STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265548	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daybreak Nursing Center	410 H Road Sikeston, MO 63801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were kept free from possible accident hazards when the facility staff failed to monitor one resident (Resident #10) out of four sampled residents and one resident (Resident #29) outside the sample during scheduled resident smoke breaks. The facility census was 66. Review of the facility's policy titled, Smoking Policy - Residents, dated October 2023, showed:- This facility has established and maintains safe resident smoking policies;- Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences;- Smoking is only allowed in designated resident areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances;- Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation);- Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.Review of the Smoke Schedule Time posting showed: - Smoke breaks scheduled for 6:00 A.M., 8:00 A.M., 10:00 A.M., 1:00 P.M., 3:00 P.M., 6:00 P.M., and 8:00 P.M.;- All smoke breaks are taken outside;- The door is at the end of the 300 Hallway.1. Review of Resident #10's medical record showed:- admitted on [DATE];- Diagnoses of tremors (involuntary, rhythmic shaking movements affecting hands, arms, legs, head or voice), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) of left, non-dominant side, cerebral infarction (stroke), unspecified dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and seizures (abnormal brain activity). Review of the resident's Care Plan, dated 09/30/25, showed:- A smoker;- Supervision when smoking due to a history of behavioral/mental health issues;- At risk to make poor decisions;- An apron needed to smoke for safety. Burn marks had been noted to clothing.Review of the resident's Safe Smoking Evaluation, dated 08/20/25, showed:- Dementia and cognitive loss;- Dexterity problems (skill performing tasks with hands);- Left sided arm weakness;- Required supervision;- Safe to smoke with supervision;- Did not address the need for a smoking apron.During an observation on 10/01/25 at 1:06 P.M., of the resident smoking showed:- The resident sat outside in the designated smoking area;- Supervised by staff;- Did not wear a smoking apron;- Did not have on socks or shoes and had a 1 1/2-inch ash on the end of the cigarette that fell to the ground near the resident's right foot.During an interview on 09/29/25 at 12:11 P.M., the resident said he/she smoked cigarettes. During an interview on 10/02/25 at 1:41 P.M., Certified Nurse Assistant (CNA) B said Resident #10 should have worn a smoking apron when he/she smoked. The smoking aprons were kept at the nurses' station. 2. Review of Resident #29's medical record showed:- admitted on [DATE];- Diagnoses of dementia, type II diabetes mellitus (DM - a condition that affects the way the body processes blood (continued on next page)

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugar), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), low back pain and hypertension (high blood pressure).Review of the resident's Care Plan, revised 07/29/25, showed: - A smoker;- Observe clothing and skin for signs of cigarette burns;- Required supervision while smoking. Review of the resident's Safe Smoking Evaluation, dated 09/24/25, showed:- Dementia and cognitive loss;- Vision difficulty;- Could light own cigarette;- Safe to smoke with supervision. Observations on 10/01/25 of the resident's smoke break showed: - At 1:08 P.M., the resident sat unsupervised in in his/her wheelchair under the smoke area with an awning with his/her eyes closed; - At 1:16 P.M., the resident awakened when CNA A spoke to the resident and gave him/her a cigarette to hold in each of his/her hands; - At 1:18 P.M., CNA A lit the resident's cigarette in the left hand, walked away to the other smoke area in front of the 300 Hallway exit door, and left the resident to smoke without supervision; - At 1:19 P.M., with no supervision, the resident took a puff of the cigarette held in his/her left hand;- At 1:23 P.M., the resident sat unsupervised in his/her wheelchair, his/her eyes closed, the lit cigarette in his/her left hand with a visible ash and the burnt cigarette paper at the end of the cigarette; - At 1:24 P.M., the resident sat unsupervised in his/her wheelchair, his/her eyes closed, the lit cigarette in his/her left hand, and ashes lay on the area beside his/her left foot;- At 1:29 P.M., the resident sat unsupervised in his/her wheelchair, his/her eyes closed, and the cigarette held in his/her left hand was no longer lit;- At 1:34 P.M., CNA A walked over to the resident to check on him/her. During an interview on 09/29/25 at 11:23 A.M., the resident said he/she smoked