

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>16311C</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/17/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUMMITVIEW TERRACE ASSISTED LIVING BY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12101 EAST BANNISTER ROAD KANSAS CITY, MO 64138</b>
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(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) COMPLETE DATE
A2298	<p>19 CSR 30-86.022(17) Oxygen Storage Requirements</p> <p>Oxygen storage shall be in accordance with NFPA 99, 1999 Edition. II/III</p> <p>This regulation is not met as evidenced by: Class III</p> <p>Based on observation and an interview on 3/17/22 the facility failed to provide proper storage for oxygen in accordance with NFPA 99, 1999 Edition. The facility census was twenty-six (26). This potentially affected twenty-six (26) of twenty-six (26) residents.</p> <p>Observation on 3/17/22 at 11:25 A.M. showed a concentrator refill station and 16 oxygen bottles stored in resident Room 121.</p> <p>During an interview on 3/17/22 at 12:40 P.M. the administrator stated he/she would get the excess oxygen moved to the proper oxygen storage area and explain to the resident only one bottle in use and one spare bottle with the refill station is allowed within their room.</p>	A2298		

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