STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	**503 S 18TH ST** **LARAMIE, WY 82070**

(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 A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on February 26, 2020. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, two-story building with a basement of Type V (111) construction built in 1920, 1972, and 1993. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop, and a zoned fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 72 residents.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety	K 211	K211: Corrective Action: The exit nearest the oxygen storage room means of egress with abrupt change in elevation	3/22/20

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

Electronically Signed | 03/16/2020

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.

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K 211	Continued From page 1 Code. Failure to maintain the means of egress as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous exits. The findings were: Observation on 2/26/2020 at 11:35 AM by the exit nearest the oxygen storage room, revealed an abrupt change in elevation which exceeded 1/4" with a maximum change of elevation measured at 1-1/2". Interview with the maintenance director at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 7.1.6.2 .	K 211	which exceeded ¿ will be corrected by or on day of compliance. Systemic Changes: The maintenance director/designee will monitor means of egress for change in elevation which exceeds ¿. Maintenance Director will monitor for compliance and bring any issues to QAPI Date of compliance 3/22/2020	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at	K 222		3/22/20

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K 222	Continued From page 2 all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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K 222	Continued From page 3 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress from the building during an emergency resulting in injury or death. The deficiency affected one (1) of numerous exits. The findings were: Observation on 2/26/2020 at 9:34 AM at the Dining Room #2 exit revealed that the delayed egress failed to operate as designed. When tested the release process failed to activate an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds. The door could only be released by entering a code on the adjacent keypad. Interview with the maintenance director at the time of observation acknowledged the delayed egress failure, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (3)	K 222	K222: Corrective Action: Dining room #2 exit delayed egress was fixed on 3/13/2020 by maintenance director. Systemic Changes: The maintenance director/designee will monitor all delayed egress doors weekly for three weeks and monthly thereafter and bring any issues to OAPI. Date of compliance. 3/22/2020	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		3/22/20

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K 321	Continued From page 4 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiencies affected seven (7) of numerous	K 321	K321: Corrective Action: 1. the clean laundry room door is now closed without wire around the door handle hardware. Systemic Changes: Laundry team members will be educated by maintenance director/designee on or before date of compliance on proper	

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K 321	Continued From page 5 rooms in the facility. The findings were: 1. Observation on 2/26/2020 at 10:02 AM revealed the rated self-closing corridor door at the Clean Laundry room was held open with a wire around the door handle hardware. Interview with the maintenance director at the time of observation acknowledged the door being held open with wire, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2; 7.2.1.8.1 2. Observation on 2/26/2020 at 10:02 AM revealed the rated self-closing corridor door at the Clean Laundry room failed to close when tested. Interview with the maintenance director at the time of observation acknowledged the door failed to close, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 3. Observation on 2/26/2020 at 10:15 AM revealed the boiler room near the laundry room had multiple unprotected penetrations through the wall and ceiling. In many cases penetrations had previously been sealed but overtime the caulk has delaminated from the ceiling creating new openings.	K 321	closing of doors. The maintenance director/designee will monitor all laundry doors weekly for three weeks and monthly thereafter and bring any issues to OAPI. Date of compliance. 3/22/2020 2. Laundry room door will have self-closured on or before date of compliance by maintenance. Maintenance department will be educated by NHA on or before date of compliance on self-closing doors. The Maintenance Director/designee will monitor all laundry doors weekly for three weeks and monthly thereafter and bring any issues to OAPI. Date of compliance. 3/22/2020 3. Boiler room near the laundry room with multiple unprotected penetrations through the wall and ceiling has been corrected by maintenance on or before the date of compliance. Maintenance Director has been educated by NHA on maintaining unprotected penetrations in wall and ceiling. The Maintenance Director will monitor rooms next to laundry room for unprotected penetrations through the wall and ceiling weekly for three weeks and monthly thereafter and bring any issues to QAPI. Once compliance is achieved Maintenance will monitor as needed. Date of compliance. 3/22/2020 4. The unprotected air transfer opening in janitors closet adjacent housekeeping room has been repairs. Once compliance is achieved Maintenance will monitor as	

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K 321	Continued From page 6 Interview with the maintenance director at the time of observation acknowledged unprotected openings, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 4. Observation on 2/26/2020 at 10:23 AM revealed the janitor closet/storage room, near the laundry room, had an unprotected air-transfer opening to the adjacent housekeeping room. Interview with the maintenance director at the time of observation acknowledged the air-transfer opening, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 5. Observation on 2/26/2020 at 11:15 AM revealed the Oak solid utility room door failed to be self-closing. Further observation revealed that the soiled station #1 door also failed to be self-closing. Interview with the maintenance director at the time of observation acknowledged the doors to not be self-closing, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 321	needed. Maintenance Director has been educated by NHA on maintaining air transfer opening. Maintenance Director/designee will monitor janitors closet air transfers for openings weekly for three weeks and monthly thereafter and bring any issues to QAPI. Once compliance is achieved Maintenance will monitor as needed. 5. Oak solid utility room will be self-closing on or before date of compliance. Maintenance Director/Designee will monitor all utility room doors to ensure the doors are self-closing for three weeks and monthly thereafter and bring any issues to QAPI. Once compliance is achieved Maintenance will monitor as needed. Date of compliance. 3/22/2020 6. Room 69 central supply door was replaced with a fire rated door by maintenance on or before the date of compliance. Maintenance/Designee will approve all newly installed doors to ensure fire rated compliance. Maintenance/designee will bring any concerns to QAPI. Date of compliance 3/22/2020	

