STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045195	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Broadway	800 West Broadway West Memphis, AR 72301

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews, record review, and facility policy review, it was determined that the facility failed to perform ADLs to maintain good nutrition, grooming, and personal care for one (Resident #2) of one resident reviewed. The findings include: Based on interviews, record review, and facility policy review, it was determined that the facility failed to perform ADLs to maintain good nutrition, grooming, and personal care for one (Resident #2) of one resident reviewed. The findings include:A review of the admission Record indicated the facility admitted Resident #2 on 02/16/2026 with diagnoses that included type-2 diabetes, malnutrition, depression, and unsteadiness on feet.A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2026, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS revealed, Resident #2 needed substantial/maximal assistance with toileting hygiene, lower body dressing, putting on/taking off footwear, chair/bed transfer, toilet transfer, and tub/shower transfer. The MDS also revealed Resident #2 needed partial/moderate assistance with sit-to-lying, lying to sitting on side of bed, sit-to-stand, and to roll left and right, and that Resident #2was occasionally incontinent of bowel and bladder.A review of Resident #2's Care plan, initiated on 02/17/2026, revealed that Resident #2 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included that Resident #2 required extensive assistance with bathing and dressing, required one person assist with transfers, set up assistance with meals/eating, and limited assistance with bed mobility.A review of an Activity of Daily Living Task Documentation Survey Report, revealed for the months of February 2026, Resident #2 had 5 times that tasks for Bed mobility, dressing and toileting ADLs were not documented and 3 times for snack. In March 2026 Resident #2 had 5 times for transferring not documented; 13 days for bowel and bladder elimination not documented; and 6 days of snacks not documented. In April 2026 Resident #2 had 22 times that bowel and bladder elimination, 9 times for transferring and 11 times for snacks that were not documented. During an interview on 06/30/2026 at 12:33 PM, the Lead Certified Nursing Assistant (CNA) #1 stated, At the end of the day, I look to see what has not been charted by the CNAs. The Lead CNA #1 stated, In-services have been done on charting, and the CNAs sign the in-service indicating understanding that disciplinary action will be taken if charting is not done by the CNA. During an interview on 07/01/2026 at 11:09 AM, the Assistant Director of Nursing (ADON) revealed, when documenting care for a resident, You are acknowledging what you have done. The ADON also stated that if documentation was not completed, the consequence could be a resident could be neglected, or the facility staff could miss care that the resident required. The ADON stated, If it is not documented, the care was not done.During an interview on 07/01/2026 at 11:24 AM, the Director of Nursing (DON) stated, The importance of documentation is that it shows the care you gave and what happened. The DON stated, If documentation is not done the care was not done, and the resident or family can say the facility neglected the resident. The DON indicated if documentation was not completed the facility could not prove the care was actually completed for the resident and the resident's needs were not neglected. A review of facility Staff In-Service Sheet with a written title of Charting for Nursing Staff, dated 03/11/2026 and completed by the ADON, revealed instructions to chart the following assigned tasks: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals, bowel movements, grooming, skin changes, and resident concerns must be documented properly and in a timely manner. The in-service also revealed that accurate documentation is essential for resident care, communication and facility compliance.A review of a facility Staff In-Service Sheet with a written title of Accurate Charting dated 04/12/2026 and completed by the ADON, revealed that continued incorrect charting may result in disciplinary actions. A review of Staff In-Service Sheet with a written title of Charting dated 05/07/2026 and completed by the ADON revealed, All charting is completed accurately, honestly and before end of shift. Chart all assigned tasks correctly including showers, bowel movements, meals, grooming, skin changes and any refusals or concerns. Documentation must reflect the care that Based on interviews, record review, and facility policy review, it was determined that the facility failed to perform ADLs to maintain good nutrition, grooming, and personal care for one (Resident #2) of one resident reviewed. The findings include:A review of the admission Record indicated the facility admitted Resident #2 on 02/16/2026 with diagnoses that included type-2 diabetes, malnutrition, depression, and unsteadiness on feet.A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2026, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS revealed, Resident #2 needed substantial/maximal assistance with toileting hygiene, lower body dressing, putting on/taking off footwear, chair/bed transfer, toilet transfer, and tub/shower transfer. The MDS also revealed Resident #2 needed partial/moderate assistance with sit-to-lying, lying to sitting on side of bed, sit-to-stand, and to roll left and right, and that Resident #2was occasionally incontinent of bowel and bladder.A review of Resident #2's Care plan, initiated on 02/17/2026, revealed that Resident #2 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included that Resident #2 required extensive assistance with bathing and dressing, required one person assist Based on interviews, record review, and facility policy review, it was determined that the facility failed to perform