

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Hudson Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 N. College Avenue El Dorado, AR 71730	
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. Based on facility document review, facility policy review, and interviews, it was determined that the facility failed to ensure residents were supervised when receiving medications that were crushed and placed in liquid supplements resulting in one (Resident #1) of five residents reviewed consuming unprescribed medications. The findings include: Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2025 indicated Resident #1 had diagnosis which included non-Alzheimer's dementia, and body mass index of 19 or less. The MDS also indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which revealed the resident had severe cognitive impairment, and that Resident #1 exhibited no behaviors, required set up with eating, and supervision/touch for mobility. Review of a Nsg (Nursing) &ndash; General Note dated 10/23/2025 at 5:54 PM indicated Resident #1 was noted to be drinking from a [named liquid supplement] which did not belong to (Resident #1). A Certified Nursing Assistant (CNA) in the dining room noted Resident #1 took the supplement from the correct resident (to whom the medications in the drink had been prescribed) and picked the second supplement up from the table. Both drinks had crushed medications in them, and Resident #1 drank from both. One supplement contained an expectorant and a medication used to treat the symptoms of Alzheimer's dementia and the second supplement contained an antianxiety and an antidepressant medication. The Advanced Practice Registered Nurse (APRN) was contacted, after the APRN determined the resident was not allergic to any of the medications that had been consumed the nurse was instructed to closely monitor the resident. Review of a form titled, Medication Error Report for Resident #1 dated 10/23/2025 at 5:25 PM, indicated Resident #1 was in the dining room and the resident was noted drinking from a [named liquid supplement] which did not belong to (Resident #1). A CNA in the dining room noted that the resident took the [named liquid supplement] from another resident and picked the [second named liquid supplement] up from the table before drinking from both. Both drinks had crushed medications in them. The [named liquid supplement] contained an expectorant medication and a medication that treats the symptoms of Alzheimer's dementia. The [second named liquid supplement] contained an antianxiety and antidepressant medication. The Medication Error Report also indicated Resident #1 was orientated to person, confused, and had impaired memory, and that the APRN was notified of the incident. Review of the form titled, Medication Discrepancy Report' completed 10/24/2025 for Resident #1 for the incident dated 10/23/2025 at 4:45 PM, revealed Resident #1 took a [named supplement] that contained an antidepressant, an antianxiety, an expectorant and a medication that treats 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse involved in the incident and re-educate her on correct medication administration. The MDS Coordinator stated that the nurse was instructed that no matter what form medications were given in that she must stay with the resident to ensure the medication was taken before leaving the resident. The MDS Coordinator indicated no other staff were in-serviced regarding the incident and the in-service was just with LPN #1. During an interview on 11/07/2025 at 12:05 PM CNA #4 indicated that on the 3-11 shift of 10/23/25, she was the CNA caring for Resident #1. CNA #4 stated that she was assisting residents to go to the dining room for supper and noted Resident #1 drinking a supplement that she had never seen her drink before and spitting some of it out. CNA #4 stated she gave Resident #1 something to spit into and she saw crumbles that looked like medication. CNA #4 stated she and another aide took the drink from Resident #1 and took it to the RN Supervisor. During an interview on 11/7/2025 at 3:05 PM, the DON confirmed that she had been notified by the RN Supervisor on October 23, 2025, that Resident #1 had picked up another resident's medications and taken (consumed) them. The DON indicated she spoke to LPN #1, who was the nurse responsible for giving the medications. The DON indicated LPN #1 told her that once it was realized Resident #1 had drank the supplements belonging to two other residents, the supplements were taken from the resident, who had not drank all the supplement. The DON indicated she verbally instructed LPN #1 that she should not leave a resident until they had taken all their medication and if she was going to crush the medication and put it in a liquid supplement that she should not put it in the full amount of the supplement, but put some of the supplement in a cup, add the medication and observe the resident until all the medication was taken. The DON indicated the APRN was contacted, and staff were instructed to monitor the resident. The DON confirmed that LPN #1 was given a written warning on 10/24/25 for not observing the residents until they took their medications and a written re-education on medication administration. During an interview on 11/07/2025 at 3:55 PM, the APRN confirmed that on October 23, 2025, she was contacted and notified that Resident #1 had drank someone else's supplements containing medications. The APRN indicated she first determined that the resident did not have any allergies to the medications. The APRN indicated her concern was that the resident might become drowsy because of the antidepressant and she ordered the staff to monitor the resident and let her know of any changes. The APRN indicated that she believed any effects the resident might have from the medications would not last more than 4-6 hours. The APRN stated she was not informed after that of any change in the resident condition. During an interview on 11/07/2025 at 5:10 PM, the Administrator indicated she was informed by the DON on October 23, 2025, that Resident #1 had taken two separate drinks with other resident's medications in them. The Administrator indicated the nurse responsible was given a written warning and retrained on medication administration. Review of the policy titled, Medication Administration - General Guidelines with a revision date of November 2011 indicated, medications are administered as prescribed in accordance with good nursing principles including following the five rights for medication administration of right patient, right dose, right medication, right time and right route. Residents are identified before medication administration and observed after to ensure doses are completely taken.		