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	02/12/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, interview, record review, and facility policy review, the facility failed to serve meals in accordance with the established menu and required portion sizes, which had the potential to affect all residents consuming their meals from the facility's kitchen. The findings include: Review of the facility policy titled, Dietary Supervision, undated, revealed the Dietary Manager was responsible for the overall dietary program and was accountable for ensuring acceptable standards of food preparation and service. Per review of the policy, the Dietary Manager, was responsible for serving of all diets, maintenance of food service standards, and the training and supervision of dietary staff to ensure compliance with established dietary practices and procedures. Review of the facility policy titled, Menus and Adequate Nutrition, date reviewed/revised 09/01/2024, revealed the facility was responsible for ensuring menus were developed, prepared, followed, and approved in accordance with established national nutritional guidelines and resident needs. Continued review the policy required dietary services (staff) to ensure menu substitutions provided had comparable nutritional value. Review of the facility policy titled, Standardized Menus, reviewed/revised 09/01/2024, revealed the facility was required to follow menus as planned, approved and signed by a Registered Dietitian (RD). Per review, the facility was also to ensure the menus were implemented by dietary services staff using standardized portions identified in ounces and/or measurements. Continued review revealed the policy required dietary management oversight to ensure menus were being followed as planned, revised as necessary based on resident needs and preferences, and maintained on file. Further review revealed dietary services leadership was responsible to ensure menu accuracy, portion consistency, and ongoing review for nutritional adequacy to support residents' nutritional needs. Observation, on 02/09/2026 at 11:45 AM, during the lunch meal service, revealed dietary staff utilized a scoop identified as a 4-ounce (oz) serving to portion beef noodle casserole for residents. Review of the posted menu and/or serving guide revealed the planned serving size for the beef noodle casserole was to have been 6 oz. of casserole. Further observation revealed no additional scoops or portions were observed being added by dietary staff to the residents' plates during the meal service. Observation, on 02/09/2026 at approximately 12:15 PM, during lunch meal preparation, revealed a Dietary Aide (DA) portioned chicken salad onto bread to prepare sandwiches using a scoop identified as a 1 7/8-oz serving. Further observation revealed staff did not add extra portions of the chicken salad during sandwich preparation. During interview with R35, on 02/09/2026 at 2:31 PM, he stated there had been time the meals he was served was not enough to make him feel full, and he would still be hungry. He reported he told nursing staff about that, and sometimes they would bring him a sandwich. R35 further stated other times none of the nursing staff would come back with anything, and he would have to eat a snack he personally had bought. During interview with [NAME] 1 on 02/09/2026 at 12:15 PM, she stated when preparing alternative meals, such as sandwiches, the menu was not referenced to determine the planned portion sizes for the sandwiches. [NAME] 1 stated, I figure you don't want a big scoop of chicken salad and said she always utilized a scoop identified as a 1 7/8-ounce serving when portioning chicken salad. Per interview, [NAME] 1 said she did not enjoy a sandwich with a lot of chicken salad because that would be messy and no one like a messy sandwich. (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] 1 further stated it was important to serve the correct amount of food, so residents did not go hungry or experience weight loss. During interview with [NAME] 2 on 02/09/2026 at 12:22 PM, he stated the facility did not have serving scoops available for portion sizes of 1 1/3 ounces, 1 5/8 ounces, and 6 ounces. [NAME] 2 reported approximately two years ago someone from their corporate offices came into the kitchen and told dietary staff they did not use those size scoops enough to keep them and threw the scoops in the garbage. He continued to state when the menu required a scoop size not available at the facility, the closest smaller scoop was used. [NAME] 2 stated when the menu required a scoop size not available at the facility, the closest smaller scoop was used instead of a larger scoop to prevent serving more food than was planned. He further stated however, by using smaller scoop sizes, residents were not receiving the portion sizes indicated on the menu. During interview with the Director of Nursing (DON) on 02/11/2026 at 10:18 AM, she stated it was important for residents to receive meal portions that matched what was indicated on the menu. She said it was important to do that to ensure meals were provided as planned. She stated nursing staff documented residents' meal intakes, and depended on the dietary staff to follow the menus and serve the correct portion sizes. She reported she was aware the Administrator had performed observations of the kitchen recently. The DON said providing meals as planned supported accurate assessment of residents' intake, and assisted in monitoring residents' nutritional status. The DON further stated however, residents' meal intakes could not accurately be recorded if dietary staff were not serving the correct portion sizes as indicated on the menu. During interview with the Administrator, on 09/11/2026 at 10:39 AM, he stated the facility employed a Registered Dietitian (RD). The Administrator said the RD's responsibilities included reviewing residents' medical records, assessing nutritional needs, and reviewing their documented food and fluid intake. He reported the RD's responsibilities also included: monitoring residents' weight changes; and reviewing and approving menus to ensure nutritional adequacy and appropriate portion sizes. The Administrator stated it was his expectation for dietary staff to follow all facility policies and procedures, including following posted menus and serving correct portion sizes as indicated. He further stated he had performed audits on the dietary staff, and had not noted any concerns. The Administrator further stated he had not provided any suggestions to the dietary team on things they could do for improvements. During interview with the RD, on 02/11/2026 at 12:09 PM, she stated inaccurate portioning by dietary staff interfered with her ability to effectively perform her job responsibilities. She said she reviewed residents' charts and their documented food consumption to assess their nutritional status. The RD stated she had instructed the DM to in-service dietary staff after performing a tray line observation where portion sizes were not being followed. She said however, the DM had not communicated with her that the requested in-services were performed. The RD reported when dietary staff did not follow posted menus and served incorrect portion sizes, residents' intake could not be accurately documented. She explained that prevented her from accurately determining what residents were actually consuming. The RD said not being able to accurately determine residents' intake limited her ability to appropriately assess and address their nutritional needs. She stated she had advised the DM to provide in-services to dietary staff regarding the importance of following menus and using correct portion sizes. The RD further stated failure to provide correct portion sizes could result in negative outcomes for residents such as, weight loss, decreased energy, increased risk of falls, and skin breakdown. During interview with the DM, on 02/11/2026 at 3:19 PM, she stated it was important for dietary staff to follow the posted menus and serve the correct portion sizes to meet each resident's nutritional needs. The DM said doing that supported residents' energy levels and their overall health. The DM stated it was her expectation for dietary staff to follow all facility policies and procedures, including serving the correct portion sizes as indicated. The DM reported however, she had not been performing tray audits and had not been actively monitoring dietary staff as they were serving food on the tray line. She reported she discussed scoop sizes with staff upon hire, but didn't really talk about it after that. The DM said she should start talking about using the correct scoops to her staff so they (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would understand the importance of serving residents the correct portion sizes. The DM stated the correct portion size for chicken salad was 3 ounces and she was aware of which staff member had prepared the sandwiches. The DM further stated the dietary staff member did not always follow the correct portion sizes. She additionally stated she did not have any staff on any performance reviews for not following the correct portion sizes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 12 of 22 sampled residents.The findings include: Review of the facility policy titled, Infection Prevention and Control Program revised 04/28/2025, revealed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Continued review revealed environmental cleaning and disinfection shall be performed according to facility policy. Further review revealed all staff had responsibilities related to the cleanliness of the facility and were to report problems outside of their scope to the appropriate department. Observation on 02/09/2026 at 2:45 PM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed no bag was in the trash can. Continued review revealed a bed pan and graduate were located on the floor of the bathroom. Further observation revealed an opened pack of wipes located on a geri-chair. Observation on 02/09/2026 at 3:00 PM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed an unbagged urinal located between the wall and handrail next to the toilet. Further observation revealed a bedside commode located in the bathroom unbagged with an opened brief lying on top of the bedside commode. Observation on 02/09/2026 at 3:05 PM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed two opened packages of briefs lying on the bathroom floor. Observation on 2/09/2026 at 3:10 PM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed a package of opened briefs lying on the floor. Further observation revealed an opened unpackaged brief located between the wall and handrail behind the toilet. In interview on 02/09/2026 at 3:20 PM, Certified Nursing Aide (CNA) 1 stated personal items such as briefs and wipes were to be kept in the resident's closet. CNA 1 further stated any items located in the bathroom were to be placed in a bag for sanitary reasons as that could be an issue with infection control. CNA1 stated that they were responsible for caring for the residents that utilize the bathrooms in question but could not give an answer as to why the items were left in the bathroom floor. CNA1 stated, I don't know why they are in the bathroom, they're usually kept in the resident closets. Observation on 02/11/2026 at 11:30 AM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed oxygen tubing hanging on the handle of the toilet. Continued observation revealed a bed pan and graduate located on the floor of the bathroom. Further observation revealed an opened pack of wipes located on a geri-chair that was stored in the restroom. Observation on 02/11/2026 at 11:35 AM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed an unbagged urinal between the wall and handrail next to the toilet. Further observation revealed the bedside commode remained stored in the bathroom unbagged with an opened brief located on top of it. Observation on 02/11/2026 at 11:40 AM, of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER], revealed the two opened packages of briefs remained lying on the bathroom floor. On 02/11/2026 at 11:45 AM, observation of the shared bathroom in room [ROOM NUMBER] and room [ROOM NUMBER] revealed an opened package of briefs lying on the floor. Further observation revealed an opened unpackaged brief remained located between the wall and handrail behind the toilet. In interview on 02/11/2026 at 12:00 PM, the Director of Nursing (DON) after observing the bathrooms, stated it was unacceptable for that to be occurring. The DON said her staff knew better, as they were educated monthly on infection control. She reported the importance of sanitizing and bagging items was to lower the risk of spreading illnesses from resident to resident. The DON further stated she would not be satisfied with the infection control observation issues if it was her mother or father living in the facility. In interview on 02/11/2026 at 2:00 PM, with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Preventionist (IP), she stated her expectations for staff was for them to follow what they had been taught monthly pertaining to infection control. The IP stated that she usually conducts drop ins on the floor to observe CNAs and nurses to ensure that infection control was being followed such as handwashing, gowning up, bagging items not being used and that she has never found an issue on the floors with infection control practices. In interview on 02/11/2026 at 2:20 PM, the Administrator stated his expectation for infection control and storage was for staff to put dirty items in the dirty storage until cleaned and put back into service on the floor.