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	02/27/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation an interview, the facility failed to prevent the accumulation of debris on the blade of the table top can opener; failed to remove the accumulation of food particles and debris from under the 6-burner stove; failed to prevent a buildup of dust on the vent fans and the sprinkler head in the walk-in refrigerator; failed to prevent the accumulation of dust and grease on the light fixtures; and failed to prevent the presence of a dust buildup inside the ceiling vents in the kitchen. This practice potentially affected 58 residents who ate food from the kitchen. The facility census was 59 residents. 1.Observation on 2/23/26 from 9:56 A.M. to 12:24 P.M., during the lunch meal preparation, showed:-The presence of food debris on the can opener point.-The presence of food debris under the 6-burner stove.-An accumulation of dust on the sprinkler head and on the vent fans in the walk-in refrigerator.-The presence of dust on light fixtures over the microwave, dust on the ceiling vent over the microwave. -The presence of dust on the light fixtures over the dish storage area next to the reach-in fridge.During an interview on 2/23/26 at 12:58 P.M. the Dietary Manager said:-The dietary staff should clean the debris from under the stove every night. -- It was probably the two weekend nights before the start of survey on 2/23/26, that the area under the 6- burner stove has not been cleaned.-As far as the lights were concerned, the accumulation of dust on the light fixtures had to do with the fact there was not a regular maintenance person in the facility.-He/she expected maintenance to clean the sprinkler head and the fans in the walk-in refrigerator, because cleaning those parts are beyond the duties dietary staff.

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

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	02/27/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the ceiling vents in the following areas free from a buildup of dust, the dining room, the shared restroom between 308 and 310, 300 Hall Central bath, the shared restroom between 306 and 304, resident room [ROOM NUMBER], resident room [ROOM NUMBER], 100 Hall Central Bath, and the 200 Hall Central Bath; failed to maintain the floor in good repair and in an easily cleanable condition in the shared restroom of resident rooms [ROOM NUMBERS], the 300 Hall Central Bath, the restroom floor in resident room [ROOM NUMBER], and the restroom floor in resident room [ROOM NUMBER]; failed to maintain the floors in the following areas clean and free of debris, resident rooms 313, 307, 304, 302, 305, 303, 300, 111, 105, 106, and 102; failed to maintain the personal fans in resident rooms 300, 303,103, 107, free of a heavy buildup of dust; and failed to maintain the base of the tube feeding pole in resident room [ROOM NUMBER] free from tube feeding debris. This practice potentially affected at least 40 residents who resided in or used those areas. The facility census was 59 residents. 1. Observation on 2/23/26 at 10:39 A.M, and on 2/25/26 at 2:49 P.M, showed a heavy buildup of dust in three ceiling vents over the dining room.2. Observation on 2/25/26 with the Regional Director of Operations showed the following on the 300 Hall:-At 11:12 A.M., in resident room [ROOM NUMBER] there was a heavy buildup of dust in the ceiling vent and a 49-inch (in.) area where the floor peeled away from its base.-At 11:23 A.M., there was a buildup of debris, including hair and dust under and behind the beds in resident room [ROOM NUMBER].-At 11:33 A.M. there was an area of the shower room floor that was 8 inches (in.) long by 10 in. wide where the tiles were peeled away.-At 11:40 A.M., the floor in the restroom of resident room [ROOM NUMBER] had numerous tears in the floor.-At 11:44 A.M., there was a buildup of grime on the floor in resident room [ROOM NUMBER].-At 11:47 A.M, there was a buildup of grime on the floor in resident room [ROOM NUMBER].-At 11:49 A.M., there was a buildup of hair rand dust in on the floor in resident room [ROOM NUMBER], a buildup of dust in the restroom ceiling vent and numerous rips and tears in the restroom floor.-At 11:51 A.M. there was a brown colored substance on the base of the tube feeding pole in resident room [ROOM NUMBER]-At 11:54 A.M, there was a buildup of dust on the fan blades of the fan, a buildup of grime on the floor and a buildup of dust in the restroom vent of resident room [ROOM NUMBER].-At 11:59 A.M., there was a buildup of dust on the fan and a buildup of dust and grime on the floor in resident room [ROOM NUMBER].3. Observation on 2/25/26 with the Regional Director of Operations showed the following on the 100 Hall:-At 12:20 P.M., there was a buildup of grime on the floor of resident room [ROOM NUMBER].-At 12:34 P.M, there was a buildup of dust in the ceiling vent in the 100 Hall Central Bath.-At 12:37 P.M., there was a buildup of dust on the blades of the personal fan in resident room [ROOM NUMBER].-At 12:40 P.M., there was a buildup of dust and debris on the floor in resident room [ROOM NUMBER].-At 12:47 P.M., there was a buildup of grime on the floor in in resident room [ROOM NUMBER].-At 12:55 P.M, there was a buildup of grime on the floor in resident room [ROOM NUMBER].4. Observation on 2/25/26 at 1:49 P.M., with the Regional Director of Operations showed a heavy buildup of dust in the ceiling vent of the 200 Hall Central bath.5. During an interview on 2/25/26 at 2:25 the Housekeeping Supervisor said the following after looking at resident rooms [ROOM NUMBERS]:-He /She was away from his/her duties as a Housekeeping Supervisor from 9/30/25 to 2/3/26 for personal reasons.-No one stepped up to be the Housekeeping Supervisor when he/she was away.-He/She expected the floors to be mopped and swept daily.-The personal fans had not really been cleaned since the former maintenance person left. -The former maintenance person used to clean the ceiling vents, but no one took care of cleaning the ceiling vents at the current time.-He/she expected the housekeepers to clean all floor areas that could be cleaned. During an interview on 2/25/26 at 2:34 P.M., Housekeeper A said:-It was difficult to remove the grime from the floors because scrapers (a tool or device used for scraping, especially for (continued on next page)

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	02/27/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removing dirt, paint, ice, or other unwanted matter from a surface) were not available for the housekeepers at the facility.-He/She did not want to move the beds to clean under the beds if residents were sleeping on their beds.During an interview on 2/26/26 at 11:24 A.M, Housekeeper B said:-The floor in the shared restroom of resident rooms [ROOM NUMBERS], had been like that for several months.-The floor of the restroom in resident room [ROOM NUMBER], was difficult to clean because of the damage to the floor.During an interview on 2/26/26 at 1:36 P.M., Licensed Practical Nurse (LPN) B said:-He/She would have to find out who cleaned the tube feeding pole. -He/She did not clean the tube feeding pole.During an interview on 2/27/26 at 2:03 P.M., the Assistant Director of Nursing (ADON) said it was the responsibility of the housekeepers to clean the tube feeding pole.During an interview on 2/27/26 at 2:07 P.M, Housekeeper A said:-They cleaned the tube feeding pole.-On 2/26/26, the tube feeding pole was missed.

