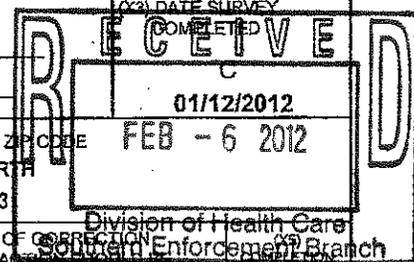


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
F 000	INITIAL COMMENTS A standard health survey was conducted on 01/10-12/12. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY17127) was also conducted at this time. The complaint was unsubstantiated with related deficient practice identified.	F 000	Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.		
F 151 SS=B	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to ensure four of eight residents attending the Group Interview meeting were provided the opportunity to exercise his/her rights as a citizen or resident of the United States. Residents #12, #18, #19, and #20 voiced a desire to vote in the state election in November 2011. However, the facility failed to assist the residents wishing to vote in the election. The findings include: A review of the facility Voting/Absentee Ballot policy (dated February 2006) revealed the Activity Director (AD) in conjunction with the facility Social	F 151	Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator, DATE: Feb. 3, 2012

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 1 Worker (SW) were to assist residents wishing to vote in the election. The facility AD/SW was to register the residents for absentee ballots at the local voter registration office(s). The policy further stated the AD/SW was responsible to coordinate transportation/provide assistance to the polls. The policy stated the AD/SW would request the absentee ballots and ensure each resident would receive their ballot. The facility AD/SW was to assist the resident with reading/completing the ballot without influencing resident opinions and election outcomes. The AD/SW was to also mail the ballots according to the deadlines, and include mailing materials as needed. During the Group Interview conducted on 01/11/12, with eight alert and oriented residents, it was determined four residents attending were not allowed the opportunity to vote in the 11/08/11 election. The four residents (Residents #12, #18, #19, and #20) further stated they had wished to participate in the election process. The residents stated the absentee ballots were not obtained by the responsible facility staff. A review of the Resident Council Grievance Follow-Up Form, dated 11/11/11, revealed the residents had complained about not being afforded the opportunity to vote in the election on 11/08/11. The Grievance Form indicated the facility had investigated the complaint and the SW had not obtained the absentee ballots as required. An interview conducted with the facility AD on 01/12/12, at 2:10 PM, revealed the AD forgot to obtain the absentee ballots until he/she was	F 151	ID Prefix Tag F 151 The facility will continue to provide residents with the right to exercise his or her rights as a resident of the facility and as citizen or resident of the U.S. Resident #12, #18, #19, and #20 were interviewed by the activities director to determine if they wanted to participate in the next elections. Registration for each resident desiring to vote was completed as needed. All residents able to voice their need/wants were interviewed for wishes to participate in voting. A list of residents was obtained and registration completed as needed. A resident voting list has been assembled and will be kept by the activities director/social worker with any new admissions desiring to vote added as indicated.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 2 reminded by the residents during the 11/11/11 Resident Council Meeting. An interview was conducted with the facility Administrator on 01/12/12, at 1:30 PM. The facility Administrator stated the facility SW had forgotten to obtain the absentee ballots for the facility's eligible registered voters prior to the election. The Administrator stated he was made aware of the oversight on 11/11/11, after the November Resident Council Meeting. The facility Administrator stated the AD shared some of the responsibility for not obtaining the absentee ballots. The facility Administrator stated the SW was no longer employed at the facility.	F 151	The Administrator/QI Executive Committee will review list of residents desiring to vote quarterly and remind AD/SW to make needed arrangements for Voting/Absentee Ballot residents one month before time to vote.	1/31/12
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	<u>ID Prefix Tag F 272</u> Residents #4, #6, #11 and #14 were reviewed and new assessments/care plans were completed on 1-18-12. A 100% audit completed on all residents and those identified as not having accurate assessments were re-evaluated and new assessments completed. The new Social Worker was inserviced on 1-24-2012 by the MDS Coordinator for the completion of social assessments per RAI manual requirements for the completion of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 272	<p>Continued From page 3</p> <p>Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to conduct accurate clinical assessments for four of sixteen sampled residents (Residents #4, #6, #11, and #14) regarding the residents' mental status. The facility assessed Residents #4, #6, #11, and #14's speech as "usually understands" and to be "understood." However, the facility failed to assess Residents #4, #6, #11, and #14's mental status utilizing the Brief Interview of Mental Status per RAI user manual guidelines.</p> <p>The findings include:</p> <p>There was no specific facility policy regarding the accurate completion of the Minimum Data Set (MDS) Assessment.</p>	F 272	<p>Social Services Assessments. The MDS coordinator will review each section of assessments before submission to ensure accuracy and completion.</p> <p>Social Assessments will be monitored to include those identified residents through utilization of QI tool by the QI nurse weekly for 1 month, then bi-weekly for 1 month, then monthly for 3 months, the quarterly with any area of concern forwarded to administrator for follow up as necessary.</p> <p>Audit results will be forwarded to Administrator/Executive Committee for follow up as appropriate and to determine the frequency and/or need for continued monitoring.</p>	1/24/12