cigarettes. During an interview on 10/01/25 at 1:34 P.M., CNA A said he/she should not have left Resident #29 unsupervised if he/she had to wake up the resident prior to smoking and should not have left the resident unsupervised as he/she had just woke up. He/She should have moved the resident to the smoke area where he/she was supervising and monitoring other residents for safety purposes. During an interview on 10/02/25 at 2:04 P.M., the Assistant Director of Nursing (ADON) said if a resident was asleep during a smoke break, he/she should not have been woken up to smoke. Staff should not leave the resident but rather stay to ensure he/she was safe to smoke. Staff should move the resident to the area where staff could monitor and supervise during smoke breaks. There needed to be two staff members supervising and monitoring the residents' scheduled smoke breaks. Smoking aprons were provided to residents that had been assessed to use for safety purposes.During an interview on 10/02/25 at 2:11 P.M., the Director of Nursing (DON) said staff should notify the charge nurse when a resident was asleep outside during a smoke break to get guidance on what to do. Staff should not leave the resident after lighting his/her cigarette upon being woken up, should stay to ensure the resident was safe to smoke, and should move the resident to the area where other residents were monitored and supervised during the smoke breaks. Smoking aprons should be placed on residents that were required for safety.During an interview on 10/02/25 at 2:14 P.M., the Administrator said staff should not leave the resident after lighting his/her cigarette upon being awakened. The resident should not receive two cigarettes at one time. The staff should stay to ensure the resident was safe to smoke and should move the resident to the area where other residents were monitored and supervised during smoke breaks. Smoking aprons should be placed on residents that were required for safety.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, and provide supportive interventions for two residents (Residents #42 and #50) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of four sampled residents. The facility's census was 66.The facility did not provide a PTSD policy.1. Review of Resident #42's medical record showed:- admitted on [DATE]; - Diagnoses of bipolar disorder (a mental disorder that causes unusual shifts in mood), PTSD, schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), major depressive disorder (MDD - long-term loss of pleasure or interest in life), anxiety (persistent worry and fear about everyday situations) disorder and craniosynostosis (a rare birth defect that occurs when the fibrous joints between a baby's skull bones fuse too early, before the brain is fully formed).Review of the resident's September 2025 Physician's Order Sheets (POS) showed: - An order for Depakote (an anticonvulsant medication) extended release 24 hours 500 milligram (mg) two tablets at bedtime for bipolar disorder, dated 08/22/25;- An order for Invega Sustenna (an antipsychotic (medications used to treat psychotic disorders) 156 mg/milliliter (ml) intramuscularly (IM - injection into the muscle) every day shift every 28 days related to schizophrenia, dated 06/27/25;- An order for sertraline (an antidepressant medication) 100 mg 1.5 tablet one time a day related to major depressive disorder, dated 04/21/25.Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 10/22/24, showed:- Diagnoses of chronic PTSD, bipolar disorder, and MDD;- Reported triggers of being picked on and seeing other people being picked on;- History of abuse;- An altercation with another resident due to him/her becoming upset because he/she didn't like to see others be rude and aggressive towards staff, dated 02/16/25.Review of the resident's Behavioral Notes showed:- On 07/16/25, the resident held the back door down to the smoke area and let himself/herself out of the facility;- On 08/24/25, the resident was on a smoke break, was goofing around, and unintentionally knocked off another resident's hat and caused the resident's glasses to fall off.Review of the resident's Trauma Informed Care Assessment, dated 04/08/25, showed:- Physical and sexual assault or abuse.Review of the resident's Care Plan, revised 06/17/25, showed:- Mood diagnoses of bipolar, MDD, and anxiety;- Monitor/document/report as needed (PRN) any signs or symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, and tearfulness;- Did not address PTSD;- Did not address the resident's past trauma or any triggers that would cause the resident to have behaviors.During an interview on 10/01/25 at 10:55 A.M., the resident said he/she had PTSD due to being picked on in school by classmates and abused physically by family members. Loud noises and people fighting upset him/her. He/She did not like to be yelled at or for people to make fun of his/her forehead. 