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure hand hygiene and Enhanced Barrier Precautions (EBP - infection control measures of gown and glove use during high contact activities with residents at risk for transmission germs resistant to many antibiotics) for one sampled resident (Resident #47) with a physician's order for EBP and failed to develop a facility policy that instructed nursing staff in the use of gowns with EBP and that included the use of EBP for residents with indwelling devices (medical devices inserted into the body); failed to ensure staff used hand hygiene after insulin (medication used to manage diabetes (Types 1, 2, or gestational) administration after removing gloves and before applying new ones for one supplemental resident (Resident #31); and failed to ensure staff cleaned and disinfected shared medical equipment of a blood pressure cuff prior to its use and after for one supplemental resident (Resident #37) out of 14 sampled residents and five supplemental residents. The facility census was 59 residents. Review of the facility Standard and Enhanced Precautions policy dated July 1, 2023, showed:-No instruction for staff to wear gowns for high contact activities for residents on EBP.-No instruction to use EBP for residents with wounds or indwelling medical devices. Review of the facility Hand Hygiene policy dated October 24, 2023, showed:-The facility considered hand hygiene the primary means to prevent the spread of infections.-Facility staff were trained regularly on the importance of hand hygiene in preventing the transmission of infections. Review of the Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety & Oversight Group (QSO) memo to State Survey Agencies and long-term care (LTC) facilities dated March 20, 2024, showed:-CMS issued new guidance for State Survey Agencies and long-term care (LTC) facilities on the use of EBP to align with nationally accepted standards.-Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multidrug-resistant organisms (MDRO – germs that are resistant to many antibiotics).-Recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their MDRO status. Review of the facility's Hand Hygiene policy dated October 24, 2022, showed:-The facility considers hand hygiene the primary means to prevent the spread of infection.-Facility staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.-Facility staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances.--Wash hands with soap and water between glove changes.--Alcohol-based hand hygiene products can and should be used to decontaminate hands after removing and disposing of personal protective equipment.-Hand hygiene is always the final step after removing and disposing of personal protective equipment.-The use of gloves does not replace hand hygiene products. 1. Review of Resident #47's Physician's Orders Sheet (POS) dated 2/27/26 showed:-Diagnoses of carrier or suspected carrier of Methicillin Resistant Staphylococcus Aureus (MRSA – staph bacteria that is resistant to several common antibiotics).-EPB related to indwelling catheter and Peripherally Inserted Central Catheter (PICC a thin, flexible tube inserted into an upper arm vein used for long-term therapy including antibiotics).-Ertapenem sodium (antibiotic) solution one gram (gm) intravenously (IV into a vein) one time a day for urinary tract infection (UTI). (continued on next page)

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/25/26 at 10:03 A.M. showed:-Licensed Practical Nurse (LPN) B entered the resident's room and placed the resident's Ertapenem Sodium IV medication, IV tubing, IV port cap, IV flushes and alcohol wipe package on the resident's overbed table without first placing a barrier on the resident's overbed table. -He/She washed his/her hands, put on gloves, he/she did not put on a gown. -He/She wiped the resident's IV port with an alcohol wipe, attached the saline flush syringe and flushed the residents PICC line.-He/She attempted to mix the resident's IV medication for administration and being unable to do so left the resident's room with the medication, entered two hallways and asked for assistance with mixing the medication.-He/She continued attempting to mix the resident's IV medication until he/she was successful, returned to the resident's room and placed the resident's IV medication on the resident's overbed table without a barrier and attached IV tubing to the medication.-He/she dropped an alcohol wipe package on the floor, picked up the alcohol wipe package from the floor, opened the package and wiped the resident's PICC line cap with the alcohol wipe.-He/she then attached the IV tubing to the residents PICC line, set the rate of infusion on the IV pump, washed his/her hands and left the resident's room. Observation on 2/25/26 at 10:53 A.M. showed:-LPN B entered the resident's room; a PICC line cap and IV saline flush were on the resident's overbed table without a barrier.-He/she washed his/her hands, put on gloves and did not put on a gown.-He/she disconnected the IV tubing from the resident's PICC line, flushed the PICC line with the saline flush syringe and placed a new cap on the resident's PICC line.-He/she then removed his/her gloves, washed his/her hands and left the resident's room. During an interview on 2/26/26 at 10:58 A.M. LPN B said:-The resident was on EBP.-He/She should have put on a gown when he/she entered the resident's room to administer his/her IV medication and also when he/she entered the resident's room and disconnected the IV tubing and flushed the resident's PICC line.-He/She should have used a barrier for the resident's IV medication and PICC line supplies.-He/She should not have used the alcohol wipe he/she had dropped on the floor and should have discarded the alcohol wipe, removed his/her gloves, washed his/her hands and obtain a new alcohol pad to use. During an interview on 2/27/27 at 3:05 P.M. the Director of Nursing (DON) said:-EBP required at a minimum the use of gloves and gowns when administering IV medications.-Barriers should be used for all medications and supplies placed on a surface in a resident's room.-LPN B should have put on a gown each time he/she entered the resident's room for administration of the resident's IV medication and for disconnecting tubing and flushing the resident's PICC line. -LPN B should have discarded the alcohol wipe he/she had dropped on the floor, removed his/her gloves, performed hand hygiene and he/she could have used the resident's call light or ask for help from the resident's doorway to get a new alcohol wipe.-All management nurses were responsible to monitor that staff followed EBP and used correct infection control procedures. 2. Review of Resident #31's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 1/30/26, showed the resident was:-Cognitively intact.-Able to make his/her needs known.-Received insulin injections seven day per week.-Diagnoses included: Type 2 Diabetes Mellitus (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin) and hypoglycemia (low blood glucose level). Review of the resident's Physicians Order Sheet (POS) dated February 2026 showed an order for Humalog Solution 100 milligram (mg)/milliliter (ml) to inject per sliding scale subcutaneously before (continued on next page)

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals for diabetes notify provider if less than 70 or 451, ordered on 2/8/26. Observation on 2/24/26 at 12:34 P.M. showed:-LPN C performed hand hygiene with sanitizer and applied gloves.-LPN C placed blood glucose testing supplies on tray and entered the resident's room.-LPN C cleaned fingertip with alcohol and pierced it with lancet.-LPN C wiped blood drop with gauze and squeezed fingertip to get a new drop.-LPN C tested blood drop with glucometer (small, portable device used to measure the concentration of glucose (sugar) in the blood).-LPN C applied pressure to the finger with gauze.-LPN C took tray with supplies back to medication cart and with the same gloves opened the bottom of the drawer and took out a disinfectant wipe.-LPN C removed gloves and did not perform hand hygiene prior to putting on a new pair of gloves.-LPN C cleaned glucometer with a disinfectant wipe.-LPN C failed to perform hand hygiene after contact with resident and removal of gloves before applying new ones. During an interview on 2/24/26 at 12:45 P.M., LPN C said:-He/She had not realized he/she did not perform hand hygiene between gloves changes.-He/She should have washed or sanitized his/her hands between glove changes and before giving the resident his/her insulin.-He/She had been in-serviced on appropriate hand hygiene procedure. During an interview on 2/27/26 at 2:19 P.M., LPN A said:-Nursing staff should always practice good hand hygiene.-Staff should perform hand hygiene between gloves changes-Staff received regular in-services on hand hygiene policy and procedure. During an interview on 2/27/26 at 3:30 P.M the DON said:-Trainings and in-services that included proper hand hygiene were conducted monthly and as needed.-A skills check was done for nursing staff in January 2026.-The Assistant Director of Nursing (ADON) was responsible for making sure that the trainings were done.-He/She would expect staff to perform hand hygiene between glove changes. 3. Review of Resident # 37's admission record showed he/she was admitted with the following diagnoses:-Dementia ((a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).-Paroxysmal atrial fibrillation (afib) (an irregular, often rapid heart rhythm that starts and stops suddenly on its own or with treatment, lasting less than 7 days).-Hypertension (HTN- high blood pressure).-Heart failure (a chronic, progressive condition where the heart muscle cannot pump enough blood to meet the body's needs, often causing fluid buildup (congestion) in the lungs and legs). Review of the resident's Quarterly MDS dated [DATE] showed:-The resident had moderate cognitive impairment.-The resident was able to make his/her needs known. Review of the resident's POS dated 2/22/26 showed the resident was taking the following medications daily that required a blood pressure measurement prior to administration:-Cardizem LA Oral Tablet Extended Release 24 Hour 300 milligrams (mg) (Diltiazem HCl). Give 300 mg by mouth one time a day for HTN. Hold if systolic blood pressure (sbp) was less than 50.-Metoprolol Tartrate Tablet 50 mg. Give one tablet by mouth two times a day for afib, hold for sbp less than 50. Observation on 2/25/26 at 10:21 A.M. with Certified Medication Technician (CMT) B during medication pass showed:-He/She performed hand hygiene.-He/She entered the resident's room.-He/She did not sanitize the blood pressure cuff prior to using it on resident.-He/She took the resident's blood pressure per physician's order before administering blood pressure medication to the (continued on next page)