-------	---	-------	--	---------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 272	Continued From page 4	F 272		
	<p>A review of the Resident Assessment Instrument (RAI) user's manual (dated 09/2010) revealed facilities were required to assess residents' cognitive patterns to determine the resident's attention, orientation, and ability to register/recall new information. According to the manual; these items were crucial factors in many care planning decisions and structured cognitive interviews assisted in identifying needed supports. The manual stated the "Brief Interview of Mental Status (BIMS) should be conducted if the resident was at least sometimes understood verbally or in writing. According to the instructions, if the resident was determined to be "rarely, never understood," then the BIMS was not attempted and a staff assessment of mental status should be conducted. Further instructions included for staff to place a dash (-) in the code entry area if the interviewer stopped the interview if the resident was not able to respond or the responses were nonsensical.</p> <p>1. A review of the admission MDS assessment, dated 09/04/11, for Resident #4 revealed the resident was assessed to have clear speech, to be understood, and to usually understand others. The facility conducted the BIMS and the resident's score was 12 out of a possible 15. According to the Resident Assessment Instrument (RAI) manual, a score of 8 to 12 indicated moderate impairment. A significant change MDS assessment, dated 11/26/11, revealed Resident #4 continued to have clear speech, to be understood, and to usually understand others. However, there were only dashes (-) in the code entry areas with no evidence the facility conducted the BIMS</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 5 assessment for Resident #4 with this MDS.</p> <p>Observations of Resident #4 on 01/11/12, at 4:30 PM, revealed the resident was alert/oriented and in good spirits. The resident's conversation was appropriate.</p> <p>According to the Certified Medication Aide on 01/11/12, at 9:50 AM, Resident #4 was alert/oriented and able to make his/her needs known.</p> <p>2. A review of the MDS dated 03/04/11, revealed Resident #6 was assessed to usually understand and to usually be understood. The BIMS assessment revealed Resident #6 was considered to be moderately impaired in cognitive status with a score of 9. The MDS assessment conducted on 12/03/11, continued to assess Resident #6 as able to understand and to be understood, but the BIMS interview coding areas contained dashes indicating the interviewer stopped the interview.</p> <p>Observations of Resident #6 on 01/11/12, at 12:30 PM, revealed the resident was awake, alert, and was appropriate in conversation.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 01/12/12, at 12:15 PM, revealed Resident #6 was able to make staff aware of his/her needs.</p> <p>3. A review of the annual MDS assessment dated 03/01/11, for Resident #11 revealed the resident was assessed to usually understand and to usually be understood; however, in the next section of the MDS the resident was assessed as</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 6 rarely, never understands and a BIMS was not completed. A quarterly MDS assessment dated 11/15/11, revealed Resident #11 continued to be assessed to usually understand and to usually be understood, however, there were dashes (-) in the code entry area with no evidence the BIMS was attempted during this assessment.	F 272			
	<p>Observations of Resident #11 on 01/12/12, at 12:15 PM, revealed the resident to be alert, awake, and being fed lunch. The resident responded to staff regarding food preferences and positioning with appropriate yes/no answers.</p> <p>4. A review of the admission MDS assessment for Resident #14 who was a closed record revealed the resident was assessed to usually understand and to usually be understood. In the "Cognitive Patterns" section of the assessment there were no numbers coded into the questions, only dashes (-), and no evidence the BIMS was attempted/completed.</p> <p>An interview with the MDS Nurse Coordinator on 01/12/12, at 2:00 PM, revealed the Coordinator was responsible to ensure the MDS was completed on schedule and to complete specific sections of the MDS. The MDS Nurse stated she was responsible to complete the sections regarding understanding/being understood and the Social Worker (SW) was responsible to complete the BIMS interview section. According to the MDS Nurse, the MDS is completed via computer program and the program flags any areas that are due to be assessed but not completed yet and it is within her job description to remind other staff if their particular section was not done. The MDS Nurse voiced that she had</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 7 reminded the SW on several occasions that the BIMS section was due for various residents. According to the MDS Nurse, once a section is completed it does not flag anymore as incomplete but there is a way to remove the flag by clearing that section. Clearing means that the assessment area was not done, but the section was cleared, which removed the flag and then it would appear that portion of the MDS had been completed as required. The MDS Nurse stated she did not look at each section to ensure completion but trusted the SW had completed her sections of the MDS since there were no flagged areas. The SW was no longer employed by the facility and was not available for interview. An interview with the facility's Administrator on 01/12/12, at 11:30 AM, revealed that he was the direct supervisor for the SW; however, the Administrator stated he had not monitored the MDS assessment for accuracy or to ensure the assessments were completed as required. The Administrator further stated he became aware of the MDS concerns in 11/2011 and had verbally counseled the SW. An interview with the facility's Corporate Consultant Nurse (CCN) on 01/11/12, at 3:30 PM, revealed the facility was aware that the SW was lacking in some areas. The CCN stated she may have cleared the MDS sections thinking that she would go back at a later date to complete them and then just didn't.	