STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185433	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri-Cities Nursing and Rehabilitation Center	19101 US Highway 119 North Cumberland, KY 40823

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 18947 Based on record review, interviews, and review of facility policy, the facility failed to ensure two out of three residents (Resident (R) 15 and R48) reviewed for abuse/neglect were free from physical abuse of 23 sample residents. R15 and R48 got into a physical altercation in the facility's smoking area and both residents were injured related to the altercation. The facility's failure to ensure measures were in place to prevent the incident of resident-to-resident abuse between R15 and R48 created the potential for both residents to continue to be abused leading to potential physical and/or psychosocial harm to the residents. Findings include: Review of the facility's policy titled, Abuse, Neglect, or Misappropriation of Resident Property Policy, dated 05/01/13, revealed, in pertinent part, The facility believes that our residents have the right to be free from abuse, neglect, involuntary seclusion, or misappropriation of property. The facility will do whatever is in its control to prevent mistreatment, neglect, and abuse of our residents or misappropriation of their property. 1. Review of R48's Admission Record, dated 10/09/24 and located in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The document indicated diagnoses which included type two diabetes, restlessness and agitation, and cognitive communication deficit. Review of R48's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/24 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. Review of R48's Progress Note, dated 06/11/24 and located in the EMR under the Notes tab, revealed, Allegation of resident to resident altercation. Residents separated. Resident assessed for injuries with small scratch noted to upper lip and skin tear to the right lower arm. Resident denied pain and showed no s/s of pain upon assessment. MD [Medical Doctor] and RP [Resident Representative] notified. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Incident and Accident Logs, dated 01/01/24 through 10/08/24 and provided directly to the survey team, revealed an incident of resident-to-resident abuse between R15 and R48, entered on 06/11/24. Review of a document provided by the facility titled Initial Report, dated 06/11/24, indicated the resident-to-resident, which involved R15 and R48, happened on this same date. The report indicated the residents' representatives and physician were notified of the incident. According to the report, R15 was out in the back waiting for a smoke break, when R48 wheeled up next to her. The report indicated R15 directed R48 to move to a certain spot and the two residents began to slap each other. Both residents were immediately separated. Interviews were gathered from R15 and R48 and witness statements. There have been no further incidents of resident-to-resident with R15 and R48. Review of the facility's final investigation summary, dated 06/17/24 and provided directly to the survey team, related to the incident of resident-to-resident abuse between R15 and R48 on 06/11/24 was reviewed and revealed, At approximately 12:30 pm on 6-11-24, resident [R15] was in the back courtyard waiting on smoke break when resident [R48] wheeled up next to her. After that [R15] apparently tried to direct [R48] to sit in a certain spot pointing with her hand. At approximately 12:35 p.m., the two residents began to slap and hit each other until two staff members arrived in the area and separated the two. The facility is monitoring the residents for further behaviors; and Each (resident) suffered scratches requiring minor first aide. 2. Review of R15's EMR titled Admission Record indicated the resident was admitted to the facility in 09/28/10 with a diagnosis of schizophrenia. Review of R15's EMR quarterly MDS with an ARD of 04/26/24 indicated the resident had a BIMS score of eight out of 15 which revealed the resident was moderately cognitively impaired. The assessment indicated that the resident had no behaviors directed to others. The assessment revealed the resident used a wheelchair for mobility and had an impairment on one side of her upper extremity. Review of R15's EMR titled Incident Report located under the Prog (Progress) Note, dated 06/11/24, indicated R15 was involved in a resident-to-resident with R48 and R11 and sustained three small scratches to her left upper/inner arm. The scratches had scant blood and some bruising. The resident denied any pain. R15's representative and physician were notified of the incident. During an interview on 10/09/24 at 12:44 PM, R15 stated she remembered the resident-to-resident altercation with R48, and she was currently not afraid of R48. During an interview on 10/10/24 at 10:11 AM, Certified Nursing Assistant (CNA) 1 stated R15 could become agitated if things did not go her way. CNA1 stated the resident-to-resident incident between R15 and R48 was the first time this happened, and he stated he witnessed the two of them begin to argue and then went after each other. CNA1 stated he went and separated the two residents and reported the incident. CNA1 stated he considered the resident-to-resident abuse since both residents sustained scratches. During an interview with the Administrator and Director of Nursing (DON) on 10/10/24 at 12:44 PM, both indicated their expectation was residents should not be subjected to any type of abuse. The DON stated, It is our job to protect them (residents).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review and interview, the facility failed to ensure six of six residents (Resident (R) 3, R19, R46, R56, R1, and R8) reviewed for care conferences out of a sample of 23 residents contained evidence the resident and/or her representative participated in the development or revision of their care plans. This failure would affect all residents and/or representatives who were scheduled for quarterly care plan meetings. Findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 08/19, indicated .Documentation of the invitation [to the resident's care conference] with follow-up is made in the progress notes. If the resident representative chooses not to participate, this is noted in the progress notes. Residents who are able to participate in planning their care and treatment are involved in the care planning process as well .The invitation and the resident's participation, or lack there-of, is documented in the progress notes, to include the offering of an individual review .reviews the care plan after (at a minimum) each admission, quarterly, annual, or significant change assessment . 