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident.-He/She documented the resident's blood pressure finding.-He/She returned to the resident's room and administered medications.-He/She did not sanitize the blood pressure cuff after using it. During an interview on 2/25/26 at 10:30 A.M. CMT B said:-The blood pressure cuff was used on multiple residents during medication pass.-Blood pressure and pulse should always be checked prior to administering blood pressure medication.-The blood pressure cuff should be cleaned before and after each use.-It was his/her responsibility to make sure shared medical equipment were cleaned before and after each use. During an interview on 2/27/26 at 3:30 P.M., the DON said:-Shared medical equipment should be cleaned before and after use.-Trainings and in-services for the nursing staff including infection control were conducted on a monthly schedule and as needed when an issue comes up.-The ADON was responsible for making sure this was done.

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	02/27/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that only residents assessed and determined safe by the interdisciplinary team (IDT) may self-administer medication and failed to ensure medications were not left unattended for a resident assessed as unable to self-administer for one sampled resident (Resident #17) out of 14 sampled residents. The facility census was 59 residents. The Medication Self-Administration policy was requested on [DATE] but was not provided before exit time. Review of the facility's policy titled Medication Administration dated [DATE] showed:-Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner, or as consistent with state law.-Medications will not be left at the bedside.-The Licensed Nurse will remain with the resident until the medicine is actually swallowed.-If resident is refusing to take medication, the Licensed Nurse who is passing the medication will initial and draw a circle around his/her initials in the designated area on the Medication Administration Record (MAR). Documentation will be entered on the back of the MAR stating the reason for the refusal.-The Licensed Nurse will re-approach the resident and attempt to give the medications at a later time, but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse will notify the Attending Physician and document in the medical record.-If the resident repeatedly refuses medication, the Licensed Nurse will contact the physician to discuss alternative measures for medication administration. The plan of care will be updated as indicated.-If the resident has difficulty swallowing pills, the Licensed Nurse will notify the Attending Physician to discuss the possibility of a different form of the medication.1. Review of Resident #17's face sheet showed he/she was admitted with the following diagnoses:-Cerebral Infarction (a type of ischemic stroke caused by a blockage in brain blood vessels, resulting in tissue necrosis (death) due to lack of oxygen).-Dysphagia (difficulty swallowing).-Congestive Heart Failure (a chronic condition where the heart cannot pump blood efficiently, causing fluid buildup, fatigue, and shortness of breath).-Atrial Fibrillation (reduces cardiac output and significantly increases the risk of stroke, blood clots, and heart failure).-Pulmonary Hypertension (high blood pressure in the lung arteries, causing them to become stiff, narrow, or blocked).-Chronic Kidney Disease (long-term, irreversible loss of kidney function, commonly caused by diabetes and high blood pressure).-Chronic Obstruction Pulmonary Disease (a progressive, incurable, yet treatable lung disease mainly caused by smoking, that restricts airflow, making it difficult to breathe).Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE] showed he/she:-Was cognitively intact.-Was able to understand others and make his/her needs known.Review of the resident's Medication Self-Administration Safety Screen dated [DATE] showed:-The resident was assessed for self-administration of all medications.-The assessment was to be completed at least quarterly.-The resident was determined to require assistance with correctly reading label and/or identifying each medication, correctly stating what each medication was for, correctly stating the time/frequency medications were to be taken, correctly stating the correct dosage and quantity for each administration.-All medications were to remain with staff.-The IDT determined it was not safe for the resident to self-administer any medications.-The results of the resident's assessment were categorized as may NOT self-administer medications.Review of the resident's Physician Order Sheet (POS) dated February 2026 showed:-B-Complex with Vitamin C and Folic Acid oral tablet (supplement) one tablet by mouth one time a day.-Bactrim DS table 800-160 milligram (mg) (Sulfamethoxazole-Trimethoprim) one tablet by mouth one time a day every Tuesday, Thursday and Saturday for prophylaxis (preventative) prostatitis (inflammation of the prostate gland).-Folic Acid oral tablet 400 micrograms (mcg) (supplement) one tablet by mouth one time a day.-Furosemide tablet 40 mg one tablet by mouth one time a day for edema (fluid retention).-Hydrochlorothiazide oral tablet 25 mcg one tablet by mouth one (continued on next page)

