/25 at 4:30 p.m., cook #1 stated they were not filling in as the dietary manager. The cook stated the activities director was responsible for ordering the food and based the order off what was needed to prepare the scheduled meals from the menu. [NAME] #1 stated the facility did not require a food handler's permit to work in the kitchen and the registered dietician told them if anything needed to change. On 12/18/25 at 4:40 p.m., the DON stated the activities director reviewed the menu and ordered the food but if they ran out of something, they went to the local grocery store to purchase it. The DON stated they gave the kitchen staff a week or two of training with the main cook and the registered dietician in-serviced the kitchen staff. The DON was asked who was responsible to ensure the kitchen staff were competent/trained in their duties. The DON stated some of the kitchen staff were not trainable. The DON stated it was hard to get someone to apply because the pay was so low for the dietary department, but they set new staff to train with kitchen staff who worked in the facility. The DON stated it was the activities director and cook #1 who monitored the kitchen duties and dietary staff. The DON stated kitchen was recently renovated and they were unaware of the holes in the kitchen.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain a commercial blender in working order for the preparation of puree meals. [NAME] #1 identified six residents ate puree meals prepared in the kitchen. Findings: On 12/15/25 at 9:20 a.m., cook #1 was observed to pour canned carrots into the bowl of a blender, placed a broken cover onto the bowl, and used a butter knife to engage the safety and start the blender. [NAME] #1 was observed to blend the canned carrots and lasagna utilizing the bowl with broken cover and a butter knife to engage the safety and start the blender. The cover to the blender bowl was observed to be cracked in several places and the plastic portion which locked the blender bowl in place was missing and appeared to have broken off. On 12/15/25 at 9:19 a.m., cook #1 stated the top to the blender they used to puree foods was broken and they had to work the safety with a butter knife to get the blender to work. [NAME] #1 stated the office had ordered another top for the blender.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to ensure routine inspection of a resident bed and side rails were conducted for 1 (#18) of 2 sampled residents reviewed for accident hazards.The DON identified six residents used side rails.Findings:On 12/09/25 at 12:06 p.m., Resident #18 was observed lying in their bed with their eyes closed. On each side of the bed, around the resident's shoulder and head, a quarter side rail was observed attached to the bed frame and in the up position.On 12/12/25 at 3:18 p.m., Resident #18 was observed lying in bed with their eyes closed. The bilateral quarter rails on the resident's bed located around the resident's shoulders and head were in the up position.On 12/16/25 at 10:37 a.m., Resident #18 was observed lying in their bed with their eyes open. The two bed rails attached to the resident's bed frame were in the up position.A MDS annual assessment, dated 11/07/25, showed in Section C Resident #18 had a BIMS score of 13 which indicated the resident's cognition was intact and suggested normal memory and thinking abilities. On 12/16/25 at 10:52 a.m., the facility maintenance supervisor was asked how long they had been in charge of facility maintenance. They stated they had been in that position for 1.5 years. They were asked to describe the maintenance program they had regarding bed frames and side rails. They stated when someone reported an issue with the beds or the rails they went and fixed them. They were asked if they had a program to routinely inspect the bed frames and bed rails. They stated they did not do that, but only made repairs when they got a report and put together new beds when they came into the facility.On 12/16/25 at 11:48 a.m., the DON was asked if residents' beds and bed rails were routinely inspected. They stated they believed they were inspected before a resident used them, but they did not have any documentation of bed frame or bed rail inspections. They were asked if they had a policy and procedure regarding bed frame and bed rails use. They stated they did not.