F 272			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 8 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, and review of facility training records it was determined the facility failed to develop and implement appropriate plans of action to correct identified quality deficiencies. A review of the medical record for one of sixteen sampled residents (Resident #16) and the turn and repositioning documentation revealed the facility had developed a care plan for Resident #1 to be turned and repositioned every two hours.	F 520	<u>ID Prefix Tag F 520</u> The facility will continue to maintain a quality assessment and assurance committee consisting of the Director of Nursing Services, a physician designated by the facility and at least three other members of the facility staff. Resident #16 is no longer a resident of the facility. A 100% audit was completed on 1-16-2012 all residents to review turning and repositioning documentation. Residents were observed by Administrative Nursing to be receiving turning and repositioning but the documentation was not always done timely. Treatment nurses will initiate individualized turning and repositioning flow sheets depending on the type and frequency of turning and repositioning needs each resident has and the flow sheet will be completed by the SRNA providing care. All direct care staff were in serviced on 2/2/12 by the Staff Development nurse on turning and repositioning		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 9</p> <p>However, review of the resident's turn and repositioning documentation revealed facility staff had failed to document that care was provided as outlined in the resident's individualized care plan.</p> <p>The findings include:</p> <p>A review of the facility policy titled Quality Assurance Policy (not dated) revealed the facility's Quality Improvement Program would recognize concerns in resident care, and would develop a plan of action for the resolution of those concerns. The facility policy also stated an evaluation of the plan of action would occur to ensure the identified concerns were resolved and that they did not reoccur.</p> <p>A review of the facility in-service training reports revealed Certified Nursing Assistants (CNAs) had received training on 07/12/11 and again on 10/14/11, related to the lack of documentation after the provision of resident care.</p> <p>A review of the turn and reposition documentation for Resident #16 for the months of September 2011, October 2011, November 2011, and December 2011, revealed facility staff failed to document that turning and repositioning had been provided as outlined in the resident's individualized plan of care.</p> <p>An interview with Certified Nursing Assistant (CNA) #3 on 01/11/12, at 10:10 AM, revealed she was required to go to the computer screen and document all care provided to the residents directly after it had occurred. Continued interview revealed she was able to turn and reposition her assigned residents, however, was unable to</p>	F 520	<p>documentation and any staff not attending inservice will be inserviced before they are allowed to work. This will be included in orientation of any new staff also.</p> <p>Treatment nurses and QI nurse will monitor turning and repositioning documentation weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months with any identified areas of concern forwarded to Director of Nursing for review and additional in servicing of staff and/or disciplinary measures as needed. Findings will be reviewed in the Executive QI Committee quarterly meetings.</p>	2/2/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 10</p> <p>provide documentation every two hours as required due to other tasks which arose during her rounds such as answering call lights, assisting other residents to the bathroom, etc.</p> <p>An interview with CNA #1 on 01/12/12, at 10:15 AM, revealed she had been trained to document the care provided to the residents when it was provided. The CNA stated she was able to turn and reposition her assigned residents, however, due to other responsibilities and tasks which arose during her resident care rounds, she was unable to document timely.</p> <p>An interview with the facility Nurse Consultant on 01/10/12, at 1:30 PM, revealed the facility had implemented computer documentation "a little over a year ago," and since implementation the staff was having difficulty documenting the residents' turn and repositioning in a timely manner. Further interview with the Nurse Consultant revealed the computer system was "time sensitive" therefore when facility staff turned and repositioned a resident and was unable to immediately go to the computer and document, the care would not appear to be provided until the time of documentation. Continued interview revealed facility staff had received in-services in July 2011 and October 2011 related to timely documentation of residents' care.</p> <p>An interview with the Quality Assurance (QA) Coordinator on 01/12/12, at 1:15 PM, revealed the facility's staff began using the new computer system in August 2010 to document resident care. Further interview revealed there had been a problem identified "a few months back" related to the facility staff timely documenting resident</p>	F 520			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520	Continued From page 11 care as provided per the resident's individualized care plan. Continued interview revealed the QA Coordinator stated the lack of timely documentation was an "ongoing thing" and that administrative staff continued to rein-service and retrain staff.	F 520		
