STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045407	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Maples at Har-Ber Meadows	6456 Lynchs Prairie Cove Springdale, AR 72762

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Number of residents sampled: Number of residents cited: Based on record review and interviews the facility failed to ensure a resident was not administered an incorrect, unordered medication to prevent a significant medication error for one (Resident #84) of four residents reviewed for medication errors. Findings include: A review of Medical Diagnosis revealed Resident #84 had diagnoses that included right hip pain, rheumatoid arthritis (chronic autoimmune disease primarily affecting the joints), and heart failure. A review of an annual Minimum Data Set with an Assessment Reference Date of 07/20/2025 revealed a Brief Interview for Mental Status score of 15 which indicated Resident #84 was cognitively intact. The MDS also indicated Resident #84 received pain medication as needed (PRN.) A review of a Medication Administration Record, revealed a Physician Order dated 07/15/2024 for a synthetic opioid 50mg (milligrams), two tablets, four times a day PRN for pain. A review of Reportable initiated 10/28/25 at 08:45 AM, submitted on 10/28/2025 at 10:45 AM, revealed on 10/27/2025 at 08:50 PM, Licensed Practical Nurse [LPN] #1 administered two opioids (two tablets) belonging to another resident, instead of two synthetic opioid tablets to Resident #84. A telehealth visit with an on-call physician had no negative findings, a family member requested Resident #84 be assessed in the ED. A review of 800 Hall Vitals, dated 10/28/2025, revealed vital signs were monitored on Resident #84 from 10/27/25 at 10:35PM to 10/28/2025 at 6:00AM. During an interview on 12/01/2025 at 3:00 PM, Resident #84 stated, I remember LPN #1 gave me the wrong pain medication and thought it may have contained an [opioid] that I am allergic too. Resident #84 stated that they had lethargy and even days later when a nurse checked Resident #84's blood sugar, Resident #84 did not wake up. A [unknown] nurse came to give me insulin and when I asked if she was going to check my blood sugar the nurse said that she had already taken my blood sugar. Resident #84 stated that they have an allergy or intolerance to some opioids that can cause nausea and/or lethargy and I was lethargic. During an interview on 12/02/2025 at 9:35 AM, a family member of Resident #84 stated they requested Resident #84 be seen in the emergency room [ED] because Resident #84 was given an (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opioid that they might have an allergy to,, causing lethargy and/or nausea. Resident #84's family member stated the Administrator was unable to tell them how or why this medication error occurred During an interview with the Director of Nursing [DON] on 12/02/2025 at 11:01 AM, DON confirmed nurses could pull medications from the medication cart and take them to the resident or roll the medication cart on the hall to resident rooms during medication pass, but it was the nurses preference. The DON revealed on the evening of 10/27/2025, LPN #1 was passing medications and pulled the wrong narcotic medication card in front of Resident #84 and administered another resident's [Opioid] medication to Resident #84. The on-call physician, administration, and the family were notified, and a family member wanted Resident #84 to go to the ED. The DON revealed body audits were done on cognitively impaired residents, and cognitively intact residents were interviewed. There were no negative findings. LPN #1 and nursing staff were in-serviced on medication administration. During an interview on 12/03/2025 at 10:33 AM, the Administrator stated he was told LPN #1 was training with LPN #2 and that LPN #1 administered two [Opioids] instead of two [synthetic Opioids] to Resident #84. LPN #1 realized the mistake and contacted the on-call physician and the family of Resident #84. Resident #84 did not have any ill effects, and a family member asked for the resident to be sent to the ED, no negative findings were found. The Administrator revealed Resident #84 had allergies to aspirin, [a specific] opioid, iodine, shellfish and sulfa. The Administrator stated he had no knowledge as to how LPN #1 pulled the wrong medication, and that following the six rights of medication, specifically right person, right medication could have prevented a medication error. During an interview on 12/03/2025 at 11:02 AM, the Administrator clarified that LPN #2 was not training, but LPN #1 asked LPN #2 for help when the medication error was discovered. During a phone interview on 12/03/2025 at 2:29 PM, LPN #2 stated that on the evening of 10/27/2025, LPN #2 was taking over LPN #1's medication cart and discovered the cart was short two [opioids] during a narcotic count. LPN #1 was concerned that the [opioids] were given to Resident #84 in error and immediately assessed Resident #84 with no concerns found. LPN #1 called the on-call physician and administration, and LPN #2 called a family member of Resident #84. LPN #2 revealed the family member was super worried and wanted Resident #84 to be seen in the ED. LPN #2 stated Resident #84 denied symptoms at that time and said opioids give her nausea. LPN #2 stated part of the process to identify Resident #84 was to ask the resident to identify self, and to look at the resident and electronic record. LPN #2 revealed LPN's report to the DON and the on-call nurse manager when something occurs on shift. During a phone interview on 12/03/2025 at 2:58 PM, LPN #1 stated they were passing medications when a CNA came up to ask questions., LPN #1 thought they had Resident #84's medication card in hand but must have picked up the medication card that was behind Resident #84's narcotic card. I popped out the two pills and gave them to Resident #84. Later LPN #1 and LPN #2 realized the narcotic count was off and LPN #1 realized that Resident #84 was given the wrong medication. LPN #1 stated, I went to Resident #84's bedside and told her what happened, and resident freaked out a little bit. Resident #84 was told they were given an [opioid] but not the specific [opioid] Resident #84 was allergic too. Resident #84 stated the [opioid] resident was allergic to makes the resident feel tired. LPN #2 called the family member and may not have explained to the family that Resident #84 did not get the opioid she had a known allergy to. Resident #84 told LPN #1 that they did not want to go to the hospital but went due to family wishes. Resident #84 returned to the facility without findings. LPN #1 confirmed receiving competency training on medication administration on hire and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in-serviced after the medication error incident occurred. Review of a facility policy titled Resident Identification System, revised December 2017, revealed a photo identification system has been adopted to ensure medications and treatments are administered to the right resident. Review of a facility policy titled Administering Medications, revised April 2019, revealed medications are to be administered in a safe, timely manner as prescribed. Staffing is arranged in a manner to prevent medication errors by preventing unnecessary interruptions. The staff member administering medications identifies the correct resident by identification band, checking photo in the medical record, or having another staff member verify the identity of the resident. Nursing staff are expected to check the medication label three times for the right resident, right medication, right route, right time and right dose of medication, and allergies should be checked before giving any medication. Review of a policy titled Adverse Consequences and Medication Errors, revised February 2023, revealed an adverse consequence is an unwanted, uncomfortable, or dangerous side effect received from a medication that may cause a mental or physical decline. A medication error occurs when a drug or biologic is given to a resident without a physician's order. A significant medication error can result in disability, cognitive impairment or even death. Residents should be monitored for adverse condition after a medication error and take the action necessary to promote the safety of the resident when there is a significant medication error or adverse consequence. The physician should be contacted as soon as possible, and residents monitored over 24-72 hours. Following this incident and prior to the survey team entering the facility, the following corrective actions were performed, resulting in a citation at past non-compliance: 10/28/2025 - Nursing staff in-serviced including lecture, discussion, handouts on the six rights of medication administration. Interviews with staff, including staff involved in incident, confirmed understanding of materials covered. No further issues documented or observed during survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, and interview, it was determined the facility failed to ensure staff followed appropriate infection control practices when providing wound care for one (Resident #2) of three residents reviewed for skin issues.The findings include: A review of Resident #2's December Order Summary Report revealed diagnoses that included type 2 diabetes mellitus with diabetic neuropathy and non-pressure chronic ulcer of other part of left foot limited to skin breakdown. A review of a quarterly Minimum Data Set with an Assessment Reference Date of 09/15/2025, revealed Resident #2 had a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. A review of Physician Orders dated 12/02/2025 for Resident #2 indicated, cleanse diabetic ulcer to left Achilles area with [a brand of hypochlorous acid-based wound cleanser used to clean and irrigate various wounds], pat dry, spray with skin prep, apply [a brand of medical-grade wound dressings using Active Leptospermum Honey]to wound bed, cover with cut to fit foam, apply ABD (abdominal) pad, wrap with [a brand of woven gauze bandage] and secure with tape every day shift on every Monday, Wednesday, Friday for wound care. A review of a Care Plan with a revision date of 06/16/2025 indicated that Resident #2 had potential for pressure ulcer development related to impaired mobility and history of wounds and ulcers. The interventions included following facility policies and protocols for the prevention and treatment of skin breakdown. During an observation on 12/03/2025 at 10:53 AM, the Treatment Nurse (TN) donned gloves before cleaning the wound to Resident #2's left heel. The TN removed a soiled bandage from Resident #2's left heel. She then cleaned Resident #2's left heel with wound cleanser. The TN patted the wound dry with 4x4, then sprayed the wound with skin prep. The TN did not change her gloves or perform hand hygiene after cleaning the wound. This surveyor observed the resident had an open area to the left heel. The TN applied Medi-honey with white foam, applied ABD pad, wrapped with kerlix, and secured with tape. The TN indicated that the ulcer was a diabetic ulcer. During an interview on 12/03/2025 at 2:20 PM, the TN indicated that she should have changed gloves after the wound was clean when providing wound care. She indicated that she did not change gloves when she provided wound care because she was disoriented. She indicated that she was allergic to bleach, and she had used bleach wipes to clean the table that she had not used prior to this. During an interview on 12/03/2025 at 3:05 PM, the Director of Nursing indicated that gloves should be changed after cleaning a wound, and before touching a clean dressing. She indicated that gloves should also be changed if anything was touched, and before picking up clean supplies. A review of the CDC guidelines for infection control titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, indicated that standard precautions and hand hygiene should be used to care for all residents. The guidelines indicated that the use of an alcohol-based hand rub or washing hands with soap and water should be used before moving from work on a soiled body site to a clean body site on the same patient, and after contact with blood, body fluids or contaminated surfaces.A review of a policy titled, Handwashing/Hand Hygiene, indicated that hand hygiene should be performed before moving from work on a soiled body site to a clean body site on the same resident.