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	02/27/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time a day for hypertension (high blood pressure).-Magnesium Oxide tablet 5 mg one tablet by mouth two times a day for hypomagnesemia (low magnesium).-Multiple Vitamins-Minerals tablet one tablet by mouth one time a day for supplement.-Natto kinase oral capsule 100 mg one capsule one time a day for supplement. Medication in bottles called peak blood flow. -Omeprazole oral tablet delayed release 20 mg one tablet by mouth one time a day for heartburn (GERD).-Potassium Chloride ER tablet extended release 20 Milliequivalent (MEQ) one tablet by mouth one time a day for hypokalemia (low potassium).-Vitamin D3 125 mcg (5000 units) one capsule by mouth one time a day for supplement.Review of the resident's MAR dated February 2026 showed:-B-Complex with Vitamin C and Folic Acid oral tablet (supplement) one tablet by mouth one time a day.-Bactrim DS table 800-160 mg (Sulfamethoxazole-Trimethoprim) one tablet by mouth one time a day every Tuesday, Thursday and Saturday for prophylaxis (preventative) prostatitis (inflammation of the prostate gland).-Folic Acid oral tablet 400 mcg (supplement) one tablet by mouth one time a day.-Furosemide tablet 40 mg one tablet by mouth one time a day for edema (fluid retention).-Hydrochlorothiazide oral tablet 25 mcg one tablet by mouth one time a day for hypertension (high blood pressure).-Magnesium Oxide tablet 5 mg one tablet by mouth two times a day for hypomagnesemia (low magnesium).-Multiple Vitamins-Minerals tablet one tablet by mouth one time a day for supplement.-Natto kinase oral capsule 100 mg one capsule one time a day for supplement. Medication in bottles called peak blood flow. -Omeprazole oral tablet delayed release 20 mg one tablet by mouth one time a day for heartburn (GERD).-Potassium Chloride ER tablet extended release 20 MEQ one tablet by mouth one time a day for hypokalemia (low potassium).-Vitamin D3 125 mcg (5000 units) one capsule by mouth one time a day for supplement.-NOTE: There was no physician's order for the self-administration or the ability to keep medications at bedside.Observation on [DATE] at 11:42 A.M. showed the resident had an expired Vitamin D3 bottle with unidentified medication in it that were not Vitamin D3 capsules.Observation on [DATE] at 9:27 A.M., showed the resident:-Had an expired Vitamin D3 bottle with unidentified pills in it on bedside table.-Had an open bag of cough drops on bedside table.During an interview on [DATE] at 9:27 A.M. the resident said: -The pills were for strength and he/she administered them daily.-The cough drops were given to him/her on [DATE].Observation on [DATE] at 9:20 A.M., showed the resident:-Had an expired Vitamin D3 bottle with unidentified pills in it on bedside table.-Had an open bag of cough drops on bedside table.-Had a small plastic cup filled with medications on bedside table.During an interview on [DATE] at 9:20 A.M. the resident said the medications were given to him/her that morning and he/she wasn't ready to take them yet.During an interview on [DATE] at 9:38 A.M., Certified Medication Technician (CMT) A said:-He/She gave the resident all their morning medication between 8:30 A.M. and 8:45 A.M.-He/She watched the resident take all his/her medications and ensured they were swallowed completely.-He/She was not sure if the resident was approved to self-administer any medications and was not aware of any medications kept in the resident's room.-He/She did not know where to find the resident's self-administration assessment information.-He/She always marked each medication cup with resident's name and room number so if was not marked, he/she did not give the medications.-If a resident refused medication at the time of administration, he/she should ask again, advise them of the adverse effects related to not take medication, notify the charge nurse and document it.During an interview on [DATE] at 3:30 P.M. the Director of Nursing (DON) said:-All residents should be assessed quarterly for being able to self-administer or keep medications at beside.-Resident who had been assessed for medication self-administration and determined to be ineligible should not have medications left with them or kept at bedside.-The provider, Assistant Director of Nursing (ADON), and him/her were responsible for determining the resident's eligibility for self-administration.-There should be a physician's order that indicated whether it was safe for the resident to self-administer medications.-Staff should make sure all medications were taken and swallowed before leaving the room.-Residents should be care planned for the self-administration and ability to keep medication at bedside.-Trainings and in-services that included safe medication administration were done monthly and as needed when there was a new (continued on next page)

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	02/27/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issue.-Possible outcomes when allowing a resident who was ineligible for medication self-administration and keeping medication at bedside were medication errors and adverse effects.

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	02/27/2026

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit a Third Party Liability (TPL- a form which is sent to Missouri (MO) Health Net, which gives an accounting of the remaining balance of that resident's funds in the resident trust account) forms were completed and sent to Missouri (MO) Healthnet (a state agency which administers the provision and payment of services for Missouri's Medicaid program) within 30 days of death for one discharged resident (Resident #11) out of three sampled residents selected for TPL submission review. The facility census was 59 residents. 1. Review of Resident #11's medical record showed the resident died on [DATE].Review of the resident's Trust Fund Balance showed the resident had a balance of $8.68 in his/her account.Review of the resident's Trust Fund records on [DATE] (49 days after the resident's death), showed the absence of a TPL that was submitted within 30 days after the resident's death.During an interview on [DATE] at 3:43 P.M., the Business Office Manager (BOM) said he/she did not submit a TPL for the discharged resident because he/she thought the guardian submitted the TPLs.

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	02/27/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview and record review, the facility failed to ensure the facility policy and procedure for checking the Criminal Background Check was followed for two sampled employees (Maintenance Worker A and Certified Nursing Assistant (CNA) C) out of 10 sampled employees. The facility census was 59 residents. Review of the facility Abuse and Neglect policy and procedure dated 10/24/22, showed:-The purpose was to ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.-Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of property. -The facility does not knowingly employ anyone who has had disciplinary action against his/her professional license or a finding entered into the state nure aide registry related to abuse, neglect, mistreatment or misappropriation or has been convicted of abusing, neglecting or mistreating other people. The facility screens for potentially abusive staff during the pre-screening process.1. Review of Maintenance Worker A's employee record showed:-He/She was hired on 7/1/23. -His/Her criminal background check showed the facility requested it on 8/19/24 and received it on the same date.2. Review of CNA C's employee record showed:-He/She was hired on 1/6/25. -His/Her criminal background check showed the facility requested it on 9/18/24 and it was received on the same date.During an interview on 2/27/26 at 12:53 P.M., the Human Resources Director said:-Maintenance Worker A was not a re-hire. -His/Her original hire date was 2016 but when the facility was purchased, the corporate office used the date they took over as the new hire date for staff who were current at that time and documented a new hire date. -They did not update the background check information (they were unable to find the original criminal background check for this employee). -Maintenance Worker A was no longer an employee at the facility.-CNA C was rehired on 1/6/25 and it looked like the former Human Resource Director did not re-run the background check and they should have.-He/She completed an audit of all the current staff and noted the staff who were re-hired did not have background checks completed, so he/she completed criminal background checks on staff today. -They were all up to date.

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	02/27/2026

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 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 a comprehensive investigation was completed that included details of the circumstances of the fall, notification of the emergency contact/family and completing the risk analysis of what occurred and interventions implemented to prevent the fall from recurring for one sampled resident (Resident #9) who fell, sustaining a minor injury and who was confused and unable to make decisions independently out of 14 sampled residents. The facility census was 59 residents. Review of the facility's Fall Prevention policy and procedure dated 10/24/22, showed:-Following a resident's fall, the licensed nurse will complete an incident report and a Post? Fall Assessment & Investigation within 24 hours or as soon as practicable. -The Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated.-The Interdisciplinary Team (IDT) Committee will meet within 72 hours of a fall. The IDT Committee will review and document summary of review following a fall, root cause analysis, referrals as necessary and interventions to prevent further falls.-The IDT committee will document findings and recommendations in the resident's medical record. Nursing staff will document the resident response to interventions being utilized in the resident's medical record. The residents care plan will be updated as necessary.1. Review of Resident #9's Face Sheet showed he/she was admitted with the following diagnoses:-Heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs).-Depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act).-Anxiety (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation).-Arthritis in the left ankle and foot.-Auditory and visual hallucinations (the apparent perception of something not present).-Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).-Muscle weakness. Review of the resident's Fall Risk assessment dated [DATE], showed a fall risk score of 4.0 which was determined to be low risk.Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/16/26, showed:-The resident had significant cognitive incapacity.-Had no upper or lower extremity range of motion incapacity.-Needed supervision for transfers and mobility and did not use a wheelchair or walker to mobilize.-Did not show the resident had a history of falls or prior falls since the prior assessment.Review of the resident's Care Plan dated January 2026 showed the resident was at risk for falls related to confusion. Interventions showed staff would: -Anticipate and meet the residents needs as needed.-Encourage the resident to participate in activities of resident's choice.-Ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed.-Follow facility fall protocol.Review of the resident's Nursing Notes showed:-On 1/28/26 at 6:01 P.M., resident's peer notified this nurse that the resident had fallen out of his/her chair.-The peer stated (the resident) was asleep and was leaning forward right before he/she fell.-The resident was lying face down on the floor and was able to roll himself/herself over. The nursing assistant assisted this nurse, using a gait belt to lift the resident back into the chair.-His/Her vital signs (blood pressure, temperature, respirations, pulse and oxygen level) and range of motion were within normal limits. The resident had an abrasion to the middle of his/her forehead and the bridge of his/her nose. The Nurse Practitioner and Director of Nursing (DON) were notified.Review of the resident's Fall incident report dated 1/28/26 at 7:00 A.M., showed the resident:-Had an unwitnessed fall out of his/her chair on 1/28/26. -The resident was found lying face down on the floor.-His/her socks were in place without grips.-The resident was sitting in a chair and had fallen asleep and was leaning forward.-The resident was able to roll himself/herself over but was not able (continued on next page)