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K 321	Continued From page 7 REF: 2012 NFPA 101, Section: 19.3.2 6. Observation on 2/26/2020 at 12:00 PM revealed that room 69, central supply, had been converted into a storage room containing combustible supplies with an area greater than 100 sq feet. The door for the room did not have a fire resistance rating. Interview with the maintenance director at the time of observation acknowledged that the door was not fire-rated, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2	K 321		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		3/22/20

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K 351	Continued From page 8 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to to maintain the fire sprinkler system in accordance with the 2010 NFPA 13, Standard for the Installation of Sprinklers. Failure to properly maintain the fire sprinkler system could result in injury or death in the event of a fire. The deficiency was observed throughout the facility. The findings were: Observation on 2/26/2020 at 10:45 AM and throughout the survey revealed fire sprinkler heads with escutcheons that were not flush to the ceiling. Further observation revealed that many escutcheons that were flush to the ceiling did not fully cover the hole in the ceiling. Escutcheons shall be used to cover the annular space around the sprinkler head. Interview with the maintenance director at the time of observations acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 13, Sections: 6.2.7.1 .	K 351	K351 Corrective Action: Fire sprinkler heads with escutcheons will be flush with the feeling and all holes covered by maintenance/designee on or before the date of compliance. Maintenance/Designee will monitor all fire sprinkler heads monthly until compliance is achieved and quarterly thereafter. Any non-compliance will be brought to QAPI. Date of compliance 3/22/2020	
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99	K 919		3/2/20

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K 919	Continued From page 9 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous electrical panels in the facility. The findings were: Observation on 2/26/2020 at 12:28 PM in solid station #1 revealed obstructions in front of an electrical panel. A working space of three (3) feet in front of the panel is to be maintained. Interview with the maintenance director at the time of observation acknowledged the obstruction, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2011 NFPA 70, Section 110.26	K 919	K919: Corrective Action: In solid utility room on station #1 garbage barrel on wheels was moved from in front of electrical panel. Maintenance/Designee will monitor solid utility rooms to ensure electrical panels have no obstructions for three weeks and quarterly thereafter until compliance is complete. Date of compliance 3/22/2020	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and	K 920		3/22/20

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K 920	Continued From page 10 Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 2/26/2020 at 9:56 AM in room 46 revealed a power strip plugged into another power strip creating a daisy chain. Interview with the maintenance director at time of	K 920	K920 Corrective Action: 1. The daisy chain in room 46 was removed by maintenance on or before date of compliance Maintenance/designee was educated by NHA on or before date of compliance. Maintenance/Designee will monitor each resident room monthly for three months and quarterly thereafter until compliance is complete. Noncompliance will be review in monthly QAPI. Date of compliance 3/22/2020 2. Oxygen concentrators in room 3, 10 and 72 are not plugged directly into	

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K 920	Continued From page 11 observation acknowledged the daisy chain, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2011 NFPA 70, Section 400.8 Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code and the 2012 NFPA 99, Health Care Facilities. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected four (4) of numerous rooms in the facility. The findings were: Observation on 2/26/2020 at 11:18 A.M. revealed that resident room 52 had a power strip located within the patient care vicinity. The resident room contained patient care related electrical equipment. Power strips cannot be located within the patient care vicinity in resident rooms that use patient care related electrical equipment. Further observation found oxygen concentrators plugged into power strips in rooms 3, 10, and 72. Interview with the maintenance director at time of observation acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 9.1.2 2012 NFPA 99, Section 10.2.3.6 2011 NFPA 70, Section 400.8	K 920	electrical outlet. Maintenance/Designee will monitor each resident room monthly for three months and quarterly thereafter until compliance is complete. Noncompliance will be review in monthly QAPI. Date of compliance 3/22/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	**503 S 18TH ST** **LARAMIE, WY 82070**

(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 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923		3/22/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	**503 S 18TH ST** **LARAMIE, WY 82070**

(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 923	Continued From page 13 by: Based on observation and staff interview, the facility failed to maintain gas cylinder storage in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain gas cylinder storage as required could result in injury or death. The deficiencies affected one (1) of numerous rooms in the facility. The findings were: Observation on 2/26/2020 at 11:51 AM at nurses station #1 revealed an oxygen cylinder sitting unsecured on the floor. Interview with the facility maintenance staff at the time of observation acknowledged the unsecured oxygen cylinders, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 11.6.2.3 (11)	K 923	K923: Corrective Action: The oxygen cylinder on station #1 was removed to a secure location. NHA will educate nurse managers and maintenance department on or before the date of compliance on securing oxygen cylinder requirements on or before the date of compliance. Maintenance/Designee will monitor each nursing stations weekly for three weeks and monthly thereafter until compliance is achieved. Noncompliance will be review in monthly QAPI. Date of compliance 3/22/2020	