FedEx

DEPARTMENT OF HEALTH AND HUMA. ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

4/9/07

(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 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations the facility failed to seal a penetration in one of one fire barriers. The finding was: Observation on 02/21/07 at 10:45 AM revealed the 2-hour fire rated barrier wall separating the facility and the Villa had one unsealed conduit penetration above the ceiling tile.	K 011	K 011 NFPA 101 Life Safety Code Standard Penetration was sealed on 3/6/07. A picture of the sealed conduit were taken on 3/14/07. (See attachments # 1 & 2) POC ACCEPTED W/ DENNIS MAHAFFEY, MNTC. DIRECTOR ON 4/9/07	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K 018 NFPA Life Safety Code Standard Pemko seal was ordered on 3/13/07 to complete seal on Resident Room Doors. Product will be installed by 4/4/07. (See attachment #2a, 2b, 2c, 2d, 2e, 2f)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4-6-07

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.

RECEIVED
APR 06 2007
Wyoming Dept of Health
Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations the facility failed to protect 5 of 65 corridor doors. The findings were: Observation on 02/21/07 between 9 AM and 10 AM revealed the following corridor doors did not fit tight into the frame to resist the passage of smoke: a. Resident room #18. b. Resident room #20. c. Resident room #24. d. Resident room #25. e. Resident room #26.	K 018		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain 3 of 10 smoke barrier doors. The findings were: 1. Observation on 02/21/07 at 9:19 AM revealed	K 027	K 027 NFPA Life Safety Code Standard New door closures were installed on both doors on 2/23/07. Door by room 1 holes were sealed on 2/23/07. Door by room 10 was adjusted to latch into frame on 2/23/07. (See attachments 3a1, 3a2, 3b, 3c1, 3c2)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(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 027	Continued From page 2 one of two smoke barrier doors near resident room #20 impeded the width of egress. The door's self-closing device was not able to hold the door to the fully opened position. NFPA 101 Section 7.2.1.4.1 states "...The door shall be designed and installed so that it is capable of swinging from any position to the full required width of the opening in which it is installed. 2. Observation on 02/21/07 at 9:42 AM revealed one of two smoke barrier doors near resident room #1 had two circular holes, preventing the door from being smoke resistant. 3. Observation on 02/21/07 at 9:58 AM revealed one of two smoke barrier doors near resident room #10 would not latch into the frame.	K 027	K 056 NFPA Life Safety Code Standard Sprinkle head was moved on April 3, 2007. The sprinkler head in the medication room was moved 5" from the wall on 4/3/07. (See attachment # 4a). Based on NFPA 13 exception all the sprinkler heads in question are within the distance from the finish ceiling as requred by the installation reccommendations by the manufacturer. The manufacturer states that the spinkler deflector should be ¾" (+) ¼" form the finished ceiling. The instillation diagram from the manufacturer is included as attachment 4b. (see attachment 4b).	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations the facility filed to properly install and maintain the fire sprinkler system. The findings were: 1. Observation on 02/21/07 at 9:17 AM revealed	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

4/19/07

(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 056	Continued From page 3 the only sprinkler head in the medication room was installed one inch from the wall. NFPA 13 Section 5-6.3.3 states "sprinklers shall be located a minimum of four inches from a wall". 2. Observation on 02/21/07 between 10 AM and 10:45 AM revealed the following sprinkler heads were installed less than the required one inch from the ceiling: a. One of eight sprinkler heads in the kitchen. b. One of four sprinkler heads in the kitchen store room. NFPA 13 Section 5-6.4.1.1 states" ...the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 inch and an maximum of 12 inches".	K 056		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a fire watch policy for the loss of water to the automatic sprinkler system for 4 hours in a 24 hour period. The findings were: 1. Review of the maintenance departments emergency policies revealed the facility did not have a fire watch policy for the impairment of the automatic sprinkler system. 2. Interview with the Maintenance Supervisor on	K 154	K 154 NFPA Life Safety Code Standard Fire watch policy has been written and put into safety manual. Training will be done in each department at monthly inservice and orientation for new hires. Policy is attached (# 5).	3/19/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE ROCK CONVALESCENT CTR	1445 UINTA GREEN RIVER, WY 82935

(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 154	Continued From page 4 02/21/07 at 11:52 AM revealed there was no record to review.	K 154		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535033	MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 2/21/2007
NAME OF PROVIDER OR SUPPLIER: CASTLE ROCK CONVALESCENT CTR	STREET ADDRESS, CITY, STATE, ZIP CODE: 1445 UINTA GREEN RIVER, WY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to test the installed commercial cooking equipment and protection system every six months The findings were: 1. Review of the kitchen hoods fire-extinguishment system testing records revealed eight months had passed between the last two tests. NFPA 96 Section 11.2.1 states "An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fireactuated water system shall be made at least every 6 months by properly trained and qualified persons". 2. Interview with the Maintenance Supervisor on 02/21/07 at 4 PM revealed he was aware the testing was over due. K069 – The Maintenance Supervisor will audit records to ensure testing is done on time.

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

The above isolated deficiencies pose no actual harm to the residents