

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2026
NAME OF PROVIDER OR SUPPLIER  The Springs of El Dorado		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 East Short Hillsboro 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review, interview, and facility document review, the facility failed to provide a safe care environment by placing one (Resident #1) of five residents reviewed for Quality of Care, at risk. Specifically, Resident #1 consumed alcohol brought in by Certified Nursing Assistant (CNA) #3 and became intoxicated in the facility.</p> <p>The findings include:</p> <p>A review of Resident #1's admission Record revealed an admission date of 05/22/2024, with which included diagnoses of Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, mild protein-calorie malnutrition, and alcohol abuse (in remission).</p> <p>A review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/17/2026, revealed a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. Resident #1's MDS further revealed the resident's history of alcohol abuse (in remission), anxiety disorder, COPD, and malnutrition.</p> <p>A review of Resident #1's Care Plan did not reveal an allowance for consumption of alcohol. Resident #1's Care Plan indicated an intervention which revealed the resident was using anti-anxiety medications, with the following warning statement: Abuse, misuse, and addiction. The use of benzodiazepines, including [generic anti-anxiety medication], exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death. Abuse and misuse of benzodiazepines commonly involve concomitant use of other medications, alcohol, and/or illicit substances, which is associated with an increased frequency of serious adverse outcomes.</p> <p>A review of Resident #1's Order Summary did not reveal a provider's order for consuming alcohol.</p> <p>A review of Resident #1's Progress Notes from 03/08/2026, revealed an entry at 3:48 PM, by Licensed Practical Nurse (LPN) #1, which indicated there were four empty alcohol bottles found under Resident #1's sink by the CNAs on the shift.</p> <p>A review of Resident #1's Progress Notes from 03/08/2026 revealed an entry at 10:00 PM, by LPN #2, which indicated LPN #2 witnessed Resident #1 drinking from an alcohol bottle. The same entry also revealed LPN #2 searched the resident's room and found two more bottles of alcohol, at that time.</p> <p>A review of Resident #1's Provider Note from 03/10/2026, revealed the resident was taking anti-anxiety medications as follows:</p> <p>[Generic Anti-anxiety] Oral Tablet 0.5 mg (one tablet by mouth at bedtime). (continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Generic Anti-anxiety] Oral Tablet (one tablet by mouth one time a day).</p> <p>A review of Resident #1's Advanced Practice Registered Nurse (APRN) Note from 03/11/2026 at 6:57 AM, indicated, Today [Resident #1] is not [their] normal self and seems significantly more drowsy than normal.</p> <p>A review of Resident #1's APRN Note, with an effective date of 03/14/2026 at 11:00 PM, indicated [Resident #1's] roommate reports that patient has had trouble walking and has been showing irritation behavior, which is out of the ordinary. [Resident #1's roommate] reports that [they] knew [Resident #1] had alcohol and wasn't going to rat [Resident #1] out but also voices concern and would like to keep [Resident #1] safe.</p> <p>A review of Resident #1's Progress Notes from 03/15/2026 revealed an entry at 10:12 AM, by LPN #1, which indicated Resident #1 was moved to the secure unit and nine more pints of alcohol were found in Resident #1's previous room.</p> <p>A review of Resident #1's Progress Note by the APRN, with a service date of 03/15/2026, revealed Today [Resident #1] is sitting in [their] chair. [Resident #1] is lethargic, slurring words, and does not recall me seeing [them] yesterday and having a 45-minute-long conversation with me. When initially asked about sneaking alcohol, [Resident #1] reported an old friend brought me some half pints and would not give specific answer as to how many or how often. [Resident #1] did not report how much [they] drank. Today when I asked [Resident #1] about it, [Resident #1] stated, what are you talking about? and appeared to be confused/incoherent. [Resident #1] is grimacing and reports that everything is echoing in [their] ears and it sounds like [they are] screaming when [they] whisper.</p> <p>During an interview on 04/15/2026 at 10:25 AM, LPN #1 indicated she first found Resident #1 seemingly drunk on Saturday [03/07/2026] and the CNAs found some alcohol bottles [in the resident's room]. LPN #1 stated they did not do a room search at that time because the Director of Nursing (DON) instructed them not to. LPN #1 confirmed to have also found Resident #1 drinking alcohol in the bathroom on 03/08/2026.</p> <p>During an interview on 04/15/2026 at 11:15 AM, LPN #2 indicated on the evening of 03/08/2026, she witnessed Resident #1 drinking alcohol. LPN #2 then revealed to have worked a day or two after that incident and described Resident #1 as groggy and a little confused, during that time.</p> <p>During an interview on 04/15/2026 at 1:40 PM, the APRN indicated that a few days prior to the first time Resident #1 was found drinking, it was decided Resident #1 could have had an equilibrium [state of physical balance] problem. Resident #1 was slurring words, and their speech was getting delayed. The APRN also indicated that the equilibrium issues started a couple of days before the alcohol was first found on 03/08/2026, they were not sure what all was going on with Resident #1, but they now knew Resident #1 became intoxicated. The APRN also mentioned that the (generic anti-anxiety) medication had been increased at one time, since Resident #1 mentioned being more depressed, but ordered the medication to be held when she knew the resident had become intoxicated.</p> <p>During an interview on 04/15/2026 at 3:40 PM, the DON indicated Resident #1 admitted to her and the APRN, that it was CNA #3 that had been supplying the alcohol to Resident #1. This information was discovered on 03/16/2026, after Resident #1 was moved to the secure unit on 03/15/2026. (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/16/2026 at 9:45 AM, the Administrator indicated that staff contacted her on 03/08/2026 and explained that Resident #1 appeared intoxicated. The Administrator indicated that Resident #1 agreed to an alcohol-recovery program and did an initial visit via telemedicine on 03/12/2026. The Administrator also indicated that she received a phone call from staff the following weekend on 03/15/2026, indicating to the Administrator Resident #1 appeared intoxicated and was hallucinating, and trying to exit out the back door. As a result, on 03/15/2026, the Interdisciplinary Team decided to place Resident #1 on the secure unit and instructed every staff member to watch Resident #1 around the clock. The Administrator indicated that after Resident #1 was moved to the secure unit, a room search was completed that revealed more alcohol bottles like the ones found on the previous weekend. The Administrator added that it was the next day, 03/16/2026, that Resident #1 confessed to the APRN that it was CNA #3 that had been providing them with alcohol. In addition, the Administrator indicated that CNA #3 confessed to bringing Resident #1 alcohol on 03/16/2026, because Resident #1 told CNA #3 they just wanted a taste.</p> <p>A review of CNA #3's Termination Record, signed by CNA #3, had nature of infraction as follows: CNA was bringing alcohol to a resident that didn't have a doctor's order. Resident consumed large amount of alcohol on two different occasions and was intoxicated in facility. Termination date 03/16/2026.</p> <p>A review of an article titled, Drinking alcohol and getting older &amp;ndash; What do I need to know? dated 05/29/2024, from the Mayo Clinic Press, revealed that as people age, alcohol tolerance can be significantly diminished, effects of alcohol can be exacerbated, and drinking while taking medications across a host of drug classes (like anxiety medication) can cause serious side effects. In addition, the article indicated alcohol consumption in adults 55 and older could contribute to falls, and alcohol contributes to 65% of falling deaths.</p>		