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	02/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to give a description of what occurred.-The resident was alert oriented to person and was ambulatory without assistance.-The nurse assessed the resident and obtained vital signs (undocumented). The Certified Nursing Assistant (CNA unknown) assisted the nurse using a gait belt to get the resident up off the floor.-The resident had an abrasion to the top of his/her scalp (without description).-His/Her Pain assessment showed the resident had no pain.-Had no predisposing environmental factors, physiological factors, or situational factors checked to show what could have contributed to the resident's fall.-There were no injuries observed on the resident after/post incident.-The physician was notified. Documentation showed the resident representative was self and did not show that the resident's family or responsible party was notified.-Predisposing factors did not show the resident was not wearing grips on his/her socks.-The document did not show where the resident was when the fall occurred, when the last time staff had seen the resident and what the resident was doing at that time, a description of the abrasion was not documented (size, color, drainage if applicable) and there was no documentation showing the resident's family or emergency contact was notified (since the resident was unable to make decisions, had confusion and sustained an injury).Review of the resident's Post Fall 72 Hour Documentation showed neurological checks (evaluates brain and nervous system functioning. It's a series of tests that assesses mental status, reflexes, movements and more) were initiated on 1/28/26 and continues through 1/31/26.Review of the resident's Care Plan showed an update dated 1/29/26, that showed the resident had an actual unwitnessed fall with minor injury on 1/28/26. Interventions showed staff would:-Encourage to go to room and go to bed when he/she was asleep in chair in lobby.-Review his/her medication and make changes indicated.-Monitor/document/report as needed for 72 hours to the physician for signs/symptoms of pain/bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, agitation.-Provide neurological checks per facility policy.Observation on 2/25/26 at 2:54 P.M., showed the resident:-Was sitting in a chair in front of the nursing station dressed for the weather without odor. -Was wearing fuzzy socks.-Was sitting quietly.-Was alert but not interacting.-Was watching residents and staff as they passed by. -Was very friendly however he/she was unable to state what occurred on the date he/she fell (unable to recollect).Observation on 2/26/26 at 9:18 A.M., showed the resident:-Was sitting in the dining room finishing breakfast. -Was dressed for the weather without odor and was groomed, wearing fuzzy socks. -Stood up and ambulated out of the dining room without any assistance or assistive device after he/she was finished with breakfast.-Was ambulating without any balance control concerns. No concerns were noted at this time.During an interview 2/27/26 at 1:13 P.M., Licensed Practical Nurse (LPN) B said:-On the day the resident fell, he/she and another staff were sitting at the nursing station, and the resident was sitting in a chair across from the nursing station.-He/She caught the tail end of the resident falling out of the chair onto the floor.-When he/she went over to the resident, he/she assed the resident and he/she had a goose egg a little knot on his/her head.-He/She and another staff assisted the resident up into the chair and he/she started vital signs and neurological checks on the resident.-He/She notified the Physician and the DON.-The resident was his/her own responsible party, so they did not notify anyone from his/her family or emergency contact. -He/She was aware that the resident has a BIMs of 3 but he/she was his/her own responsible party.-He/She did not know if the resident had family. -They were supposed to fill out the incident report, a risk management assessment, which was checkoff sheet to show what was done, and the neurological check sheet. They also wrote the nursing note stating what occurred. -The incident report was the investigation, and it should be comprehensive.-They also had a huddle sheet (review of the fall) that was just implemented about a month ago to discuss the resident's fall and determine the root cause and how to prevent further falls.-He/She did not remember if they completed a huddle for the resident's fall.During an interview on 2/27/26 at 2:15 P.M., the DON said:-They had a fall packet that had a list of items the nurse was supposed to complete when a resident fell that included completing the incident report, writing a nursing summary regarding what occurred, documentation of the resident's (continued on next page)

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	02/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vital signs and neurological checks and injuries, documenting all notifications. -The incident report should be comprehensive and include all elements related to the resident's fall.-He/She would expect the nurse to notify family, but in this case, the resident was considered his/her own responsible party so the nurse did not notify any family/emergency contact. -The resident had a BIMS of 3 and he/she did not believe the resident was able to make his/her own decisions.-This resident's daughter was uninvolved in the resident's care and the resident had only had one visitor. He/She did not have any other family (to his/her knowledge) and it would be against the resident's rights for the family to receive information that the resident may or may not want them to have. -They may need to have a conversation about emergency guardianship for the resident.

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	02/27/2026

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain a physician's order and failed to update the care plan for one sampled resident (Resident #1) to provide own self-care for his/her Colostomy (bowel) and Urostomy (bladder) (surgical openings (stomas) in the abdomen allowing waste to exit the body into a pouching system, used when bowel or bladder function is compromised) out of 14 sampled residents. The facility resident census of 59 residents. Review of the facility Policy and Procedure for Colostomy care revised on 10/24/22 showed: The stoma and surrounding skin will be monitored for irritation with routine care and as part of licensed nurses' weekly assessment. Requested the facility policy for self-administrating of medication and treatments and did not receive at time of exit. 1. Review of Resident #1 admission Face sheet showed he/she was admitted to the facility with diagnoses of:-Paraplegia (is an impairment in motor or sensory function of the lower extremities). -Colostomy status (is an surgical opening (stoma) on your abdomen (belly) that connects your colon (large intestine) to the outside of your body).-Neuromuscular dysfunction of bladder. (is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition).-Artificial opening of urinary tract status. (surgical opening into the urinary tract system, a stoma) Review of the resident's Nursing Self-Medication assessment dated [DATE] showed:-The resident may not self-administer medication (keep medication at bedside or provide own medication). -Nursing staff must be present and administer medications.-There was no nursing assessment to assess the resident's ability and knowledge to provide own self-care of colostomy and urostomy.Review of the resident's Care Plan revised on 12/20/25 showed:-The resident had activity of daily living (ADL) for self-care performance deficit related to Paraplegia.-NOTE: There was no care plan related to the resident's ability to provide own self-care for his/her colostomy or urostomy.Review of the resident's Physician Order Sheet (POS) dated February 2026 showed: -The resident had a urostomy: required a 64-millimeter (mm) wafer, ordered on 1/16/26.-Nursing to provide care and change urostomy every three days (every 72 hours) and as needed, ordered on 12/26/25.-Monitor and document urostomy stoma for signs and symptoms of infection every shift and as needed, ordered on 12/26/25.-Check urostomy site every shift and change bag as needed every shift, ordered on 12/26/25. -Colostomy wafer size of a 38 mm.-Nursing staff to care and change colostomy every three days (every 72 hours) and as needed, ordered on 2/26/25.-Check colostomy site every shift and change bag as needed every shift, ordered on 12/26/25.-NOTE: There was no physician's order for the resident to provide own self-care of ostomy sites and applying ostomy appliance and no nursing assessment to assess the resident ability and knowledge to provide own colostomy and urostomy care. Review of the resident's Treatment Administration Record (TAR) dated February 2026 showed:-Monitor and document colostomy stoma for signs of infection every shift ordered on 12/26/25.-Monitor and document urostomy stoma for signs of infection every shift ordered on 12/26/25.-Check urostomy site every shift and change bag as needed: dated 12/26/25.-Provide urostomy care and change urostomy every 3 days and as needed every 72 hours AND as needed ordered on 12/26/2025.-Provide colostomy care and change colostomy every 3 days and as needed every 72 hours ordered on 12/26/25-There was documentation that nursing staff checked the colostomy and urostomy sites every shift indicated by the nurse's initials in each box by each order. -NOTE: There was no physician's order for self-care assessment for the residents ability to provide own ostomy care and did not physicians order for the resident allowed to assist with or provide own ostomy care. During an interview on 2/24/26 at 2:22 P.M., the resident said:-He/she had a colostomy and urostomy and he/she provided his/her own care. -He/she had shown staff how he/she cared for his/her colostomy and urostomy sites and changing the bags. -He/she had no issues at the urostomy and colostomy sites at that time.Observation on 2/25/26 at 9:15 A.M. showed the resident did not (continued on next page)