2. Review of Resident's #50's medical record showed:- admitted on [DATE];- Diagnoses of schizoaffective (a chronic mental health condition characterized by symptoms of both schizophrenia and MDD) disorder bipolar type ,PTSD, intellectual disabilities (significant limitations in intellectual functioning and adaptive behaviors that are present before the age of 18), other stimulant abuse in remission, alcohol abuse in remission, cannabis abuse in remission, dependent personality disorder (a mental health condition characterized by an excessive and pervasive need for others to care for and make decisions for them), unspecified dementia (a decline in cognitive (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function that does not meet the diagnostic criteria for a specific type of dementia), unspecified psychosis (a mental health condition characterized by a loss of touch with reality), and anxiety.Review of the resident's September 2025 POS showed: - An order for alprazolam (an antianxiety medication) 0.5 mg by mouth at bedtime for anxiety, dated 08/14/25;- An order for clozapine (an antipsychotic medication) 400 mg by mouth at bedtime for schizoaffective disorder, dated 09/04/25;- An order for clozapine 50 mg by mouth in the morning for schizoaffective disorder, dated 09/04/25;- An order for Depakote 500 mg by mouth three times daily for schizoaffective disorder, dated 09/04/25;- An order for mirtazapine (an antidepressant medication) 7.5 mg by mouth at bedtime for schizoaffective disorder, dated 08/14/25;- An order for Prazosin (a blood pressure medication) 5 mg by mouth at bedtime for PTSD, dated 06/24/25; - An order for risperidone (an antipsychotic medication) 1 mg by mouth at bedtime for schizoaffective disorder, dated 08/14/25.Review of the resident's PASARR, dated 02/08/21, showed:- Diagnoses of schizophrenia paranoid type, schizoaffective disorder, bipolar type, delusional disorder, MDD, anxiety, PTSD, polysubstance abuse, mild intellectual disability, and dementia;- Poor impulse control when demands were not met; - Suicidal ideations and attempts due to stress.Review of the resident's Behavioral Notes showed:- On 06/23/25, the resident said he/she needed to go to the mental hospital. The resident expressed the same paranoid thoughts that he/she experienced since admission. He/She believed the scanners through the tv and radio were talking to him/her and that the scanners were listening to him/her as well. The resident said his/her medication was not the same as it was at the other place;- On 07/28/25, the resident said the scanner and speaker were attacking his/her brain and he/she needed something really bad to stop the noise. He/She needed help. The Assistant Director of Nursing (ADON) notified the psychiatric physician and received a one-time order;- On 08/20/25, the resident burst into the Administrator's office during the morning meeting yelling and cursing. He/She was hearing voices, had scanners, and was acting aggressive. The Administrator calmly tried to de-escalate the situation and reassured the resident he/she was safe and did not need to be afraid or upset. The resident said the facility was keeping him/her against his/her will and wanted to be in a lock down unit. The Administrator again calmly redirected the resident, asked him/her would like to smoke a cigarette, and the resident agreed; - On 09/21/25, the resident used a thumbtack to inflict five scratches to his/her left forearm down to the wrist. He/She was depressed and cut his/her arm so that he/she could go to the hospital. He/She had scanners in his/her head, was out of medicine, breakfast was always late, and his/her guardian was taking his/her money. The Director of Nursing (DON) was called, and the resident was placed on 15-minute checks. The resident said he/she was going to run away. The resident went down to his/her room and sat on the bed.Review of the resident's Trauma Informed Care Assessment, dated 06/20/25, showed:- Experienced an event that was unusually or especially frightening, horrible, or traumatic. During an interview on 10/02/25 at 12:02 P.M., the Social Service Director (SSD) said when a resident was admitted with a PTSD diagnosis, a Trauma Informed Care Assessment was completed and triggers were documented on the form, and given to the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator to be included on the care plan under behaviors. If triggers that caused behaviors were documented on the resident's PASARR, it should be included as well. During an interview 10/02/25 at 12:05 P.M., the MDS Coordinator said if a resident had a diagnosis of PTSD, his/her triggers with interventions should be part of the care