1. Review of R3's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R3's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/05/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which revealed the resident was moderately cognitively impaired. Review of R3's EMR titled care plan Progress Notes located under the Prog (Progress) Note tab failed to contain evidence the resident and/or his representative were invited and then potentially participate in the resident's quarterly care conferences prior to 09/10/24. There was no evidence in R3's EMR that the interdisciplinary team (IDT) held quarterly care conferences to review and revise the resident's care plan after each annual and quarterly assessment. During an interview on 10/07/24 at 2:38 PM, R3 stated he was not sure if he was invited to his quarterly care plan meetings. 2. Review of R19's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R19's EMR titled quarterly MDS with an ARD of 09/12/24 indicated the resident had a BIMS score of 12 out of 15 which revealed the resident was moderately cognitively impaired. Review of R19's EMR titled care plan Progress Notes located under the Prog Note tab failed to contain evidence that the resident and/or his representative were invited and then potentially participate in the resident's quarterly care conferences. There was no evidence in R19's EMR that the IDT held quarterly care conferences to review and revise the resident's care plan after each quarterly assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/07/24 12:28 PM R19 stated she was not sure if she got invited to her quarterly care plan meetings. During an interview on 10/08/24 at 1:16 PM, the Social Services Director (SSD) stated she alerted residents' representatives with an invitation card. SS stated the mailing of the invitation card was done annually and if there was a significant change in the status of the resident. SS stated she was unaware that residents and/or their representatives were to be invited to care conferences on a quarterly basis. SS stated the facility did not hold quarterly care conferences nor did they document in the residents' clinical records that a care conference was held. 3. Review of R46's undated Admission Record located in the EMR under the Profile tab, revealed R46 was admitted to the facility 08/12/22 with diagnoses including chronic obstructive pulmonary disease, chronic congestive heart failure, chronic kidney disease, schizophrenia, and anxiety disorder. Review of R46's quarterly MDS with an ARD of 05/22/24, revealed the resident had a BIMS score of 15 out of 15, which indicated R46 was cognitively intact. During an interview on 10/07/24 at 3:42 PM, R46 stated that he was not invited to care plan meetings. During an interview on 10/09/24 at 2:07 PM, the DON stated that there has not been a care plan meeting because R46 refused to attend. The DON was asked if there had been an interdisciplinary team care plan meeting, and she stated she would find out. Further interview with the DON on 10/10/24 at 1:26 PM revealed that there had been no care plan meetings for R46. 4. Review of R56's undated Admission Record located in the EMR under the Profile tab, revealed R56 was admitted to the facility 12/15/22 with diagnoses including right side hemiplegia following cerebral infarction, type two diabetes mellitus with diabetic chronic kidney disease and neuropathy, schizoaffective disorder, bipolar disorder, depression, anxiety, and chronic post-traumatic stress disorder. Review of R56's quarterly MDS with an ARD of 05/03/24, revealed the resident had a BIMS score of 99, which indicated facility staff were unable to complete the interview. Further review revealed the resident had short-term and long-term memory problems and cognitive skills for daily decision making was moderately impaired - decisions poor, cues/supervision required. During an interview with the DON on 10/09/24 at 1:52 PM it was determined that the last care plan meeting for R56 was in January 2023. The DON further stated that an invitation to a care plan meeting was mailed to the resident's representative on 08/02/24, and the facility has not heard back. Further interview revealed the DON was not aware that quarterly care plan meetings were not being scheduled. 5. Review of R1's Admission Record, dated 10/09/24 and located in the EMR under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The document indicated diagnoses which included anoxic brain damage and functional quadriplegia. The record revealed the resident's medical decision-maker was her father, Family Member (FM) 1. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's quarterly MDS with an Assessment Reference Date (ARD) of 09/11/24 and located in the EMR under the MDS tab, revealed a BIMS assessment was not able to be completed due to the resident's poor cognition and inability to communicate. Review of a R1's Progress Note, dated 09/11/24 and located in the EMR under the Notes tab, revealed, Completed resident's quarterly MDS interview. Resident alert, mostly non verbal. Resident with dx (diagnoses) including Anoxic brain damage, mood affective disorder, anxiety, depression, chronic bronchitis, convulsions, hypokalemia, contractures, functional quadriplegia. Resident requires total care per staff. Receives gtube feeding as ordered, resident is NPO [nothing by mouth]. Incont [incontinent] of bowel and bladder with attends [adult brief] in use. Contractures noted. Dad visits daily. Hearing adequate. No speech, mumbles sounds at times. Vision is highly impaired. Resident is unable to answer when attempting pain interview. Interviewed staff on all shifts that provide care to resident. Staff reports no s/s [signs/symptoms] or indicators of pain noted in last 5 days. No SOB [shortness of breath] noted at this time. Will continue to observe and proceed with current POC [Plan of Care]. Review of R1's comprehensive record revealed nothing to indicate an interdisciplinary team care planning meeting had been held for R1 since 03/17/24 (almost seven months prior to survey) or that FM1 had been invited to a care planning meeting since that date. Review of R1's care planning invitation card, dated 03/17/24 and provided directly to the survey team, revealed FM1 was most recently invited to a care planning meeting on that date. During an interview on 10/08/24 at 11:51 AM, FM1 stated he visited his daughter in the facility daily and stated he did not recall ever receiving an invitation to a care planning meeting for R1. He stated if he was invited to a care planning meeting he would attend and stated he actually had a few questions he would like addressed by the facility. 6. Review of R8's Admission Record, dated 10/09/24 and located in the EMR under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included epilepsy and schizoaffective disorder. The record revealed the resident was his own medical decision-maker. Review of R8's quarterly MDS with an ARD of 07/05/24 and located in the EMR under the MDS tab, revealed a BIMS score of nine out of 15, which indicated the resident was moderately cognitively impaired. Review of a R8's Progress Note, dated 10/07/24 and located in the EMR under the Notes tab, revealed, Resident is own RP [representative]. Care plan card [an invitation to the resident's care planning meeting] delivered to resident in his room. Denies need for care plan meeting at this time. Review of R8's comprehensive record revealed nothing to indicate an interdisciplinary team care planning meeting had been held for R8 related to the 10/07/24 meeting invitation or any time since 03/02/22 (almost two and 1/2 years prior to survey). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/08/24 at 1:24 PM, the SSD confirmed she was responsible for scheduling care planning meetings for residents and ensured an invitation to the meeting was provided to the resident and/or their responsible party. She confirmed that recent IDT care plan meetings had not been held for R1 or R8 and stated she was not aware an IDT care plan meeting needed to be held for each resident quarterly unless the resident or the RP requested a meeting. She stated a care planning meeting had not been held for R8 because he said he didn't need one and confirmed FM1 had not been invited to a care planning meeting, nor had an IDT care plan meeting been held for R1 since March of 2024. She stated, We just don't have a care plan meeting if they (residents) don't want one. No IDT meeting at all. During an interview on 10/10/24 at 12:35 PM, the Administrator and Director of Nursing (DON) confirmed the facility should be conducting care plan meetings for each resident at least quarterly and with any significant change of condition, confirmed their expectation was an IDT care plan meeting be held with all pertinent departments in attendance for each meeting, and confirmed they expected an invitation be provided to each resident and/or representative prior to each meeting. The DON confirmed care plan meetings had not recently been held for any residents who stated they did not want a meeting held according to the report she received from the SSD. The Administrator and DON both stated future care plan meetings, and invitations to these meetings were expected to be clearly documented in each resident's record. 15189 18947

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 38) reviewed for weight/nutrition was provided with recommended and physician prescribed interventions to prevent weight loss of 23 sample residents. This failure created the potential for R38 to experience further weight loss. Findings include: Review of the facility's policy titled, Weight Policy, dated 08/13, read, in pertinent part, It is the policy of the facility to weigh residents on admission and on a monthly basis thereafter. If a resident either gains or loses 5% in 30 days or 10% in 180 days, the following steps will be completed: 1) The resident will be re-weighed 2) Dietary Manager will be notified if he/she determines weight variance is significant 3) Physician and responsible party will be notified 4) Continuing weight loss or gain of 5% monthly, 10% in 180 days, or a total gradual weight loss or significant gain will be brought before the weight management team to determine if a significant change has occurred 5) Weight committee/Care Plan Team will review and take appropriate measures to resolve weight loss or gain 6) The dietician will review residents with significant weight loss. Review of R38's Admission Record, dated 10/09/24 and located in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The document indicated diagnoses which included heart disease, chronic kidney disease, and acute respiratory failure. Review of R38's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/24 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident had no known significant weight loss prior to admission and indicated the resident was not on a prescribed weight loss regimen. Review of R38's Order Summary Report, dated 10/09/24 and located in the EMR under the Orders tab, indicated an order dated 09/06/24 for the resident to receive a regular diet with regular texture and add a Mighty Shake (a nutritional supplement) with each meal. Review of R38's Medication Administration Record (MAR), Treatment Administration Record (TAR), and Certified Nursing Assistant (CNA) daily documentation, all dated 09/04/24/through 10/09/24, revealed nothing to show R38 had been receiving the ordered Mighty Shakes with meals. Nothing was recorded in the record to indicate R38 had been refusing the supplements. Review of R38's Nutrition/State of Nourishment Care Plan, dated 09/01/24 and located in the EMR under the Care Plan tab indicated the resident's state of nourishment was less than body requirement characterized by weight loss, inadequate intake. Goals included Will not experience significant weight loss through next review. Interventions included diet as ordered, offer substitutions for uneaten meals, weigh per facility protocol, and refer to dietitian for evaluation/recommendations. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R38's weight records indicated the following weights, which indicated a significant loss of 12.69% weight loss in one month prior to 10/03/24. The record also indicated R38 was not re-weighed, per facility policy, after she lost seven pounds between 09/19/24 and 10/03/24 (a loss of 5.65% in two weeks): -08/29/24: 134.0 pounds -09/05/24: 133.0 pounds -09/09/24: 134.0 pounds -09/12/24: 127.0 pounds -09/19/24: 124.0 pounds -10/03/24: 117.0 pounds Review of R38's Registered Dietician Recommendations, dated 09/04/24 and provided directly to the survey team, indicated a recommendation to update R38's likes/dislikes and liberalize her diet related to her poor oral intake. The document included a recommendation for R38 to receive Mighty Shakes with her meals. Review of R38's undated Meal Card, provided directly to the survey team, revealed the resident was to receive Mighty Shakes three times daily with meals. During observation on 10/08/24 at 12:26 PM and again on 10/09/24 at 12:15 PM revealed R38 was being served and consuming her lunchtime meals. The resident was observed to be served a regular diet and received assistance to set up her meal prior to consumption. The resident did not receive her ordered Mighty Shake with either of the meals observed. During an interview on 10/09/24 at 12:15 PM, Certified Nursing Assistant (CNA) 4 indicated she was very familiar with R38 and stated the resident did not receive a Mighty Shake with her meals. She stated residents who received a supplement with their meals were populated on a list on the CNA tablet. CNA4 showed the surveyor the list of residents who received supplements and R38 was not on the list. During an interview on 10/09/24 at 12:28 PM, CNA6 indicated she was very familiar with R38 and stated the resident was supposed to receive a Mighty Shake with each meal, however if the resident received a Mighty Shake with breakfast, she did not receive one with lunch because if the resident was served too many supplements, she would not eat her real food. During an interview on 10/09/24 at 1:37 PM, the Dietary Manager (DM) stated she was not familiar with R38 since she did not interact with her very much. She stated she received a weekly email from the Registered Dietitian (RD) with recommendations for residents who were losing weight, but that she did not do anything to follow-up with the recommendations until she received an order from the nursing staff related to the recommendations. She stated she was not aware of R38's weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 2:00 PM, the RD confirmed she was