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	02/27/2026

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have any lingering odors present.During an interview on 2/25/26 at 9:15 A.M., the resident said:-He/she did not have any concerns with his/her ostomy care.-There was no redness or soreness at either the colostomy or urostomy sites. During an interview on 2/25/26 at 11:19 A.M. Director of Nursing (DON) said: -The resident completed his/her own colostomy and urostomy care. -He/she was unsure if the resident had a physician's order to provide his/her own colostomy and urostomy care. During an interview 2/25/26 at 11:25 A.M., Licensed Practical Nurse (LPN) B said: -The resident had been providing his/her own urostomy and colostomy care.-The resident did not have a physician's order to provide his/her own urostomy and colostomy care.-There should be a physician's order for the resident to provide his/her own urostomy and colostomy care.-Nursing staff should have completed a resident self-care assessment to assess the resident's knowledge and ability to provide his/her own ostomy self-care. Observation on 2/26/26 at 12:18 P.M., of the resident's ostomy site showed:-Certified Nursing Assistant (CNA) D and CNA E were present in the resident's room assisting the resident with personal cares. -The resident had a urostomy on his/her right abdomen and a colostomy on the left side (which had brownish green stool noted). -There was no redness noted at either site and the stomas were pink with no signs of infection. During an interview on 2/26/26 at 12:18 P.M. the resident said: -He/She would change his/her own urostomy and colostomy bag as needed. -Staff were normally in the room assisting him/her when it was time to change or empty the ostomy bags. During an interview on 2/27/26 at 10:20 A.M. the Assistant Director of Nursing (ADON) and Infection Control Preventionist (ICP) said: -The resident was known to provide most of his/her own colostomy and urostomy care with stand by assistance by care staff. -Nursing had assessed the resident's ability to provide his/her own care but did not document in the resident's medical record and did not obtain a physician's order for the resident to provide his/her own ostomy cares. -He/She would expect to have a physician's order for the resident to provide his/her own urostomy and colostomy care.-He/She would expect nursing staff to have completed and documented a resident self-care assessment at least quarterly in the resident's electronic medical record.-The care plan should reflect the resident's current medical needs and care, to include own self-care for his/her colostomy and urostomy sites. -The Minimum Data Set (MDS a federally mandated assessment tool completed by facility staff for care planning) Coordinator would ensure the resident's care plan was updated as needed. During an interview 2/27/26 at 3:04 P.M., the DON said: -He/she would expect there to be a physician's order for the resident to provide his/her own colostomy and urostomy care. -Nursing staff should have a physician's order to provide self-care oversight and to assess the resident's ability to provide his/her own colostomy and urostomy care. -Nursing staff should complete the resident self-care assessment at least every quarter.-Would expect nursing staff to complete resident self-care assessment for ability and knowledge to provide his/her own cares. -He/she would expect the resident's care plan to be updated with the resident's ability to provide his/her own colostomy and urostomy cares.-Care plans were reviewed and updated during team meetings. -He/she would expect staff to document the monitoring of the resident colostomy and urostomy care and document findings in the resident's progress notes.-The resident had the right to make choices and to provide his/her own care if he/she had the ability to safely provide all or part of his/her own colostomy and urostomy care.

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	02/27/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to ensure the physician's order prescribed enteral supplemental tube feeding (tubes inserted into the gastrointestinal tract to provide a patient with enteral nutrition) formula and failed to update the resident's care plan to include details on the prescribed tube feeding formula for one sampled resident (Resident #7) who was dependent on enteral nutritional feedings out 14 sampled residents. The facility census of 59 residents. Requested the facility's Tube Feeding policy did not receive at time of exit. Review of the tube feeding formula manufacture information on website dated 2026 showed: -Diabetisource AC 1.2 calories (cal) per milliliter (ml) (a tube feeding formula made with a unique blend of carbohydrates that includes pureed fruits and vegetables for resident that are diabetic for reduce sugar intake). -Fibersource HN 1.2 cal (a nutritionally complete tube feeding formula with fiber, contains protein from milk and soy and was Lactose intolerance and gluten-free).1. Review of Resident#7's admission record showed the resident admitted with the following diagnoses:-Gastrostomy status (is a procedure in which the feeding tube (gastrostomy tube (G-tube) or Percutaneous Endoscopic gastrostomy (PEG) is placed directly into the stomach). Review of the resident's undated Care Plan showed:-The resident required tube feeding related to dysphagia (difficulty swallowing). -NOTE: There was no documentation that showed the type of supplemental formula prescribed by the Physician or by the Registered Dietitian. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 2/10/26 showed he/she:-Was severely cognitively impaired.-Required supplemental tube feeding formula for nutritional intake. Review of the resident's Physician Order Sheet (POS) dated February 2026 showed an order for tube feeding supplemental formula of Fiber Source HN 1.2 via peg tube delivered at 47 ml/ hour (hr) continuous times 22 hours. May have max of two-hour break in 24-hour period for actives and cares, ordered on 2/19/26Review of the resident's Treatment Administration Record (TAR) dated February 2026 showed Fiber Source HN 1.2 calorie via peg tube delivered at 47 ml/hr continuous times 22 hours. May have max of two-hour break in a 24-hour period, every shift, for peg tube feedings. Observation on 2/23/26 at 10:42 A.M., showed:-The resident was in bed with his/her eyes open and non-verbal, he/she would smile.-His/her tube feeding pump was running at 47 ml/hr and the bag of water flush running at 240 ml every 4 hours. -He/she had a premixed formula bag of Diabetisource AC 1.2 cal with a handwritten date of 2/23/26. Review of the resident's Nursing Note dated 2/24/2026 at 2:55 A.M. showed: -The resident continues to be nothing by mouth (NPO) with continuous PEG-tube feedings.-His/Her head of bed was elevated 45 degrees.-Oral care provided. -Resident pleasant during this shift smiling and laughing. -No signs or symptoms of acute distress, pain, or discomfort noted or reported. -Abdomen was soft and non-tender. -Resident resting in bed with call light within reach.-NOTE: The note did not indicate the type of tube feeding formula prescribed and being given.Observation on 2/24/26 at 9:21 A.M., showed:-The resident was in bed.-His/her tube feeding formula was connected to the tube feeding pump and running at 47 ml/hr.-The type of supplement formula was Diabetisource AC and was labeled with date of 2/24/26 at 12:00 A.M. -NOTE: Fibersource HN 1.2 cal was transcribed to the resident's POS on 2/19/26.Observation 2/24/26 at 9:50 AM of the resident's PEG tube medication administration showed.-Diabetisource, AC was running at 47 ml/hr per pump. The formula bag was dated 2/24/26 at 12:00 A.M.-Licensed Practical Nurse (LPN) A placed tube feeding on hold and disconnected the feeding tube.-The Director of Nursing (DON) was present, as LPN A completed administering medication via PEG tube via feeding tube syringe. -The hub of the PEG tube site, looked like a small button connected to a small narrow tubing (tip of tubing snaped into button PEG tube site). -The dry split dressing around the PEG tube site was dated 2/24/26 at 12:00 A.M.-LPN A then reconnected the Diabetisource formula after the medications were administered via PEG tube. During an interview on 2/24/26 at 10:10 A.M., LPN A said: -He/she had checked the resident's physician's (continued on next page)

