STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265275	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butler Rehab and Healthcare Center	416 S High Street Butler, MO 64730

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party for one closed record sampled resident's (Resident #1) significant change of condition when on 05/24/26 the resident acquired an unstageable (full thickness and tissue loss has occurred but the true depth of the damage cannot be assessed because the wound bed is obscured by dead tissue), necrotic (death of living tissue or cells) pressure injury/ulcer to his/her coccyx (base of spine, tailbone) out of three residents sampled for pressure injury/ulcer. The facility census was 54 residents. Review of the facility's Care and Services policy revised 10/24/22 showed:-Licensed nurse discusses with the resident, family, legal representative the possible consequences of the refusal and documents that interaction.-The Licensed Nurse notifies the physician of the resident's refusal of treatment.-The licensed nurse or designee documents and notifies the resident's physician and responsible party of:--Change in condition, including progress and/or decline in physical or mental function.--Resident refusal of care or services.--Unusual circumstances. Review of the facility's Change of Condition Notification policy revised 10/24/22 showed:-Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner.-The Facility will promptly inform the resident, consult with the resident's Attending Physician, andnotify the resident's legal representative when the resident endures a significant change in their condition caused by but not limited to an injury accident.-The Licensed Nurse will notify the resident, the resident's responsible party, or the family/surrogate decision-makers of any changes in the resident's condition in a timely manner.-Documentation pertaining to a change in the residents' condition will be maintained in the residents' medical record and on the 24-Hour Report. 1. Review of Resident #1's admission Record showed he/she was admitted to the facility with the following diagnoses:-Protein-calorie malnutrition (condition that develops when the body does not get the right amount of the vitamins, minerals, and other nutrients it needs to maintain healthy tissues and organ function).-Iron deficiency secondary to blood loss (chronic).-Need for assistance with personal care.-Contracture (a permanent tightening or shortening of muscles, tendons, skin, or other tissues that causes joints to become stiff and restricts normal movement) of muscle to right lower leg.-Contracture of muscle to left lower leg.Review of the resident's medical record showed he/she was not their own responsible party.Review of the resident's General Durable Power of Attorney (DPOA-a legal document that gives one person (such as a spouse, relative, friend, or lawyer) the authority to make medical, legal, or financial decisions for another) dated 03/12/25 showed the resident had a legal DPOA in place and active. Review of the resident's admission assessment dated [DATE] showed the resident:-Required assistance by staff to turn and reposition while in bed.-Was totally dependent on staff for transfers and required a mechanical lift.-Had no skin issues. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning) dated 04/17/26 showed the resident was cognitively intact.Review of the resident's shower sheet/skin condition report dated 05/19/26 showed an open area to the resident's coccyx noted by the Certified Nurse's Assistant (CNA) and reviewed by the Licensed (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN). Review of the resident's weekly skin observation dated 05/19/26 showed the resident had no skin issues. Review of the resident's progress notes dated 05/24/26 showed the LPN notified the Assistant Director of Nursing (ADON) of an area of concern to the back of the resident's left hip.--NOTE: There was no documentation that the resident's representative was notified. Review of the resident's progress notes dated 05/26/26 showed the ADON noted skin issues were present and to refer to the assessment for more information.--NOTE: There was no documentation that the resident's representative was notified. Review of the facility weekly pressure wound observation dated 05/28/26 showed:-The resident had a wound to his/her sacrum (bone at the base of the spine).-The wound was acquired during the resident's stay.-The wound was acquired on 05/24/26.-This was the first wound observation.-The extent of the necrosis was 75-100%.-The family/Power of Attorney (POA- a person that has the authority to make medical, legal, or financial decisions for another) was notified on 05/29/26. Review of the resident's medical record showed he/she was not receiving hospice (a specialized model of compassionate care for individuals facing a terminal illness with a prognosis of six months or less) services.Review of the third party wound care providers' Initial Wound Evaluation and Management Summary dated 05/26/26 showed:-The resident was being seen for the presence of a wound on his/her sacrum.-The resident was cognitively intact.-The resident had a pressure wound that was necrotic with 80% necrotic tissue and 20% black necrotic tissue.During an interview on 06/29/26 at 5:10 P.M., the ADON and Regional Nurse said:-The resident's wound was first observed and documented on 05/24/26.-The resident was notified. The resident's responsible party/POA was not notified because the resident was his/her own person.--The resident's medical record did not indicate that he/she was their own responsible party.-He/She would expect the nurse to notify the ADON, physician, and the resident's representative. During an interview on 06/29/26 at 6:38 P.M., the resident's POA said:-He/She first became aware of the resident's coccyx wound on 06/13/26 during a phone call with the nurse on duty at the facility when they called informing him/her that the resident had fallen.-He/She had never received notification from the facility regarding the resident's wound. During an interview on 07/01/26 at 12:49 P.M., the Nurse Practitioner (NP) said:-He/She was the primary provider that made rounds at the facility.