STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on April 22, 2021. Based on the findings it was determined the facility was in compliance with all requirements. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on April 22, 2021. 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 2010 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 54 residents. .	K 000		
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	K 222		6/7/21

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

Electronically Signed | 05/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 222	Continued From page 1 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 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 222	Continued From page 2 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 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 result in injury or death during an emergency. The deficiency affected one (1) of numerous exits from the facility. The findings were: Observation on 04/22/21 at 10:48 AM of the delayed-egress door located at the end of the wing named Station 2 revealed that when activated, the delayed-egress system alarmed and released after 15 second of operation. Additional observation revealed that although the magnetic locking mechanism had released, the door was difficult to open, and required excessive force to open the door. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement.	K 222	KN222 Corrective Action: The door located at the end of wing named Station 2 was repaired by maintenance to open with little to know force on or before date of compliance. Identification: Residents who reside at Laramie Care Center are at potential risk. Systemic Changes: NHA/Designee will educate the Maintenance Department on maintaining egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Monitoring: Maintenance Director/Designee will monitor compliance monthly and report any deficient practice to QAPI and Safety Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 222	Continued From page 3 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.1; 7.2.1.4 .	K 222		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide exit signs within a means of egress in accordance with the 2012 NFPA 101, Life Safety Code. The failure to adequately identify and mark a means of egress could result in confusion during an emergency, delaying egress from the space, which could result in injury or death. The deficiency affected one (1) of numerous means of egress throughout the facility. The findings were: Observation on 04/22/21 at 11:30 AM in the Pine Wing looking north towards the cross-corridor smoke barrier doors revealed that no exit sign was visible to identify the means of egress. The only additional means of egress identified was an exit sign located at the end of the wing at the	K 293	K293 Corrective Action: The Exit sign was made visible to identify the means of egress on Pine Wing towards the cross corridor smoke barrier by Maintenance on or before the alleged date of compliance. Identification: Residents that reside at Laramie Care Center are at potential risk. Systemic Changes: NHA/Designee will re-educate the Maintenance Department on 2012 NFPA 101, Life Safety Code Life Safety Code on adequately indenting and marking the means of egress. Monitoring: Maintenance Director/Designee will monitor Exit signs	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 293	Continued From page 4 exterior door. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the requirement. REF: 2012 NFPA 101, Sections 19.2.4.4; 7.10 .	K 293	monthly and report any non-compliance to QAPI and Safety Committee. Any deficient practice will be addressed and correct by Maintenance. Compliance Date: June 7, 2021	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 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	K 321		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 321	Continued From page 5 (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 areas in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain hazardous areas as required could result in injury or death due to fire spread. The deficiency affected two (2) of numerous hazardous areas in the facility. The findings were: Observation on 04/22/21 at 9:44 AM of the infectious waste room located in the Aspen Wing adjacent to room 27 revealed that the space was utilized for storage of combustible materials, and was provided with sprinkler protection, but that the door was not provided with a closer. Observation on 04/22/21 at 10:23 AM of the former chapel, located in the Elm Wing, revealed that the space was being utilized for storage of combustible materials. Further observation revealed that the space was provided with sprinkler protection, but that the door was not provided with a closer. Observation on 04/22/21 at 10:40 AM in the central supply office revealed that the space was utilized for large quantities of combustible storage. Interview with the facility maintenance manager indicated that the space was cited during a previous survey, and that a new 1-hr rated door had been installed to correct the deficiency. Review of the newly installed door revealed that no labeling was provided on the door by the manufacturer to indicate the doors	K 321	K321 Corrective Action: A closer was installed on the infectious waste room located in the Aspen wing adjacent to room 27, the former chapel door located in the Elm Wing on or before date of compliance by Maintenance. Change of custody documentation and correct labeling will be provided on or before the date of alleged compliance by the door manufacture on the Central Supply door. Identification: Residents who reside at Laramie Care Center are at potential risk. Systemic Changes: NHA will re-educate the Maintenance Department on hazardous area enclosures on or before the date of alleged compliance. Monitoring: Maintenance/Designee will monitor any new door installations to ensure compliance. Any door that does not meet regulation will not be installed. Non-compliance will be reported at QAPI and Safety Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 321	Continued From page 6 fire rating performance. Additional interview revealed that the facility was provided with an invoice for the door, which indicated the required fire rating, but no chain of custody documentation was available to demonstrate that the installed door was in fact the door model indicated on the invoice. As such, it could not be established that the installed door was rated as intended. Interview with the facility maintenance manager at the time of each observation acknowledged the deficiencies, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiencies. REF: 2012 NFPA 101, Sections 19.3.2.1; 19.3.2.1.3 .	K 321		
K 900 SS=D	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide ventilation for areas storing or transfilling medical gases in accordance with 2012 NFPA 99, Health Care Facilities Code. Failure to maintain medical gas	K 900	K900 Corrective Action: A professional Maintenance company or Designee will install the required ventilation for areas string or transfilling medical gasses in	6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 900	Continued From page 7 storage and transfilling areas could result in injury or death. The deficiency affected one (1) of one (1) medical gas storage and transfilling locations. The findings were: Observation on 04/22/21 at 9:48 AM in the medical gas storage and transfilling room revealed that the room was provided with a ceiling-mounted exhaust fan, and the window to the space had been left open for ventilation. Per NFPA 99, ventilation must be provided either per natural ventilation including two (2) openings within one foot of the floor and ceiling, or via mechanical ventilation with an inlet drawing from within one foot of the floor. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 99, Sections 9.3.7.5; 9.3.7.5.2; 9.3.7.5.3 .	K 900	accordance with NFPA 99, Healthcare facilities code, on or before alleged date of compliance. Identification: Residents that reside at Laramie Care Center are at potential risk. Systemic Changes: NHA/Designee educated the Maintenance Department on NFPA99 and proper ventilation for areas storing and/or transfilling medical gasses. Monitoring: The Maintenance Director/Designee will monitor areas with medical gasses for the required ventilation for compliance. Maintenance/Designee will track and trend any non-compliance to WAPI and Safety Committee.	
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	K 923		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 8 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 by: Based on Observation and staff interview, the facility failed to maintain areas for storage of positive pressure gases in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to maintain areas for storage of positive pressure gases could result in injury or death in an emergency. The deficiency affected one (1) of (1) pressurized gas storage locations. The findings were:	K 923	K923 Corrective Changes: Cylinders resting loosely on the floor were secured by Maintenance to prevent falling, oxygen over the allowable amount will be removed from the oxygen room on or before the date of compliance. Identification: Residents who reside at Laramie Care Center are at potential risk.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING **01** B. WING _____	**04/22/2021**

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 9 Observation on 04/22/21 at 9:54 AM in the medical gas storage and transfilling room revealed that the space contained (5) 41L liquid O2 dewars, (6) 24 cu. ft. cylinders, (2) 6 cu. ft. cylinders, and (6) 15 cu. ft. cylinders. Additional observation revealed that several of the cylinders were resting loosely on the floor, and not secured to prevent falling. Additionally, it was observed that the space was provided with a 90 minute fire-rated door, but it could not be established that the wall construction of the space provided the required 1-hr fire resistance rating. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the tie of exit acknowledged the deficiency. REF: NFPA 99, Section 5.1.3.3.2 (4), (7) .	K 923	Systemic Changes: NHA will re-educate the Maintenance Department of the allowable storage amount per NFPA 99, Health Care 2012 Facilities Code. Monitoring: The Maintenance Director/Designee will monitor weekly the amount of oxygen stored for 4 weeks or until facility sustains compliance. Any non-compliance will be corrected at that time and team members re-educated. The maintenance Director/Designee will report the results of monitoring to QAPI and Safety Committee.	