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	02/27/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order, and it showed the tube feeding formula was to be Fibersource HN and not Diabetisource AC. -He/she said the only difference was Diabetisource AC had less sugar, and Fibersource HN had more fiber content. Observation on 2/24/26 at 10:10 A.M. showed LPN A:-Went to a storage closet to obtain the correct formula of Fibersource HN. -Acknowledged the Fibersource HN bag was similar to the Diabeisource AC bag. Review of the resident's Nursing Note dated 2/24/26 at 10:28 A.M., showed: -The resident received Diabeticsource AC, which was not the tube feeding formula prescribed.-The resident's Nurse Practitioner (NP) the Registered Dietician were notified.-No new orders at that time. Continue with plan of care.During an interview on 2/27/2026 10:20 A.M., the Assistant Director of Nursing (ADON) and Infection Control Preventionist (ICP) said:-He/she would expect nursing staff to check the physician's orders and TAR before hanging tubing feeding formula. -The nursing staff should ensure to follow the five rights in providing medication and supplemental formulas to include: Right Resident, Right Drug, Right Dose, Right Route, and Right Time.-The MDS Coordinator would be responsible for updating the resident's care plan as needed and during the MDS quarterly review. During an interview on 2/27/26 at 3:04 P.M., the Director of Nursing (DON) said: -He/she would expect nursing staff to check the physician's order to ensure they had obtained the right prescribed tube feeding formula and to have double checked before connecting the tube feeding to the resident's PEG tube. -He/she would expect staff to the monitor the tube feeding bag and pump every shift and when making rounds on the resident to ensure the tube feeding was running and the right formula was being given. -The facility had checked with the RD and confirmed the nutritional value for the Diabetisource AC and the Fibersource HN was the same and there was no outcome from getting the wrong formula. -The resident's care plan was reviewed and was updated during the IDT meetings.

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	02/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory face masks and tubing were covered to prevent cross contamination when not in use for two sampled residents (Resident #13, and #6) out of 14 sampled residents. The facility census was 59 residents. Review of the facility Oxygen Administration policy and procedure dated 10/24/22, showed:-All oxygen tubing, humidifiers, masks and cannulas used to deliver oxygen are for single resident use only and will be changed weekly when visibly soiled or as indicated.-Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. 1. Review of Resident #13's Face Sheet showed he was admitted with diagnoses that included:-Chronic Obstructive Pulmonary Disease (COPD a condition involving constriction of the airways and difficulty or discomfort in breathing).-Heart disease.-Respiratory failure.-Chronic cough.-Rhinitis (the inflammation and swelling of the mucous membrane inside the nose). Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 8/23/25 showed the resident:-Was alert and oriented with confusion.-Was dependent on staff for bathing, dressing, toileting, transferring and mobility and used a wheelchair.-Used oxygen. Review of the resident's Nursing Notes showed:-On 12/3/25 at 4:00 P.M. the resident continued on antibiotic, Levaquin 500 milligrams (mg) for pneumonia. The resident had no signs/symptoms noted. Resident continued on scheduled breathing treatments. Call light was within reach.-On 12/4/25 Weekly risk meeting with team. This team was currently concerned that this resident was having some respiratory infection. The Nurse Practitioner had the resident on Levaquin (a potent, broad-spectrum fluoroquinolone antibiotic used to treat serious bacterial infections, including pneumonia, sinus infections, and urinary tract infections), and Lasix (a water pill that treats swelling (edema) and fluid retention caused by conditions like heart failure, liver disease, and kidney disease). This resident did appear to be better this week then previously. No further concerns at this time. Review of the resident's Shortness of Breath evaluation dated 1/25/26, showed the resident:-Had a diagnosis of COPD and shortness of breath.-Had shortness of breath or trouble breathing with exertion, when at rest and when lying flat-resident breathed better when sitting up.-Used oxygen. Review of the resident's Physician's Order Sheet (POS) dated February 2026, showed physician's orders for:-Oxygen- 2 liters continuous to maintain oxygen level above 90 percent.-Check bubble humidifier daily and fill as needed everyday shift.-Continuous Positive Airway Pressure (CPAP-a medical device that uses mild, steady air pressure to keep breathing airways open while you sleep) handwash headgear weekly in warm soapy water rinse well and allow to hang dry for COPD.-CPAP wash reusable foam filter in warm soapy water, rinse well and dry with paper towels monthly for COPD.-He/She was not currently on any antibiotics for pneumonia or any respiratory disease. Observation on 2/24/26 at 9:24 A.M., showed the resident:-Was in his/her bed with head of bed up. -Was wearing oxygen via nasal cannula (a lightweight, flexible tube with two small prongs that sits in the nostrils to deliver supplemental oxygen) with oxygen set at 2 liter per minute. -Had his her eyes closed, and he/she was resting comfortably. -There was a CPAP machine on the dresser behind him/her with tubing and a face mask on top of the machine that was uncovered. -The machine was running. -There was also a breathing treatment machine that was sitting beside the CPAP machine (continued on next page)

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	02/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with tubing that connected to another face mask that was lying beside the machine, uncovered. -The resident's room was clean without odor and was homelike. Observation on 2/24/26 at 1:21 P.M., showed the resident:-Was sitting up in his/her bed wearing his/her oxygen at 2 liters via nasal cannula. -Was eating lunch. -Had his/her CPAP machine behind him/her on the dresser with the face mask on top of it, uncovered.-The breathing treatment machine was also next to the CPAP machine with the face mask uncovered. Observation on 2/26/26 at 9:07 A.M., showed the resident:-Was in his/her bed sitting up wearing his/her oxygen at 2 liters via nasal cannula. -Had his/her CPAP machine sitting on the dresser behind him/her and the face mask was lying beside it, uncovered. -The resident's breathing treatment machine was sitting next to the CPAP machine and the facemask for that machine was also lying beside it, uncovered. During an interview on 2/26/26 at 9:07 A.M. the resident said:-He/She used the breathing treatment machine during the day to help him/her breathe better.-He/She used the CPAP machine at night.-Nursing staff assisted him/her to use both machines. During an interview 2/27/26 at 2:07 P.M., Certified Nursing Assistant (CNA) B said:-The oxygen face masks, and tubing should be stored in a plastic bag when not in use.-Most of the residents that received oxygen were on continuous oxygen, but he/she usually checked to ensure they are wearing it throughout the day.-The face masks or equipment that was only worn at night should be stored in a bag once they took the equipment off.-Night shift staff usually switched the bags out weekly along with the oxygen tubing and water bottles.-He/She tried to check to ensure the oxygen equipment was stored in the plastic bags during his/her shift. During an interview on 2/27/26 at 12:30 P.M., Nurse Assistant (NA) A said:-The facility staff have given them plastic bags to put all the oxygen equipment in when not in use.-When he/she saw a resident's bag that has been used or did not look to be in good condition, he/she would get a new bag to place their equipment in. -He/She did not know how often the face masks and tubing were replaced but the face masks and tubing should be in a plastic bag, not on the floor or laying on the bed or furniture. During an interview on 2/27/26 at 2:15 P.M., the Director of Nursing (DON) said:-Oxygen equipment (such as face masks, nasal cannulas and tubing) should be stored in a plastic bag off the floor when not in use. -The bags should be labeled with the resident's name and dated. -The night shift staff replaced the bags, tubing, face masks and water bottles every Wednesday night. -Nursing staff should check to ensure the oxygen face masks and tubing were covered when not in use as they made rounds and during the day as they provided cares to residents. 2. Review of Resident #6's admission record showed the resident was admitted with a diagnosis of COPD, nicotine dependence - smoking (addiction to tobacco products). Review of the resident's Quarterly MDS dated [DATE], showed the resident was:-Moderately cognitively impaired and was able to make his/her needs known.-Received oxygen therapy.-Smoked. Review of the resident's care plan dated 2/27/26 showed:-The resident had COPD.-The resident smoked.-The resident received oxygen therapy related to COPD. (continued on next page)

