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	11/18/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and appropriate discharge when the facility staff sent one resident, (Resident #1) out of seven sampled residents, to the hospital with discharge paperwork indicating to return the resident to a homeless shelter in the city. The facility census was 55 residents. A discharge policy was requested from the facility and not received.1. Review of Resident #1's face sheet, undated, showed:-The resident was admitted to the facility on [DATE].-The resident was his/her own representative.Review of the resident's quarterly Minimum Data Set (MDS-a standardized assessment tool that measured health status in nursing home residents) dated 5/22/25, showed:-The resident was cognitively intact. -The resident had diabetes (a chronic condition where blood sugar levels are too high).-The resident had a Traumatic Brain Injury (TBI- an injury to the brain caused by an external physical force, such as a blow, bump, jolt, or penetration to the head).Review of the resident's care plan (a document created for a person that received healthcare, personal care, or other forms of support), dated 5/25/25, showed the resident wished to stay in long term care.Review of the Physician Order Summary, dated 7/1/25, showed:-The resident was ordered:--Eliquis (medication known as a blood thinner, used to prevent and treat dangerous blood clots) Oral Tablet, 5 milligrams (mg).--Jardiance (oral medication used to treat type 2 diabetes) Oral tablet, 10 mg.Review of the nurse progress notes dated 7/31/2025, showed: -A resident approached the nurse and informed him/her that during bedtime snack pass this resident was making inappropriate comments to him/her. The resident submitted a written statement.-No other documentation in the resident's medical record regarding behaviors.Review of the facility's Electronic Progress Notes, showed:-On 8/1/2025 at 4:29 A.M. a nurse noted the resident's oxygen saturation (how the blood carries oxygen to and from the lungs to other parts of the body) was 71% (normal range was 95-100%).-When the resident answered questions the resident's oxygen saturation was 100%. -The resident began to fall asleep again and it was noted the oxygen saturation immediately began to drop again. -The resident was woken up and nursing attempted to put oxygen on the resident.-The resident refused but then stated, something is not right. -The resident was asked if he/she wanted to go to the hospital to get checked out.-The resident stated he/she would go.-On 8/1/2025 at 4:35 A.M. a nurse noted that Emergency Medical Services (EMS) arrived at the facility and the resident willingly got on the stretcher. -Administrator and Assistant Director of Nursing (ADON) were notified. -On 8/1/2025 at 3:01 P.M. a nurse noted: --The facility provided medications to the resident as he/she was leaving the hospital.--The resident took the medications and threw them all over the parking lot. Review of the residents Notice of Proposed Discharge, dated 8/1/25, showed:-The Discharge Effective Date was 8/1/25 and it was immediate.-The resident was discharged to a shelter which included the name and address of the shelter.-The Reason for Discharge stated: Immediate discharge notice was due to resident being a danger to self and others residing in the facility.-An unreadable signature was on the notice in the (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff signature line. -The resident signature line was blank.During an interview on 10/7/25 at 11:51 A.M., the Social Services Director (SSD) said:-The resident did not ask to be discharged .-The resident was discharged on 8/1/25 when he/she went to the hospital.During an interview on 10/7/25 at 1:46 P.M., the Director of Nursing (DON) said:-There was a discharge packet that was filled out by the nursing team.-He/She was unaware if the packet was completed.-He/She was unaware if discharging to a homeless shelter was an appropriate discharge, he/she would have contacted the corporate office.-He/She viewed the staff signature on the discharge form and confirmed it was the Administrator's. -Not sure who the discharge nurse was who brought the paperwork to the hospital.-There is no documentation stating who it was.-He/She expected each resident would have safe discharge plan due to ensure care and services are provided.-He/She expected there to be complete documentation regarding discharges.During an interview on 10/7/25 at 1:56 P.M., the Administrator said:-He/She told the resident he/she would not be allowed to come back to the facility.-The resident wanted to come back to the facility and said he/she was coming back and there was nothing we could do about it.-The resident would not take the notice from the charge nurse.-The resident was an immediate discharge.-The resident was not appropriate with the other residents.-The resident was drinking and sneaking alcohol in the facility.-The resident said sexually inappropriate things to other residents.-He/She felt it was safer for the other residents if the resident was no longer at the facility.-The resident was adamant that he/she wanted to stay at the facility.-The discharge paper said to return him/her to the shelter.-At the time he/she thought it was appropriate to discharge the resident to a homeless shelter, since that is where the resident admitted from.-He/She was under the impression that the resident fit the criteria for an immediate discharge. -The resident did not sign out of the facility Against Medical Advice (AMA).-When he/she was discharged from the hospital it was decided not to let him/her come back to the facility.-One of the nurses delivered the discharge notice he/she initially refused, to the hospital, along with the resident's walker, medication and belongings.-He/She was notified by the veteran's hospital that the resident was there.-He/She would have to check with corporate to see if the resident would be allowed back at the facility. -He/She would expect staff to follow discharge protocol, including completed documentation.