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 _____	10/05/2005

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 PRECEEDED 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 Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a supervised automatic dry sprinkler system and fire alarm system. K6: Date of Plan Approval: 1987 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=59;SNF/NF=59 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	ACCEPTANCE OF THIS POC W/ NANCY FENTON NHA, OD 11/10/05 @ 8:30 AM VIA TELECONFERENCE.	
K 018 SS=D	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 This facility will ensure that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors and resist the passage of smoke. There will be no impediment to the closing of the doors and doors are provided with a means suitable for keeping the door closed in accordance with NFPA 101 Section 19.3.6.3. This will be accomplished by: 1) The gaps between the top edge of the doors and the door frames of the beauty shop and resident room #04 have been sealed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 10/31/05

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.

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 _____	10/05/2005

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 PRECEEDED 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 observation the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 10/5/05 revealed the following corridor doors had gaps between the top edge of the doors and the door frames which were greater than the allowed 1/8th of an inch: a. At 9:50 AM, the beauty shop b. At 10:11 AM, resident room #04	K 018	equal to or less than the allowed 1/8th of an inch. 2) Doors will be inspected at least monthly and a QA activity completed to insure that all doors meet the standard. (Attachment #1) 3) The Maintenance Supervisor will be responsible for compliance with this standard.	10/21/05
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to seal a	K 025	K 025 This facility will ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with NFPA 101 Section 19.3.7.3. This will be accomplished by: 1) The pipe penetration in the vertical smoke barrier wall above the ceiling tile has been sealed. 2) Inspection of the smoke barriers has been added	

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 _____	10/05/2005

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 PRECEEDED 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 025	Continued From page 2 penetration in one of six smoke barriers in accordance with NFPA 101 Section 19.3.7.3. The findings were: 1. Observation on 10/5/05 at 1:50 PM revealed the vertical smoke barrier wall above the double doors near physical therapy had an unsealed pipe penetration above the ceiling tile.	K 025	to the monthly QA maintenance inspection (Attachment #1) 3) The Maintenance Supervisor will be responsible for compliance with this standard.	10/21/05
K 027 SS=E	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 observation and staff interview the facility failed to protect 3 of 6 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3 and 8.3.2. The findings were: 1. Observation on 10/5/05 revealed the following smoke barrier double doors were equipped with latching mechanisms which prevented the doors from fully latching and creating a smoke resistant seal. a. At 10:04 AM, the doors near resident room #10 b. At 10:37 AM, the doors near resident room #27	K 027	K 027 This facility will ensure that door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ¾ thick solid bonded wood core. Doors will be self-closing and create a smoke resistant seal in accordance with NFPA 101 Section 19.3.7.3 and 8.3.2. This will be accomplished by: 1) The smoke barrier double doors near resident room #10, #27 and #19 have been adjusted and lubricated to permit them to fully latch and create a smoke barrier.	

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 _____	10/05/2005

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 PRECEEDED 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 3 c. At 10:40 AM, the doors near resident room #19 2. Maintenance staff reported the latching devices needed either to be lubricated or adjusted.	K 027	2) Inspection of the smoke barrier doors has been added to the monthly Maintenance QA Activity (Attachment 4) 3) The Maintenance Supervisor will be responsible for compliance with this standard.	10/21/05
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The	K 051	K 051 This facility will ensure that a fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, Table 7-3.2. This will be accomplished by: 1) The posted central station placard has been renewed and updated to reflect that it is currently not expired. 2) The Central Station placard has been added to the master calendar for	

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 _____	10/05/2005

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 PRECEEDED 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 051	Continued From page 4 findings were: 1. Observation on 10/5/05 at 1:45 PM revealed the posted central station placard expired on March 31, 2005.	K 051	licenses/certification updates. Attachment #2 3) Review of placards has been added to the monthly Maintenance QA Activity (Attachment #1) 4) The Maintenance Supervisor is responsible for compliance with this standard.	
K 056 SS=F	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 observation and blue print review the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1 and 5-13.8.1. The findings were: 1. Review of the blue prints revealed the exterior roof above the front entrance was constructed of combustible material, wider than 4 feet, and did not have sprinkler coverage. Observation on 10/5/05 at 3:30 PM revealed the roof had two exposed wood beams.	K 056	K 056 This facility will ensure that the facility is fully sprinkled as required by NFPA 13 Section 5-1.1 and 5-13.8.1. This will be accomplished by: 1) A sprinkler system for the exterior roof above the front entrance will be installed by an outside contractor following approval of the plans by the Office of Health Facilities. 2) The sprinkler system will be maintained and inspected at least annually as part of the main building sprinkler system. 3) The maintenance supervisor will be responsible for compliance with this standard.	10/21/05
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		2/28/06

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 _____	10/05/2005

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 PRECEEDED 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 062	Continued From page 5 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 5-6.5.3. The findings were: 1. Observation on 10/5/05 at 10:31 AM revealed the fire sprinklerhead in the restroom of resident room #3 had been completely covered by masking tape. 2. Maintenance staff reported the area had been painted the previous week.	K 062	This facility will ensure that the installed sprinkler system is maintained in reliable operating condition and is inspected and tested periodically. This will be accomplished by: 1) The tape on the sprinkler head in the restroom of resident room #3 has been removed. 2) Inspection of the sprinkler heads will be part of the final inspection for the remodel project. 3) Inspection of the sprinkler heads has been added to the monthly maintenance QA activity.(Attachment #1) 4) The maintenance supervisor is responsible for compliance with this standard.	10/21/05
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation the facility failed to test 1 of 12 portable fire extinguishers in accordance with NFPA 10 Table 5-2. The findings were. 1. Observation on 10/5/05 revealed the K-type portable fire extinguisher in the kitchen was manufactured in 1999 and had not received a five-year hydrostatic test.	K 064	K 064 This facility will ensure that portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1., NFPA 10 Table 5-2. This will be accomplished by:	

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 _____	10/05/2005

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 PRECEEDED 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 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8. The findings were: 1. Observation on 10/5/05 at 11:10 AM revealed the staff lounge near the nurses' station had a power strip/surge protector attached to the wall.	K 147	1) The K-type portable fire extinguisher in the kitchen was replaced and will receive another test in 2010. 2) Inspection of the K-type portable fire extinguisher has been added to the master fire extinguisher inspection/test list. 3) The maintenance supervisor is responsible for compliance with this standard. K 147 This facility will ensure that the provided electrical system is installed in accordance with NFPA 70 Section 400-8. This will be accomplished by: 1) The power strip/surge protector in the staff lounge near the nurses' station has been removed. 2) Placement of power strips has been added to the monthly maintenance QA activity.(Attachment #1) 3) Staff has received education regarding the placement of power/strips. (Attachment #3) 4) The maintenance supervisor is responsible for compliance with this standard.	10/21/05 10/21/05