familiar with R38 and stated she was aware of her recent weight loss. The RD stated her most recent recommended intervention for the resident's weight loss was to add Mighty Shakes with each of her meals. She confirmed her recommendations were emailed, weekly, to the Director of Nursing (DON) and the DM. The RD stated the facility's process was to document the administration of the Mighty Shakes in the CNA documentation. The RD stated her expectation was facility staff would obtain a re-weight if a resident experienced a weight loss of more than 5% between weights and her recommendations should be followed related to nutritional interventions to prevent weight loss. During a follow-up interview with the RD on 10/09/24 at 3:05 PM, she stated she had just spoken with nursing staff regarding R38's weight loss and the lack of documentation of administration of the recommended and ordered Mighty Shakes and staff reported to her they were not providing the resident with the shakes with each meal because the shakes filled the resident up and then she would not eat her meal. The RD stated the information had not been previously communicated to her by nursing staff and that her expectation was facility staff would communicate any deviation in the recommended plan of care immediately so that she was able to address any concern related to the resident's diet. The RD confirmed she was not able to locate any documentation to show R38 had been receiving the Mighty Shakes in the resident's record. During an interview on 10/10/24 at 12:30 PM, the DON and the Administrator stated their expectation was residents would be re-weighed with any significant weight loss of more than 5% and RD recommendations were expected to be followed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 15189 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that a trauma survivor received trauma-informed, culturally competent care accounting for resident's experiences and preferences to avoid triggers (psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening) leading to potential re-traumatization for one of three residents (Resident (R) 56) reviewed for mood/behavior of 23 sample residents. The failure had the potential to affect residents with a diagnosis of post-traumatic stress disorder which could interfere with residents' quality of life. Findings include: Review of the facility's policy titled, Trauma and Post Traumatic Stress Disorder (PTSD) Informed Care, dated 08/19, revealed .The intent of this section is to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or PTSD receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being. Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, will receive appropriate person-centered and individualized treatment and services to meet their assessed needs .The Social Worker will: Ensure that the IDT, which includes the resident, the resident's family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. This is done through an assessment of the resident's expressions or indications of distress to determine if services are needed . During an observation and interview on 10/07/24 at 10:25 AM the resident utilized a wheelchair and was able to self-propel. The resident was observed with right side paralysis. The resident was able to answer yes or no questions but was aphasic. The resident nodded her head affirming that she had a diagnosis of PTSD. When asked if she had nightmares related to PTSD, the resident was unable to answer yes or no. Review of R56's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R46 was admitted to the facility 12/15/22 with diagnoses including right side hemiplegia following cerebral infarction, schizoaffective disorder, bipolar disorder, depression, anxiety, and chronic post-traumatic stress disorder (PTSD). Review of R56's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated facility staff were unable to complete the assessment. Further review revealed the resident had short-term and long-term memory problems, cognitive skills for daily decision making and had moderately impaired decisions, poor, cues/supervision required. Review of R56's attending physician's progress note, dated 03/05/23, located under the Misc tab of the EMR, revealed that the resident has a history of a stroke and automobile accident with multiple injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185433	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri-Cities Nursing and Rehabilitation Center	19101 US Highway 119 North Cumberland, KY 40823

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R56's Trauma Informed Assessment, dated 12/16/22, located under the Assessments tab of the electronic medical record revealed that under the Life Events Checklist .3. Any transportation accident (car, boat, train, plane accidents) .12. Any life-threatening illness or injury .17. Any other very stressful event or experiences .'Doesn't apply' was checked. Review of R56's admission Social History, dated 12/16/22 and located under the Assessments tab of the EMR, revealed .7. History of Mental Health Problems was left blank. Review of the quarterly Social Services - V 2 assessment, dated 08/01/24 and located under the Assessments tab of the EMR revealed .7. History of Mental Health Problems was left blank. Further review of R56's medical record revealed a care plan for PTSD had not been developed. The care plan failed to identify specific traumatic events. There was not a trauma-informed care approach (delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma) to providing care to R56. During an interview on 10/09/24 at 9:54 AM, the Certified Nursing Assistant (CNA) 4 stated that she was not aware of any psychiatric diagnoses for R56. During an interview on 10/09/24 at 9:56 AM, it was revealed that the Registered Nurse (RN) 3 was not aware of R56's diagnosis of PTSD and she proceeded to log onto the computer to look at the resident's diagnoses. During an interview on 10/09/24 at 11:21 AM, the Social Services Director (SSD) revealed that when the social service assessments were completed, she does not usually plug anything in on the section for history of mental health problems. SSD stated that she was aware of the resident's diagnosis of PTSD but did not recall what the resident's representative told her related to the resident's diagnosis of PTSD. During an interview on 10/10/24 at 1:20 PM, the Director of Nursing (DON) determined that her expectation was that staff needed to assess a resident with a diagnosis of PTSD for the cause, triggers, and what hurt or helped the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, record review, and interviews, the facility failed to ensure one of four residents (Resident (R) 36) reviewed for accidents was assessed for her use of side rails, had a care plan in place for use of the rails, and had an informed consent for the use of side rails out of 23 sample residents. This failure created the potential for the resident to be injured related to potentially unnecessary side rails installed and in use on her bed. Findings include: Review of R36's Admission Record, dated 10/09/24 and located