STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045134	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Jonesboro	1705 Latourette Drive Jonesboro, AR 72404

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and facility policy review, it was determined that the facility failed to ensure alleged or suspected sexual abuse was reported to the State Agency within two hours for one (Resident #1) of one resident reviewed. The findings include: Resident #1 A review of Resident #1's admission Record indicated the facility re-admitted the resident on 05/26/2021, with diagnoses which included Parkinson's disease with dyskinesia (involuntary uncontrolled muscle movements), dementia, generalized anxiety disorder, and major depressive disorder. A review of Resident #1's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/2025, revealed a Staff Assessment for Mental Status (SAMS) score of 03, which indicated the resident was severely impaired for their daily decision making and never/rarely made decisions. A review of Resident #1's Care Plan, revised 02/21/2025, revealed the resident appeared to have impaired cognitive function related to dementia, traumatic brain injury, and cognitive communication deficit. Interventions included to cue, reorient, and supervise as needed, anticipate and meet needs, and observe for physical or nonverbal indicators of discomfort or distress and follow-up as needed (revised 04/19/2021). Resident #2 A review of Resident #2's admission Record indicated the facility readmitted the resident on 09/18/2025, with diagnoses which included dementia anxiety disorder, irritability and anger, and unspecified psychosis not due to a substance or known physiological condition (clinical diagnosis for psychotic symptoms [like hallucinations or delusions] that do not fit a specific disorder, with no clear link to drugs or underlying medical issues). A review of Resident #2's annual MDS with an ARD of 10/30/2025, revealed a Brief Interview for Mental Status (BIMS) score of 01, which indicated the resident had severe cognitive impairment. A review of Resident #2's Care Plan, revised 01/05/2026 following the incident with Resident #1, to indicate the resident had a history of being physically and sexually aggressive towards females related to anger, dementia, history of harm to others, and poor impulse control. Interventions included when the resident becomes agitated: Attempt to intervene before agitation escalates; Guide away (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. A review of an OLTC (Office of Long-Term Care) Incident and Accident Report (I&A) revealed the date and time of the I&A was 01/01/2026 at 12:05 PM. The discovery date and time for the I&A was 01/01/2026 at 12:05 PM. The submission date and time was 01/01/2026 at 3:52 PM. The I&A Report contained a description of the incident, [CNA #1] entered [Resident #2's] room and observed [Resident #1] standing in [the room]. Both residents were fully clothed at the time. [CNA #2] walked [Resident #1] to [Resident #1's] room, [perineal care] was performed, and blood was noted in resident's brief. CNA notified charge nurse. Charge nurse and nurse manager assessed resident. Redness noted to vaginal area .At this time charge nurse and nurse manager assessed [Resident #2] and scant amount of dried blood was noted to first and second digits of left hand. During an interview at 01/12/2026 at 1:05 PM, Certified Nurse's Assistant (CNA) #1 revealed Resident #1 was found in Resident #2's room between the times of 10:30 AM and 10:40 AM on 01/01/2026. CNA #1 explained that CNA #2 reported seeing blood in Resident #1's brief at approximately 11:00 AM, at which time CNA #1 went to get Licensed Practical Nurse (LPN) #5. During an interview on 01/12/2026 at 1:16 PM, CNA #2 revealed on 01/01/2026 at 11:00 AM, she took Resident #1 to their room to change them and noticed blood in the resident's brief. CNA #2 reported that the blood looked fresh, and went to get LPN #5. During an interview at 01/12/2026 at 3:14 PM, LPN #5 reported around 11:00 AM on 01/01/2026, she was walking down the hall, and CNA #2 informed them during Resident #1's perineal care, the CNA saw a small amount of blood in the resident's brief. LPN #5 stated, I saw a small amount of blood in the brief. She reported she proceeded to contact the Director of Admissions and Marketing, who was the charge nurse at the time, at around 11:30 AM on 01/01/2026. During an interview on 01/13/2026 at 10:39 AM, the Director of admission and Marketing revealed that on 01/01/2026 at 11:30 AM, LPN #5 notified them of their finding of blood in Resident #1's brief. The Director of admission and Marketing explained that she went to assess Resident #1, and then afterwards at around 12:00 PM on 01/01/2026, reported the situation to the Director of Nursing (DON) and the Administrator. During an interview on 01/13/2026 at 10:10 AM, the DON revealed that on 01/01/2026 at approximately 12:00 PM, the incident was reported to administration. She explained that she was at home, and the Administrator called around noon and informed the DON that there had been an incident between Resident #1 and Resident #2. She explained that she arrived at the facility on 01/01/2026 around 1:00 PM. She then explained that the Director of Admissions and Marketing and LPN #5 assessed Resident #1. The DON stated that CNA #2 was the one who reported the incident to LPN #5. During an interview on 01/13/2026 at 11:45 AM, the Administrator revealed that she was notified of the incident on 01/01/2026 around 12:00 PM. She explained that she notified the DON and was headed toward the facility. She explained that the facility started staff interviews and then began talking to the Director of Admissions and Marketing and LPN #5. She confirmed that the Director of Admissions and Marketing and LPN #5 did the body audit for Resident #1. The Administrator revealed that she and the DON reviewed the investigation. She explained the DON and the Director and admission and Marketing did body audits on all the women on the secured neighborhood. She explained that a sister (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility was contacted and accepted transfer of Resident #2 to that facility. She then explained the facility did a one-to-one observation for Resident #2 until they were transported to the sister facility. The Administrator stated, I done my report and notified both family, police, doctor, in-services on abuse and neglect, staff interviews, and body audits. The Administrator explained that she had two hours to notify the OLTC regarding allegations or suspicions of abuse. She confirmed that it was sent to OLTC close to four hours following the discovery around 1550 [3:50 PM] and that she was notified at 12:00 PM. She explained that it was a delicate situation, and she wanted to make sure she asked all the questions she needed to and had all the facts needed to report on it. A review of a facility policy titled, Abuse Investigation Protocol, revised 11/28/2017, indicated The facility will ensure that all allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown origin and misappropriation or suspicion of a crime against a resident are reported immediately; the administrator or designee will make an initial report to the local police department as applicable and to the state licensing agency not more than 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury.