Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	641 EUCLID AVENUE HANNIBAL, MO 63401

(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
A2255	19 CSR 30-86.022(9)(I) Fire Alarm System Activation Complete Fire Alarm Systems. (I) The complete fire alarm system shall be activated by all of the following: sprinkler system flow alarm, smoke detectors, heat detectors, manual pull stations, and activation of the rangehood extinguishment system. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview, and record review, the facility failed to ensure that the complete fire alarm system including full-building alarm and automatic-closure of fire doors was activated by smoke detectors and heat detectors in individual resident rooms. The facility census was 31 Observation on 12/3/25 at 1:55 P.M. showed the following: -The fire alarm sounded in Room 236 and there was no smoke, fire, or heat present; - The fire alarm sounded in Room 247 and there was an odor of heated butter; -Rooms 236 and 247 were on different wings of the facility, separated by more than 50 feet; -Staff had escorted Resident #1 from Room 247 and unplugged an unapproved electric cooking pot that had been in use; -Resident #2 self-evacuated from his/her room and waited in a chair at the end of the hallway until the alarm was cleared; -The fire alarm did not sound in other resident rooms on the first or second floor; -The fire alarm did not sound in the common areas of the first or second floor; -The fire doors on the second floor east and south hallways did not close.	A2255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	641 EUCLID AVENUE HANNIBAL, MO 63401

(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
A2255	19 CSR 30-86.022(9)(I) Fire Alarm System Activation Complete Fire Alarm Systems. (I) The complete fire alarm system shall be activated by all of the following: sprinkler system flow alarm, smoke detectors, heat detectors, manual pull stations, and activation of the rangehood extinguishment system. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview, and record review, the facility failed to ensure that the complete fire alarm system including full-building alarm and automatic-closure of fire doors was activated by smoke detectors and heat detectors in individual resident rooms. The facility census was 31 Observation on 12/3/25 at 1:55 P.M. showed the following: -The fire alarm sounded in Room 236 and there was no smoke, fire, or heat present; - The fire alarm sounded in Room 247 and there was an odor of heated butter; -Rooms 236 and 247 were on different wings of the facility, separated by more than 50 feet; -Staff had escorted Resident #1 from Room 247 and unplugged an unapproved electric cooking pot that had been in use; -Resident #2 self-evacuated from his/her room and waited in a chair at the end of the hallway until the alarm was cleared; -The fire alarm did not sound in other resident rooms on the first or second floor; -The fire alarm did not sound in the common areas of the first or second floor; -The fire doors on the second floor east and south hallways did not close.	A2255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	641 EUCLID AVENUE HANNIBAL, MO 63401

(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
A2255	Continued From page 1 Observation on 12/3/25 at 2:00 P.M. showed the following: -Three fire fighters arrived on the second floor of the facility and were directed to Room 247 by facility staff; -The fire fighters cleared Room 247 and Room 236 and verified there was no active fire or fire risk; -Fire Fighter #1 pointed out to the Administrator's Assistant the fire doors did not close on either floor in response to the alarm and had not closed in response to a previous alarm two weeks prior; -Fire fighters cleared the scene and left the facility. During interview on 12/3/25 at 1:55 P.M., Resident #2 said the following: -He/She did not know if they should evacuate because the fire alarm often went off for no reason; -The alarm sometimes sounded in his/her room when it was not sounding in the hallway or other rooms; -He/she usually stayed in his/her room when the alarm sounded until staff gave him/her further instruction. Record review of a hand-written statement from the fire protection company technician provided by the Administrator's Assistant on 12/8/25 showed the following: -The fire alarm and protection system were assessed by the technician on 12/4/25; - The technician determined the settings of the fire alarm system had been modified to require indication of two-sources of fire or smoke in a single area to activate the building-wide fire alarm system;	A2255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	641 EUCLID AVENUE HANNIBAL, MO 63401

(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
A2255	Continued From page 2 -The fire doors on the first and second floor were not set to activate without a building-wide alarm. During interview on 12/3/25 at 2:10 P.M. and 12/11/25 at 11:55 A.M., the Administrator's Assistant said the following: -She was not aware the fire alarm system had been programmed in a way that was not compliant with regulation; -The facility had monthly fire drills, but they only set off the fire alarm that tripped the full system once per year; -She was not aware that the fire doors on both floors should have closed when a fire alarm sounded. MO259428 *The higher classification merited due to the extent of the violation and the violation's effect on residents.	A2255		
A4703	19 CSR 30-86.047(5) Administrator - Licensed The operator shall designate an individual for administrator who is currently licensed as an administrator by the Missouri Board of Nursing Home Administrators, in accordance with Chapter 344, RSMo. II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to designate an individual for administrator who is currently licensed as an administrator by the Missouri Board of Nursing Home Administrators, in accordance with Chapter 344, RSMo. 11. The	A4703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	641 EUCLID AVENUE HANNIBAL, MO 63401

(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
A4703	Continued From page 3 facility census was 31. Record review of communication from the Missouri Board of Nursing Home Administrators (MBNHA) on 11/24/25 showed the temporary emergency license (TEL) which had been issued to the person identified as the administrator's assistant expired on 10/30/25. Observation on 12/3/25 between 11:00 A.M. and 6:00 P.M., showed the person identified as the administrator's assistant who occupied the office space assigned for the administrator, met with residents and resident family member to address resident needs and concerns, performed administrative record keeping tasks, and oversaw the daily functions of the facility staff which was consistent with the duties of a facility administrator. During interview on 12/3/25 at 11:03 A.M., the Administrator's Assistant said the following: -She was not the facility administrator as her TEL had expired; -She had stayed on as the Administrator's Assistant and had been doing what she could to help run the facility including managing staffing and the day-to-day needs of the residents; -She was aware the facility was required to have a licensed administrator. During interview on 12/3/25 at 6:00 P.M., the facility Chief Executive Officer said the following: -She was aware the facility did not employ an administrator licensed by MBNHA as required; -The previous administrator had been operating under a TEL which expired; -She had been trying to recruit an administrator; -It was her intention to recruit a licensed	A4703		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25358	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW	**641 EUCLID AVENUE HANNIBAL, MO 63401**

(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
A4703	Continued From page 4 administrator to operate the facility and train the administrator's assistance to prepare for testing as an administrator. MO259428 and MO259496	A4703		

PLAN OF CORRECTION

Provider/Supplier Name:	Pleasant View Assisted Living
Street Address, City, Zip:	641 Euclid Hannibal, MO 63401
Date of Survey:	12/11/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	25358

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction is submitted as required under State regulations and statues applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
A2255	The fire alarm company has reprogrammed the system to trigger the full alarm when only one source of fire or smoke in a single area are active. The fire alarm company tested the programming and determined the system was working as programmed. The fire alarm company will monitor quarterly to ensure the settings are correct. Facility management will monitor monthly during the fire drills.	12/11/2025
A4703	The facility has applied for a Temporary Emergency license with the Missouri Board of Nursing Home Administrators requesting the facility RN be granted the TEL and the opportunity to sit for the test to gain full licensure. An advertisement has been placed on Indeed seeking a fully licensed administrator.	12/11/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.