in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The document indicated diagnoses which included hemiplegia and hemiparesis following a stroke. Review of R36's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/24 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was completely dependent upon staff to move about in her bed and to transfer in and out of her bed. The assessment did not indicate side rails were in use for R36. Review of R36's Order Summary Report, dated 10/09/24 and located in the EMR under the Orders tab, indicated no orders for the resident's use of side rails on her bed. Review of R36's comprehensive care plan, most recently dated 08/06/24 and located in the EMR under the Care Plan tab, indicated nothing to reflect the resident's use of side rails. The care plan indicated the resident was completely dependent upon staff to move in her bed and transfer in and out of her bed. Review of R36's record revealed nothing to show the resident had been recently assessed for use of bed rails or that informed consent had been provided for the use of rails. During observations on 10/07/24 at 11:36 AM, 11:56 AM and 1:44 PM, on 10/09/24 at 9:46 AM, 11:56 AM, and 12:04 PM, R36 was observed lying in her bed with a wing-tip mattress and bilateral 1/3 side rails in the raised position at the head of her bed. The resident's bed was in a low position and fall mats were placed on both sides of her bed during each of the observations. During an observation and interview alongside Certified Nursing Assistants (CNA) 2 and CNA5 on 10/09/24 at 11:56 AM, they both confirmed the resident's side rails were raised at the top of her bed and stated they didn't think residents should have raised bed rails when a wing tipped mattress was on their bed unless a resident was able to use the rails somehow. Both staff members confirmed R36 was not able to use bed rails to move within her bed or to transfer in and out of her bed. (continued on next page)

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	185433	A. Building B. Wing	10/10/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview alongside Registered Nurse (RN) 1, R36 was in bed with her bilateral side rails in the raised position at the top of her bed on 10/09/24 at 12:04 PM. RN1 indicated she was in charge of ensuring bedrails were necessary for all residents using rails in the facility and stated any resident using rails should have an assessment, care plan, and documentation of informed consent for use of the rails. During an interview with the Administrator and Director of Nursing (DON) on 10/10/24 at 12:39 PM, the DON stated any resident using side rails on their bed was expected to have informed consent as well as a care plan and assessment for use of side rails. She stated she thought R36's use of side rails had fallen through the cracks. The Administrator agreed with the DON's statements.

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	185433	A. Building B. Wing	10/10/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, record review, interviews, and facility policy review, the facility failed to ensure a medication error rate of less than 5% with two errors, involving two of five residents (Residents (R) 46 and R73), conducted out of a total of 28 opportunities for error, resulting in a 7.14% error rate out of 23 sample residents. R46 was not prompted to rinse his mouth after the administration of an inhaled steroid medication and the insulin pen was not left inserted in R73's subcutaneous (fatty) tissue for the required amount of time to ensure full absorption of the insulin. These failures created the potential for residents to experience negative physical impact related to the administration of their medications. Findings include: Review of the facility's policy titled, Administration of Kwikpen Insulin Pen Policy/ Procedure, dated 09/20, read, in pertinent part, Procedure: Dose Selection and Injection: 3. Inject the dose by inserting the needle into the skin in the back of the upper arm, abdomen or thigh. Press the injection button in all the way. Hold the button in that position for approximately 5 seconds then withdraw the needle. 1. Review of R46's Admission Record, dated 10/09/24 and located in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The record indicated the resident's diagnoses included chronic obstructive pulmonary disease (COPD). Review of R46's Order Summary Report, dated 10/09/24 and located in the EMR under the Orders tab, indicated orders for the resident to receive Tiotropium Bromide Monohydrate (Spiriva-an inhaled steroid medication) 18 MCG (micrograms) per inhalation one time daily to treat his COPD. The original order date for the medication was 10/02/24. During an observation on 10/09/24 at 9:29 AM, the Certified Nursing Assistant/Kentucky Medication Assistant (CNA/KMA) 3 was administering R46's medications. The resident's Spiriva was observed to be administered but the resident was not prompted to rinse his mouth after the administration of the medication. R46 did not rinse his mouth prior to CNA/KMA3's exit from his room. During an interview on 10/09/24 at 9:42 AM, CNA/KMA3 stated she was not aware the resident's mouth needed to be rinsed after the administration of his steroid inhaler. 2. Review of R73's Admission Record, dated 10/09/24 and located in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE]. The record indicated the resident's diagnoses included type two diabetes. Review of R73's Order Summary Report, dated 10/09/24 and located in the EMR under the Orders tab, indicated orders for the resident to receive Humulin R Injection Solution 100 UNIT/ML (units per milliliter) (insulin) per sliding scale four times daily related to her diagnosis of type two diabetes. The original order date for the insulin was 09/16/24. (continued on next page)

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	185433	A. Building B. Wing	10/10/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/08/24 at 11:14 AM, Registered Nurse (RN) 2 was observed administering R73's insulin. The resident received two units of sliding scale insulin per insulin pen related to her blood sugar reading of 236. The insulin pen needle was inserted into the resident's skin and the insulin was injected. After injection of the insulin, the needle was removed immediately (not left inserted for the expected amount of time to ensure full absorption of the medication). During an interview on 10/08/24 at 11:32 AM, with RN2 stated she thought the needle should have been left inserted in R73's skin for 10 seconds after administration of the insulin. She confirmed she had not done this. During an interview on 10/09/24 at 3:58 PM, the Director of Nursing (DON) stated her expectation was the resident's mouth to be rinsed after the administration of an inhaled steroid medication and the insulin pen needle was to be left inserted in a resident's skin for 10 seconds after the administration of insulin. During an interview on 10/10/24 at 12:43 PM, the Administrator confirmed his expectation was medications were to be administered according to established guidelines/policies/procedures and per the direction of the DON.