ADLs to maintain good nutrition, grooming, and personal care for one (Resident #2) of one resident reviewed. The findings include:A review of the admission Record indicated the facility admitted Resident #2 on 02/16/2026 with diagnoses that included type-2 diabetes, malnutrition, depression, and unsteadiness on feet.A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2026, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS revealed, Resident #2 needed substantial/maximal assistance with toileting hygiene, lower body dressing, putting on/taking off footwear, chair/bed transfer, toilet transfer, and tub/shower transfer. The MDS also revealed Resident #2 needed partial/moderate assistance with sit-to-lying, lying to sitting on side of bed, sit-to-stand, and to roll left and right, and that Resident #2was occasionally incontinent of bowel and bladder.A review of Resident #2's Care plan, initiated on 02/17/2026, revealed that Resident #2 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included that Resident #2 required extensive assistance with bathing and dressing, required one person assist with transfers, set up assistance with meals/eating, and limited assistance with bed mobility.A review of an Activity of Daily Living Task Documentation Survey Report, revealed for the months of February 2026, Resident #2 had 5 times that tasks for Bed mobility, dressing and toileting ADLs were not documented and 3 times for snack. In March 2026 Resident #2 had 5 times for transferring not documented; 13 days for bowel and bladder elimination not documented; and 6 days of snacks not documented. In April 2026 Resident #2 had 22 times that bowel and bladder elimination, 9 times for transferring and 11 times for snacks that were not documented. During an interview on 06/30/2026 at 12:33 PM, the Lead Certified Nursing Assistant (CNA) #1 stated, At the end of the day, I look to see what has not been charted by the CNAs. The Lead CNA #1 stated, In-services have been done on charting, and the CNAs sign the in-service indicating understanding that disciplinary action will be taken if charting is not done by the CNA. During an interview on 07/01/2026 at 11:09 AM, the Assistant Director of Nursing (ADON) revealed, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when documenting care for a resident, You are acknowledging what you have done. The ADON also stated that if documentation was not completed, the consequence could be a resident could be neglected, or the facility staff could miss care that the resident required. The ADON stated, If it is not documented, the care was not done.During an interview on 07/01/2026 at 11:24 AM, the Director of Nursing (DON) stated, The importance of documentation is that it shows the care you gave and what happened. The DON stated, If documentation is not done the care was not done, and the resident or family can say the facility neglected the resident. The DON indicated if documentation was not completed the facility could not prove the care was actually completed for the resident and the resident's needs were not neglected. A review of facility Staff In-Service Sheet with a written title of Charting for Nursing Staff, dated 03/11/2026 and completed by the ADON, revealed instructions to chart the following assigned tasks: meals, bowel movements, grooming, skin changes, and resident concerns must be documented properly and in a timely manner. The in-service also revealed that accurate documentation is essential for resident care, communication and facility compliance.A review of a facility Staff In-Service Sheet with a written title of Accurate Charting dated 04/12/2026 and completed by the ADON, revealed that continued incorrect charting may result in disciplinary actions. A review of Staff In-Service Sheet with a written title of Charting dated 05/07/2026 and completed by the ADON revealed, All charting is completed accurately, honestly and before end of shift. Chart all assigned tasks correctly including showers, bowel movements, meals, grooming, skin changes and any refusals or concerns. Documentation must reflect the care that was provided to the residents. Incomplete or incorrect charting can affect resident care and facility compliance. A review of an in-service dated 04/29/2026, revealed [staff were to] assist [resident name] as needed and every two hours with all ADL care. If refusal occurred staff should inform the nurse. A second resident specific in-service dated 04/29/2026 indicated [Resident #2] was to get up every day for all meals except breakfast even on weekends unless refused.A review of a facility policy titled, Activities of Daily Living (ADLs) dated 03/2018 indicated, Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation), elimination (toileting), dining (meals and snacks).with transfers, set up assistance with meals/eating, and limited assistance with bed mobility.A review of an Activity of Daily Living Task Documentation Survey Report, revealed for the months of February 2026, Resident #2 had 5 times that tasks for Bed mobility, dressing and toileting ADLs were not documented and 3 times for snack. In March 2026 Resident #2 had 5 times for transferring not documented; 13 days for bowel and bladder elimination not documented; and 6 days of snacks not documented. In April 2026 Resident #2 had 22 times that bowel and bladder elimination, 9 times for transferring and 11 times for snacks that were not documented. During an interview on 06/30/2026 at 12:33 PM, the Lead Certified Nursing Assistant (CNA) #1 stated, At the end of the day, I look to see what has not been charted by the CNAs. The Lead CNA #1 stated, In-services have been done on charting, and the CNAs sign the in-service indicating understanding that disciplinary action will be taken if charting is not done by the CNA. During an interview on 07/01/2026 at 11:09 AM, the Assistant Director of Nursing (ADON) revealed, when documenting care for a resident, You are acknowledging what you have done. The ADON also stated that if