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and review of facility policy, the facility failed to ensure beverages were served in a palatable manner, to include temperature and taste for 6 out of 22 sampled residents (Resident (R)27, R33, R23, R35, R51, and R40), and had the potential to affect all residents consuming hot beverages from the facility's kitchen. The findings include: Review of the facility policy titled, Standardized Menus, undated, revealed the facility was responsible for providing nourishing and palatable meals to residents in accordance with established nutritional standards. Per review of the policy, it was the responsibility of dietary services staff and (their) oversight personnel to consistently implement menus in a manner that supported meal acceptability and palatability for residents. Observation on 02/10/2026 at approximately 7:40 AM, of the breakfast tray line, revealed dietary staff had prepped coffee and placed it in mugs with plastic lids, on an open metal cart behind the tray line, where it remained prior to being served during breakfast meal service. Review of the facility's posted mealtimes revealed its North Hall was scheduled to be served at 7:50 AM; the South Hall at 8:00 AM; the Restorative Dining Room at 8:00 AM; and the Railroad Dining Room at 8:15 AM. Continued observation, on 02/10/2026 at 8:08 AM, revealed the test tray left the kitchen on the meal cart. Per observation, the test tray was observed in the cart in the Railroad dining area, at 8:09 AM, waiting for nursing staff to deliver trays to the residents. Observation at 8:17 AM, revealed two nursing staff members arrived and began distributing the meal trays to residents. Further observation at 8:21 AM, revealed the last resident tray was delivered, and temperatures were obtained of the food on the test tray, by [NAME] 3 and verified by the Dietary Manager (DM). Additionally, observation and interview, at the time of the temperature checks, revealed the thermometer read 98.6, as reported by [NAME] 3, and confirmed by the DM. During interview with R35, on 02/09/2026 2:31 PM, he stated when he drank the coffee, brought to him by nursing staff, it was cold and bitter. He said he had told staff something needed to be done about the temperature of the coffee. R35 reported he was unsure when he first told nursing staff about the cold coffee; however, said it had been an issue for awhile. During a Resident Council meeting on 02/09/2026 at 3:00 PM, all Resident Council members (R27, R33, R23, and R51) stated hot food and beverages, particularly the drinks, were frequently served cold during meal service. The Resident Council members said they previously reported their concerns, regarding hot beverages being served cold, to facility staff and, at times, they were provided with a replacement hot beverage. Per interview, the Resident Council Members stated however, they were unaware of any actions having been taken by the facility to address the issue of ensuring hot beverages were consistently served at an acceptable temperature. During interview with R40, on 02/09/2026 at 3:25 PM, he stated his coffee was always served ice cold when it arrived in his room during meal service. R40 said he was aware he could obtain hot coffee if he walked to the kitchen himself to get it. The resident further stated however, he should not have to do that because his coffee should be hot and palatable when staff brought it to him. During interview with Dietary Aide 2, on 02/10/2026 at 8:06 AM, he stated dietary staff prepared the coffee and placed it in a non-insulated cart that was used to transport meals to residents. Dietary Aide 2 stated if the coffee remained on the cart for an extended period of time, the temperature would likely decrease affecting the taste. He reported he was not aware of any guidance provided for staff related to temperature monitoring of beverages once they were placed on the meal cart. Dietary Aide 2 further stated, nor had he had been instructed to remove the coffee from the cart and replace it if meal service was delayed. Observation on 02/10/2026 at 8:22 AM, during the test tray observation, the DM and two State Survey Agency (SSA) Surveyors, sampled the coffee. In interview, at the time of observation, the DM stated the coffee was just slightly above room temperature and bitter to the taste. Both SSA Surveyors also sampled the coffee and confirmed the coffee was not being served at an acceptable temperature and agreed it had an acidic and bitter taste. She reported the coffee was not palatable, and residents should always have coffee served at an acceptable temperature and taste. The DM explained she had (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not been performing tray audits and had not been actively monitoring dietary staff on the tray line or checking temperatures of the food items being served. She stated it was her expectation for her dietary staff to follow all the facility's policies and procedures, including serving food and drink that was palatable to residents. The DM further stated she assumed her dietary staff were following those policies; however, she had not been monitoring them to ensure they were doing so. She additionally reported she could not recall the last time she had conducted a tray line audit. During interview with the Administrator, on 02/11/2026 at 10:39 AM, he stated he had recently performed observations in the kitchen area and had not identified any concerns. He reported however, he had not performed any temperature checks on trays being served to the residents. The Administrator said it was his expectation for dietary staff to follow all policies and procedures including serving food and drinks that were palatable to residents. He stated he had performed audits on the dietary staff and had not noted any concerns. The Administrator further stated, during his audits, he had not provided any suggestions to the dietary staff on things they could do to improve their process.