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	185433	A. Building B. Wing	10/10/2024

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 12679 Based on document review, interview, and policy review, the facility failed to ensure the dietary department was managed by a qualified director of food and nutrition services with the potential to affect 67 of 69 residents living at the facility. Findings include: Review of the 2022 Food Code US (United States) FDA (Food and Drug Administration), dated 01/18/23, Chapter 2-3 and located at https://www.fda.gov/media/164194/download?attachment, indicated Certified Food Protection Manager .The person in charge shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program . Review of a document provided by the facility titled, Food Service Manager, dated 07/01/16, indicated .The primary purpose of your job is to plan, organize, develop, and direct the overall operation of the Dietary Department in accordance with the current applicable federal, state, and local standards, guidelines, and regulation .Be a certified food protection manager . Review of the Dietary Manager's (DM) employee file revealed she was hired on 10/03/23 as a cook for the facility. Included in the DM's employee file was a handwritten note, dated 05/16/24, that the DM would continue to work as a weekend manager, then transition to the full-time manager and begin testing for her dietary credentials as a Certified Dietary Manager (CDM). During an interview on 10/09/24 at 12:53 AM, DM confirmed she had no prior management experience in a nursing facility prior to 05/16/24. The DM stated she was not far along in her studies to prepare for the CDM exam. During an interview on 10/09/24 at 1:59 PM, the Registered Dietitian (RD) confirmed the DM was not a CDM and had encouraged her to complete the courses. The RD stated she did not supervise the current DM. During an interview on 10/10/24 at 12:30 PM, the Administrator and the Director of Nursing (DON) stated the RD would be coming in more frequently to provide additional training to the DM and the expectation was for the DM to complete her training to become a CDM.

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	185433	A. Building B. Wing	10/10/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 12679 Based on observation, menu review, interview, and facility policy review, the facility failed to ensure the menus and menu extensions were followed which included providing appropriate approved food substitutions, ensuring recipes were followed, and proper scoop sizes were utilized for 67 out of 69 residents residing in the facility. This failure had the potential for residents to lose weight. Findings include: Review of the facility's undated policy titled, Menu Changes, indicated .Changes may be made to the existing menu by the Dietary Manager or Kitchen Supervisor for the following reasons .Product as ordered for meal was out of stock .Menu items which are substituted are noted by the Food Service Manager or Kitchen Supervisor . 1. A review of a document provided by the facility titled, Menu, dated the week of 09/09/24, indicated Monday's lunch meal included country fried steak, gravy, sour cream mash potatoes, and lima beans. During an initial tour of the kitchen conducted on 10/07/24 at 9:55 AM, Cook1 stated he had to replace lima beans with pinto beans since he could not locate the lima beans in the kitchen. Cook1 confirmed there was no evidence on the menu that a substitution had been approved. During an observation conducted on 10/07/24 at 11:46 AM, Cook1 began to serve the lunch meal. The pinto beans were observed served to the residents during this observation. During an interview on 10/09/24 at 12:53 AM, the Dietary Manager (DM) stated the menu for 09/09/24 was not the correct menu for the week. The DM stated she was the staff member to ensure the menus were the correct ones for the associated week. The DM stated the only directions that she and her staff followed were when they had to make powdered mashed potatoes, other than that she and the kitchen staff did not have menus to follow. The DM stated there was beef bouillon stocked and was not sure why Cook1 could not locate. The DM stated water was not to be used to create the pureed beef dish. DM stated the beef bouillon would provide a better taste for the pureed meat dishes. DM stated it was her expectation for the cook staff to use bouillon for the pureed meat dishes and not water. The DM stated there was no reason for the staff to use pinto beans instead of lima beans which were identified on the menu for the residents. During an interview on 10/09/24 at 1:59 PM, the Registered Dietitian (RD) stated that the DM had not been asking for enrichment menus, such as the recipe for pureed meats. The DM stated if water was added instead of beef bouillon, this would have the potential to be nutritionally inadequate. The DM stated there was a process for substitutions of menu items which included the substitution log, and she would then sign off on the substitution log. The DM stated the residents were then to be notified of the substitution. A request was made for a copy of the recipe for pureed meat, but it was not provided before the end of the survey. (continued on next page)