plan. The SSD completed a Trauma Informed Care Assessment and gave him/her a copy of the form with its findings, so it could be included on the resident's care plan. If triggers that cause behaviors were documented on the resident's PASARR, it should be included as well.During an interview on 10/02/25 at 1:54 P.M., the Administrator said if a resident (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a diagnosis of PTSD, his/her triggers with interventions should be included on the individualized care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 28 opportunities with three errors made, resulting in an error rate of 10.71% for three residents (Residents #15, #31 and #59) out of five sampled residents. The facility's census was 66.Review of the facility's policy titled, Insulin Administration, last revised March 2025, showed:- Did not address insulin administration using an insulin pen.Review of the Humalog/lispro (a rapid insulin that helps lower mealtime blood sugar spikes) Kwik Pen (insulin in a pen-type device) instructions, revised July 2023, showed:- Prime the pen by turning the dose knob to two units;- Hold the pen with the needle pointing up;- Tap the cartridge holder gently to collect air bubbles at the top;- Push the dose knob in until it stops, and zero is seen in the dose window, count to five slowly, insulin will be visible at the tip of the needle;- Select the dose;- Give the injection after selecting the area and cleaning the site with an alcohol swab.Review of the Fiasp/Novolog/insulin aspart (fast-acting insulin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed:- Prime the pen by turning the dose selector to two units;- Keep the needle upwards and press the push-button until the dose selector reads zero;- Turn the dose selector to select the number of prescribed units;- Push the needle into the skin, then press the dose button until the dose selector indicates zero;- Keep the push-button fully pushed in after injection;- Leave the needle under the skin for six seconds and then remove it.1. Review of Resident #15's Physician Order Sheet (POS), dated October 2025, showed:- An order for Humalog insulin 100 unit/milliliter (ml) inject subcutaneously (injection under the skin) per sliding scale before meals and at bedtime: if blood sugar 60-110= 0 units; 111-150 = 4 units; 151-200= 8 units; 201-250 = 10 units; 251-300 = 12 units; 301-350 = 14 units; 351-800 = 16 units and notify the physician, dated 09/23/25.Observation on 10/01/25 at 11:15 A.M., of the resident's medication administration showed:- Licensed Practical Nurse (LPN) D administered 16 units of Humalog subcutaneously for a blood sugar of 398;- LPN D failed to prime the Humalog Kwik pen per the manufacturer's instructions prior to the insulin administration.2. Review of Resident #31's POS, dated September 2025, showed: - An order for Humalog KwikPen 100 unit/ml inject subcutaneously per sliding scale before meals and bedtime: if blood sugar 60-110 = 0 units; 111-150 = 4 units; 151-200 = 8 units; 201-250 = 10 units; 251-300 = 12 units; 301-350 = 14 units; 351-999 = 16 units call the provider, dated 06/21/25.Observation on 09/30/25 at 11:29 A.M., of the resident's medication administration showed: - LPN D administered 4 units of Humalog subcutaneously for a blood sugar of 130;- LPN D failed to prime the Humalog KwikPen per the manufacturer's instructions prior to the insulin administration.3. Review of Resident #59's POS dated, October 2025, showed: - An order for Humalog insulin 100 unit/ml inject subcutaneously two times a day per sliding scale: if blood sugar 60-110 = 0 units; 111-150 = 2 units; 151-200 = 4 units; 201-250 = 6 units; 251-300 = 8 units; 301-350 = 10 units; 351-999 = 12 units and notify the physician, subcutaneously two times a day, dated 05/22/25.Observation on 10/01/25 at 11:41 A.M., of the resident's medication administration showed:- LPN D administered 4 units of Humalog subcutaneously for a blood sugar of 200;- LPN D failed to prime the Humalog KwikPen per the manufacturer's instructions prior to the insulin administration. During an interview on 10/01/25 at 11:49 A.M., LPN D said he/she wasted 2-3 units, removed the needle, and dialed up the prescribed units per the sliding scale. The rationale for priming the insulin pen was to ensure the bubbles in the pen were not administered to the resident. During an interview on 10/02/25 at 11:51 A.M., LPN C said he/she wasted 2 units to prime the pen needle that was placed on the insulin pen before administering insulin to the resident.During an interview on 10/02/25 at 10:51 A.M., the Director of Nursing (DON) said she would expect nursing staff to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dial up 2 units of insulin and waste them to prime the needle of the insulin pen.