-He/She would usually address any change of condition in an NP note.-He/She did not recall and could not find any documentation of being notified or addressing a sacrum pressure wound for the resident.-He/She would expect to be notified of any change of condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure professional standards were met related to the monitoring and documentation of pacemaker (an electrical device that stimulates the heart at a fixed rate) functionality for one sampled closed record resident (Resident #1) and one sampled resident (Resident #2) out of 2 residents sampled for heart monitoring devices. The facility census was 54 residents. Review of the facility's Care and Services policy revised 10/24/22 showed:-Purpose: To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process.-The licensed nurse or designee documents and notifies the resident's physician and responsible party of unusual circumstances.Review of the facility's Physician Orders policy revised 10/24/22 showed:-The Medical Records Department will verify that physician orders are complete, accurate and clarifiedas necessary.-Other orders will include a description complete enough to ensure clarity of the physician's plan ofcare.-Whenever possible, the Licensed Nurse receiving the order will be responsible for documentingand implementing the order.-Documentation pertaining to physician orders will be maintained in the Electronic Health Record (EHR).A copy of the facility's policy related to the maintenance of a pacemaker 'was requested but not provided.1. Review of Resident #1's admission Record showed he/she was admitted to the facility with the following diagnoses:-Dilated Cardiomyopathy (a condition where the heart's main pumping chamber enlarges, thins, and weakens, preventing it from pumping blood efficiently).-Atherosclerotic heart disease (narrowing or blockage of the arteries that supply blood to the heart).-Congestive heart failure (when the heart muscle does not pump blood efficiently).-Paroxysmal atrial fibrillation (intermittent, chaotic heart rhythm).-Presence of cardiac pacemaker.Review of the resident's Order Summary Report dated June 2026 showed the following orders:-Admit to facility with a Pacemaker Medtronic Device and check per cardiologist recommendation. Medtronic device at bedside, rate of 60 beats per minute (BPM).-Resident has a Pacemaker/Defibrillator Medtronic model #24960 serial #84724557 under the care of the local Cardiovascular Clinic Device check per cardiologist recommendation.--NOTE: The order failed to include monitoring parameters, thus there was no recorded documentation.Review of the resident's undated care plan showed he/she had a pacemaker related to atrial fibrillation (an irregular and often very rapid heart rhythm) with the following interventions:-The staff were to monitor/document/report as needed any signs or symptoms of altered cardiac output or pacemaker malfunction.-Pacemaker checks as ordered, document in chart the heart rate, rhythm, and the battery check.2. Review of Resident #2's admission Record showed he/she was admitted to the facility with the following diagnoses:-Presence of cardiac implants and grafts (specialized devices and biological tissues used to repair defects, replace failing heart valves, and redirect blood flow).-Paroxysmal atrial fibrillation.-Syncope (fainting) and collapse.Review of the resident's Order Summary Report dated June 2026 showed:-An order for a Medtronic Loop Recorder (a continuous monitor of the heart's rhythm).--NOTE: The order failed to include monitoring parameters, thus there was no recorded documentation.Review of the resident's undated care plan showed the resident had a Medtronic Loop Recorder with the following interventions:-Pacemaker checks as ordered and request results.Observation on 06/29/26 at 2:40 P.M. showed:-The resident was lying down in bed resting.-The Medtronic Loop Recorder was on the nightstand and powered on as evidenced by the power cord plugged into wall socket and the power light indicator being illuminated.3. During an interview on 06/29/26 at 5:10 P.M., the Care Plan Coordinator, Assistant Director of Nursing (ADON), and the Regional Corporate Nurse said:-The facility was responsible for making sure that residents with pacemakers had complete orders, had a care plan for the pacemaker, and that the cardiologist was contacted to find out when to change the battery.-He/She would expect a resident who had a pacemaker to have physician's orders that included regular monitoring of the resident's heart rate, proper functioning of the device, and proper setting.-The care plan coordinator, ADON, and the nurse (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on admission who was putting the orders in were responsible for making sure that orders were complete.-Nurses were responsible for making sure the monitoring was documented and carrying the orders out.During an interview on 06/29/26 at 6:38 P.M., the resident's representative said:-He/She was not sure of the date but was called by the cardiologists' device coordinator's office and did not get the call due to being on vacation at the time.-He/She received a certified letter dated 6/17/26 from the device coordination team saying that the Loop Recorder was disconnected and they were not receiving data. The letter was the office's last attempt before services would be suspended within 30 days.-He/She then made a trip to the facility to re-connect the device personally.-The facility never notified him/her there were any issues with the resident's device during this time.During an interview on 07/02/26 at 8:50 A.M., the Cardiologists' Device Coordinator said:-The Medtronic device would try to re-connect on its own for 7 days before notifying them of the disconnection.-The resident's device was first reported as disconnected on 05/12/26.-A call was placed to the resident's representative, whose contact information was what was on file, and a voicemail was left on 5/26/26. The call was not returned.-A letter was sent to the resident's representative's address, which was the contact information that was on file, on 06/02/26.-A certified letter was sent to the resident's representative's address on 06/17/26.