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	185433	A. Building B. Wing	10/10/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of a document provided by the facility titled, Principle LTC Spring Summer 2024 referred to as menu extension indicated the following: -Pureed fried steak required the use of a number eight scoop or gray handled scoop which served four ounces of pureed meat. -A regular menu item for beans was to be served with a gray handle which served four ounces of beans. -Ground fried steak required the use of a number eight scoop or a gray handled scoop which served four ounces of beef. -Mashed potatoes were to be served one half of a cup or the use of a gray handled scoop which held four ounces. An observation was conducted on 10/07/24 at 11:46 AM, and the following food items were observed prior to being served: pureed fried steak, pinto beans, mashed potatoes, and ground fried steak. Cook1 used a blue handle scoop to serve pureed beef, which indicated two ounces of food; Cook1 used a blue handle scoop to serve pinto beans which indicated two ounces of food; Cook1 used a green handle scoop to serve ground fried steak, which indicated two and two thirds' ounces of food; Cook1 used a green handle scoop to serve mashed potatoes, which indicated two and two thirds of food. During an interview on 10/09/24 at 1:59 PM, when the DM was asked about the scoop size for the observation and stated she did not have the scoop sizes memorized and then went into the kitchen. The DM and the RD were present in the kitchen and a standardized scoop size poster was posted. During an interview on 10/09/24 at 2:40 PM, the RD and the DM entered the kitchen and walked to the posted scoop size and verified each serving and scoop size that was observed during the tray line. The RD stated [NAME] 1 should have used the associated scoop size per direction from the extended menu and this was a standard of practice and had no facility policy. During an interview on 10/10/24 at 12:30 PM, the Administrator and the Director of Nursing (DON) were present. The Administrator stated the residents would prefer to have pinto beans at any time of the week and was not aware of the differences in serving size observed during the tray line and stated he would be providing the DM with more support from the corporate office. The Administrator stated he was aware of the water used instead of bouillon and stated this potentially could affect the palatability of the food being served and potentially less calories.

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	185433	A. Building B. Wing	10/10/2024

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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. 12679 Based on observation, document review, interview, and policy review the facility failed to ensure food items in the kitchen and storage areas were dated and labeled, food temperature logs were completed on a consistent manner, and utensils were not stored in ready to eat food for 67 out of 69 residents. This failure had the potential to lead to food-borne illnesses and cross contamination. Findings include: Review of the facility's policy titled, Food Temperature, dated 02/09/16, indicated .Temperature checklists and thermometers will be available in the kitchen. The Food Service Manager and/or Cooks are responsible for taking food temperatures prior to service of all foods prepared and record on the Steam Table Food Temperature form . Review of the facility's policy titled, Food Storage, dated 08/13, indicated .All incoming foods will have a delivery date and/or open date or used by date . Review of the 2022 Food Code US (United States) FDA (Food and Drug Administration), dated 01/18/23, located at https://www.fda.gov/media/164194/download?attachment, indicated .Chapter 3-13: During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored .In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon .Chapter 3-28: refrigerated, ready-to eat, time/temperature control for food safety food is prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 [degrees] C [Celsius] (41 F [Fahrenheit]) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . 1. Review of a document provided by the facility titled Steam Table Food Temperatures revealed: -Breakfast dated 09/02/24 to 09/08/24 indicated there were no temperatures recorded on 09/07/24 and on 09/08/24. -Lunch dated 09/02/24 to 09/08/24 indicated there were no temperatures recorded on 09/07/24 and on 09/08/24. -Dinner 09/02/24 to 09/08/24 indicated there were no temperatures recorded on 09/03/24 through 09/08/24. Review of a document provided by the facility titled Steam Table Food Temperatures revealed: -Breakfast 09/16/24 to 09/29/24 indicated there were no temperatures recorded on 09/20/24 through 09/22/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Lunch 09/16/24 to 09/29/24 indicated there were no temperatures recorded on 09/20/24 through 09/22/24. -Dinner 09/16/24 to 09/29/24 failed to record temperatures from 09/16/24 through 09/29/24. During an initial tour of the kitchen on 10/07/24 at 9:38 AM, Cook1 verified that the kitchen staff were not provided with the October temperature log to document the temperatures for the food items to be served. Cook1 also verified the logs for the steam table were also incomplete. During an interview on 10/09/24 at 1:59 PM, the Registered Dietitian (RD) stated she went over the importance of completing temperature logs with the Dietary Manager (DM) in 08/24 to ensure food items were at the proper temperature to ensure food items did not enter into an unsafe temperature zone prior to serving the residents. 2. During an initial tour of the kitchen conducted on 10/07/24 at 9:38 AM, Cook1 and Dietary Aide (DA) 3 opened the reach in refrigerator and the following items were identified: Two large clear containers of cooked cabbage with no date and no label; Mandarin oranges with no date and no label in a large clean plastic container; Cooked beans dated 09/30/24; Fresh tomatoes in a metal container and diced with no label and date; Two large bags of chopped wilted lettuce and one small bag of liquified lettuce with no date and label; Fruit cocktail in a clear plastic container with no date and label; and a bag of log of bologna and sliced with no date and label. DA3 confirmed the items were not labeled or dated. DA3 stated the liquified lettuce should not be in the refrigerator. During an interview on 10/09/24 at 12:53 PM, the DM stated the reach-in refrigerator was to be cleaned each Friday and that the staff member was to verify that food was labeled and dated. During an interview on 10/09/24 at 1:59 PM, the RD stated she began coming to the facility in 08/24 and stated the facility needed to date and label food when it was opened and the date the food was to be used by. The RD stated this was critical to label the date opened and use-by-date since there was potential for residents with a compromised immune system and could cause a food borne illness if the staff did not have this information available. 