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	02/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's POS dated 2/25/26, showed the following prescriber orders:-Oxygen vial nasal cannula as needed.-Check bubble humidifier daily and fill PRN (as needed) everyday shift.-If present, dispose of all O2 tubing, humidifier, & plastic bag weekly on Friday everyday shift. Observation on 2/23/26 at 10:34 A.M., showed:-The resident was sitting in the recliner in his/her room watching television.-The nasal cannula and tubing connected to the oxygen concentrator, were on the floor under clothing items.-The tubing and cannula were not bagged.-The tubing and cannula were dated 2/6/26.-The water container was not dated. Observation on 2/24/26 at 10:32 A.M., showed:-The nasal cannula and tubing connected to the oxygen concentrator, were on the floor under clothing items.-The tubing and cannula were not bagged.-The tubing and cannula were dated 2/6/26.-The water container was not dated. Observation on 2/25/26 at 9:45 A.M., showed:-The nasal cannula and tubing connected to the oxygen concentrator, were on the floor under clothing items.-The tubing and cannula were not bagged.-The tubing and cannula were dated 2/6/26.-The water container was not dated. During an interview on 2/27/26 at 2:10 P.M., CNA F said:-He/She had received trainings and in-services on infection control and oxygen administration.-Oxygen tubing, cannulas, and masks should be changed every week and initialed and dated.-Oxygen water containers should be changed every week and initialed and dated.-Nasal cannulas and tubing should always be kept off the floor.-Nasal cannulas and tubing should always be bagged when not in use.-All nursing staff was responsible for making sure this is done. During an interview on 2/27/26 at 2:19 P.M., LPN A said:-All oxygen equipment should be always kept off the floor.-Oxygen cannula and tubing should be bagged when not in use.-He/She had received training on infection control and proper use of oxygen equipment.-Oxygen tubing, cannulas, and masks should be changed every week and initialed and dated.-Oxygen water containers should be changed every week and initialed and dated.-The night shift nurse was responsible for making sure oxygen cannula, tubing, and water container were changed every week. During an interview on 2/27/26 at 3:30 P.M. the DON said:-Nursing staff had received training and in-services on infection control regarding oxygen masks, tubing, cannulas and accessories.-Nursing staff had received training to ensure all oxygen tubing and accessories were dated and placed in a plastic bag when not in use, not shared and changed weekly.-He/She would expect all oxygen equipment be kept off the floor at all times and bagged when not in use.-He/She would expect oxygen tubing and water containers to be changed weekly and dated.-Nurses were responsible for making sure this was done.-Staff should ensure this was done by making sure there was an order and documenting that it had been done.-Possible outcomes for not keeping oxygen equipment off the floor and changing it weekly could be infection and no availability of oxygen therapy.

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	02/27/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure a cold dish (cottage cheese fruit plate) was served at a temperature at or close to 41 F (degrees Fahrenheit) to three residents who received room trays and resided on the 100 Hall. The facility census was 59 residents. 1. Review of the undated recipe for cottage cheese fruit plate, showed:-Ingredients which included lettuce leaves, cottage cheese, diced peaches, diced fruit and maraschino cherry halves.-Methods which included: Return ingredients to refrigerator storage if preparation is interrupted.-Place a 4-ounce scoop of cottage cheese on top of lettuce leaf.-Drain canned fruit.-Arrange 4 ounces of fruit around the cottage cheese.-Critical Control Point (CCP- specific step or procedure in a process where control can be applied to prevent, eliminate, or reduce a food safety hazard (biological, physical, or chemical) to an acceptable level, hold for service at 41 F or lower.Observation on 2/23/25 at 11:53 A.M. showed Dietary Aide (DA) A placed the bowls of cottage cheese fruit plate on room tray carts.Observation on 2/23/26 from 11:53 A.M. to 12:19 P.M. showed the cottage cheese fruit plates were on the cart for room trays for that whole time without being replaced into the refrigerator.Observation on 2/23/26 at 12:20 P.M., showed the room trays arrived at the 100 Hall.Observation on 2/23/26 from 12:21 P.M. to 12:30 P.M. showed Certified Nursing Assistant (CNA) F delivered food trays to the 100 and 200 Halls.Observation on 2/23/26 at 12:31 P.M., in the presence of the Director of Nursing (DON) and CNA F, showed the temperature of the cottage cheese fruit plate was 52.1 F at the time of testing.During an interview on 2/23/26 at 12:57 P.M., the Dietary Manager said:-There were times that he/she checked the temperatures of the room trays, but he/she could not check the temperatures on that day (2/23/26) because he/she was the cook and did not have the time to check the temperatures.-The cottage cheese fruit plates probably got warmer because they were on the same cart with the hot foods.

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	02/27/2026

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure the pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) chicken tenders were a smooth consistency. This practice potentially affected two residents with pureed diets. The facility census was 59 residents. 1. Review of the undated recipe for pureed baked chicken, for 1 serving, showed:-1 serving of baked chicken.-Chicken base to taste with 1 ounce of water. -Commercial thickener (a substance such as cornstarch or other carbohydrate which is added to foods to increase the viscosity of liquids without altering their, taste).Observation on 2/23/26 at11:24 A.M., showed the Dietary Manager (DM):-Made pureed chicken and added broth, but did not add thickener.-There was not a recipe book open while he/she made the pureed chicken.-After he/she placed the pureed chicken in a pan, he/she did not taste the chicken.Observation on 2/23/26 at 12:02 P.M., showed the state surveyor:-Tasted the pureed chicken. -The pureed chicken did not have a smooth texture and was grainy. -The taste was flavorful.Observation on 2/23/26 at 12:38 P.M., showed the DM tasted the pureed chicken after being asked by the state surveyor.During an interview on 2/23/26 at 12:39 P.M., the DM said the pureed chicken was grainier than it should have been.During an interview on 2/23/26 at 12:43 P.M. after pureeing it the 2nd time, the DM said:-He/She did not taste the pureed chicken the first time.-If he/she had tasted the pureed chicken after making the pureed chicken the first time, he/she would have known that the texture of the pureed chicken was not smooth.