	An interview with the Director of Nursing (DON) on 01/12/12, at 1:30 PM, confirmed staff was to document resident care in the computer system directly after it had been provided to the resident. The DON stated she was aware resident care was not being documented timely by direct care staff. Continued interview with the DON revealed staff was reeducated related to the identified issue; however, no other actions had been taken to correct the deficient practice. Interview with the facility Administrator on 01/12/12, at 1:45 PM, revealed he was a member of the QA Committee and attended the QA meetings. However, he could not recall ever being made aware of facility staff's failure to document timely when resident care was provided.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED FEB 5 2012 A. BUILDING 01 - MAIN BUILDING 01 </div>	(X3) DATE SURVEY COMPLETED 01/11/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Services, Highway 119 North Southern Enforcement Center, Campbell, KY 40823
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1998 SURVEY UNDER: 2000 Existing	K 000	Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
K 052 SS=F	FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (111) SMOKE COMPARTMENTS: Six COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Natural gas generator A life safety code survey was initiated and concluded on 01/11/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052	Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Bob Miller* TITLE: Administrator DATE: 2-3-12

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	Continued From page 1 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	<u>ID Prefix Tag K-052</u> The facility will continue to ensure the building fire alarm system functions as required.		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 85 beds with a census of 79 on the day of the survey. The findings include: Observation during the Life Safety Code survey on 01/11/12, at 11:10 AM, with the Director of Maintenance (DOM), revealed a test of the fire alarm automatic dialer panel sent a trouble signal to a continuously occupied location within the facility, however, the monitoring station did not alert the facility of this phone line failure as required. A call to the monitoring station at 11:20 AM on 01/11/12, by the DOM revealed the monitoring station did not have instructions to		The Director of Maintenance notified the monitoring station on 1-11-12 to notify facility of phone line failure. The trouble signal at the occupied location within the facility was functioning and continues to function. The facility verified in writing with the monitoring station on 1-27-12 that they were to call facility in case of phone line failure. The Director of Maintenance conducted a test at 1:36 p.m. on 2-1-12. The monitoring station notified the facility of trouble at 1:39 p.m. of trouble alarm.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	Continued From page 2 notify the facility of this phone line failure. Reference: NFPA 72 (1999 Edition). 5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone. 5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally. NFPA 101 LIFE SAFETY CODE STANDARD	K 052	The facility will conduct one additional test by 2-17-12 at a different time to ensure compliance.	2/17/12	
K 064 SS=D	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	<u>ID Prefix Tag K-064</u> The facility will continue to ensure the kitchen has signage in place for the proper use of the Class-K portable fire extinguisher. There were no residents affected as stated in the Summary Statement of Deficiencies. There was, and continues to be, a sign in place at the pull station for the hood fire suppression system stating to "pull this station first."		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher. This deficient practice affected one of six smoke compartments, staff, and no residents. The facility has the capacity for 85 beds with a census of 79 on the day of the survey. The findings include: During the Life Safety Code tour on 01/11/12, at 10:30 AM, with the Director of Maintenance (DOM), a Class-K portable fire extinguisher was noted not to have signage near the extinguisher for the proper use of this type of extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. An interview on 01/11/12, at 10:30 AM, with a kitchen staff member revealed she was instructed to use this portable fire extinguisher first in an emergency. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	The signage, as requested, was installed on 1-13-12 by the Class K Fire Extinguisher by the Director of Maintenance. All dietary staff was inserviced on 1-13-12 by the Director of Maintenance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	The Director of Maintenance will conduct a monthly audit for three months with dietary staff to ensure correct usage of hood fire suppression system and fire extinguisher. <u>ID Prefix Tag K-144</u> The facility will continue to maintain the generator annunciator panel. A mechanical error caused the battery fault light to come on in the annunciator panel.	1/13/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 4	K 144	<p>The battery was tested and is in working order. The generator has, and continues to operate under full load 30 minutes each week.</p> <p>The generator service company is scheduled to provide preventative maintenance to the generator the week of 2-13-12 and will repair light then.</p> <p>The Director of Maintenance will continue to monitor the functions of the generator and document in the required weekly logs. Items requiring maintenance will be reported to the service company for repairs.</p>	2/17/12	
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the generator annunciator panel as required by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 85 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 01/11/12, at 11:30 AM, with the Director of Maintenance (DOM) a battery fault light was observed on the generator annunciator panel located at the nursing station. This panel warns of potential problems with the emergency generator. An interview with the DOM on 01/11/12, at 11:30 AM, revealed there was something wrong with the panel and not the generator's charging system. The DOM stated he reported the annunciator panel problem to Administration but no action has been taken to repair or replace the panel.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 5 compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.	K 144			