3. During an initial tour of the kitchen conducted on 10/07/24 at 9:38 AM, Cook1 verified that a scoop was left in a transparent plastic container, which contained multiple colored cereal, a scoop was left in a transparent plastic container which contained cereal flakes, and a scoop was left in a transparent plastic container which contained Cheerios. Cook1 stated by leaving the scoops in and on top of the dried cereal there was potential for cross-contamination. During an interview on 10/09/24 12:53 PM, the DM confirmed by leaving the scoops in the cereal containers there was potential for cross-contamination of the food item. During an interview on 10/09/24 1:59 PM, the RD stated scoops were not to be left in the bin due to the potential for cross-contamination of food. During an interview on 10/10/24 at 12:30 PM, the Administrator and Director of Nursing (DON) were alerted to the three concerns identified in the kitchen. The Administrator stated his expectation was for the kitchen to be maintained and sanitized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185433	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri-Cities Nursing and Rehabilitation Center	19101 US Highway 119 North Cumberland, KY 40823

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 12679 Based on observation and interview, the facility failed to ensure garbage was properly disposed of and contained; with the potential to affect 69 census residents and staff in the facility. This failure had the potential to attract pests. Findings include: During an initial tour of the kitchen on 10/07/24 at 11:30 AM, there were two outside dumpsters inside a fenced area. The lids to the dumpsters were off the hinges and exposed the partial contents of the inside of each dumpster. On the outside of the fenced area, there was debris which included old food, soup containers, disposable cups, and used adult briefs. A strong odor omitted from the trash. There was also debris which surrounded the trash bins on the inside of the fenced area. Dietary Aide (DA) 1 was present during this observation and stated that bears would climb over the fence and either pull the bags from the dumpster to the outside of the fenced area or would toss the trash bags over the fenced area and then tear the bags apart. At 11:33 AM, the Maintenance Director (MD) came out and stated he cleaned this area on a daily basis and said animal control did not work with the facility to help manage the bears. The DM stated the lids to the dumpsters were not broken but could be popped into place. The MD stated there was an area on top of the fencing which used to be an electric area, but the bears were not bothered by the electric shock. (Cross Reference F880) During an interview with the Administrator and Director of Nursing (DON) on 10/10/24 at 12:30 PM, the Administrator stated his expectation was for the area around the dumpster to be cleaned and confirmed the facility had no formal policy on this issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185433	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Many	Provide and implement an infection prevention and control program. 12679 Based on observation and interviews, the facility failed to ensure staff donned (put on) personal protective equipment (PPE) prior to cleaning the outside of two facility dumpsters. This had the potential for staff, who lacked proper PPE, to carry bacteria into the facility and possibly contaminate areas in which residents live for 69 census residents. Findings include: During an observation on 10/07/24 at 11:30 AM, a tour was conducted of the two outside dumpsters. The two dumpsters were fenced in and on the inside and outside perimeter of the fence contained a large amount of trash. The Maintenance Director (MD) stated bears came into the fenced area and either climbed out of the area with facility trash bags or tossed the trash bags over the fence. The MD stated he had to spend approximately three hours each day cleaning up the debris caused by the bears. The MD stated he did not wear any sort of PPE when cleaning up the trash thrown out by the bears. The MD stated the items that were typically in the trash were used adult incontinence briefs along with food waste from the kitchen. The MD stated he used latex gloves, with no protective boots or gowns. The MD stated he was well aware of the potential bacteria that could be carried back to the facility such as salmonella and e-coli. During an interview on 10/07/24 at 11:40 AM, Dietary Aide (DA) 1 and DA2 were sitting on the outside of the building and faced the dumpsters and confirmed the MD did not don PPE when he cleaned up the trash caused by the bears. During an interview on 10/07/24 at 1:30 PM, the Infection Preventionist (IP) stated she was aware that bears would rummage through the facility's garbage and that staff were cleaning up the trash that the bears had caused. The IP stated she was unaware that staff did not don PPE prior to cleaning up the debris and this was a potential infection control issue. The IP stated staff could potentially be dragging in unwanted bacteria into the facility. The IP stated that staff might need rubber gloves and boots since those items could be washed off. During an interview on 10/07/24 at 1:50 PM, the Director of Housekeeping stated her staff would take out trash to the dumpsters. The Director of Housekeeping stated that she was aware maintenance would clean the area where the bears had dumped and gone through all the bagged trash and there were times the housekeeping staff would complain to her about walking through the trash on the ground and were at times assisting with the cleaning. The Director of Housekeeping stated that the housekeeping staff did not don rubber boots, and this was a potential infection control issue if the staff came back into the facility. During an interview on 10/07/24 at 2:07 PM, the Administrator and the Director of Nursing (DON) both stated they were unaware that staff were cleaning up the debris left by the bears.