documentation was not completed, the consequence could be a resident could be neglected, or the facility staff could miss care that the resident required. The ADON stated, If it is not documented, the care was not done.During an interview on 07/01/2026 at 11:24 AM, the Director of Nursing (DON) stated, The importance of documentation is that it shows the care you gave and what happened. The DON stated, If documentation is not done the care was not done, and the resident or family can say the facility neglected the resident. The DON indicated if documentation was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not completed the facility could not prove the care was actually completed for the resident and the resident's needs were not neglected. A review of facility Staff In-Service Sheet with a written title of Charting for Nursing Staff, dated 03/11/2026 and completed by the ADON, revealed instructions to chart the following assigned tasks: meals, bowel movements, grooming, skin changes, and resident concerns must be documented properly and in a timely manner. The in-service also revealed that accurate documentation is essential for resident care, communication and facility compliance.A review of a facility Staff In-Service Sheet with a written title of Accurate Charting dated 04/12/2026 and completed by the ADON, revealed that continued incorrect charting may result in disciplinary actions. A review of Staff In-Service Sheet with a written title of Charting dated 05/07/2026 and completed by the ADON revealed, All charting is completed accurately, honestly and before end of shift. Chart all assigned tasks correctly including showers, bowel movements, meals, grooming, skin changes and any refusals or concerns. Documentation must reflect the care that was provided to the residents. Incomplete or incorrect charting can affect resident care and facility compliance. A review of an in-service dated 04/29/2026, revealed [staff were to] assist [resident name] as needed and every two hours with all ADL care. If refusal occurred staff should inform the nurse. A second resident specific in-service dated 04/29/2026 indicated [Resident #2] was to get up every day for all meals except breakfast even on weekends unless refused.A review of a facility policy titled, Activities of Daily Living (ADLs) dated 03/2018 indicated, Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation), elimination (toileting), dining (meals and snacks).was provided to the residents. Incomplete or incorrect charting can affect resident care and facility compliance. A review of an in-service dated 04/29/2026, revealed [staff were to] assist [resident name] as needed and every two hours with all ADL care. If refusal occurred staff should inform the nurse. A second resident specific in-service dated 04/29/2026 indicated [Resident #2] was to get up every day for all meals except breakfast even on weekends unless refused.A review of a facility policy titled, Activities of Daily Living (ADLs) dated 03/2018 indicated, Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation), elimination (toileting), dining (meals and snacks). A review of the admission Record indicated the facility admitted Resident #2 on 02/16/2026 with diagnoses that included type-2 diabetes, malnutrition, depression, and unsteadiness on feet.A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2026, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS revealed, Resident #2 needed substantial/maximal assistance with toileting hygiene, lower body dressing, putting on/taking off footwear, chair/bed transfer, toilet transfer, and tub/shower transfer. The MDS also revealed Resident #2 needed partial/moderate assistance with sit-to-lying, lying to sitting on side of bed, sit-to-stand, and to roll left and right, and that Resident #2was occasionally incontinent of bowel and bladder.A review of Resident #2's Care plan, initiated on 02/17/2026, revealed that Resident #2 had an Activities of Daily Living (ADL) self-care performance deficit. Interventions included that Resident #2 required extensive assistance with bathing and dressing, required one person assist with transfers, set up assistance with meals/eating, and limited assistance with bed mobility.A review of an Activity of Daily Living (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Task Documentation Survey Report, revealed for the months of February 2026, Resident #2 had 5 times that tasks for Bed mobility, dressing and toileting ADLs were not documented and 3 times for snack. In March 2026 Resident #2 had 5 times for transferring not documented; 13 days for bowel and bladder elimination not documented; and 6 days of snacks not documented. In April 2026 Resident #2 had 22 times that bowel and bladder elimination, 9 times for transferring and 11 times for snacks that were not documented. During an interview on 06/30/2026 at 12:33 PM, the Lead Certified Nursing Assistant (CNA) #1 stated, At the end of the day, I look to see what has not been charted by the CNAs. The Lead CNA #1 stated, In-services have been done on charting, and the CNAs sign the in-service indicating understanding that disciplinary action will be taken if charting is not done by the CNA. During an interview on 07/01/2026 at 11:09 AM, the Assistant Director of Nursing (ADON) revealed, when documenting care for a resident, You are acknowledging what you have done. The ADON also stated that if documentation was not completed, the consequence could be a resident could be neglected, or the facility staff could miss care that the resident required. The ADON stated, If it is not documented, the care was not done.During an interview on 07/01/2026 at 11:24 AM, the Director of Nursing (DON) stated, The importance of documentation is that it shows the care you gave and what happened. The DON stated, If documentation is not done the care was not done, and the resident or family can say the facility neglected the resident. The DON indicated if documentation was not completed the facility could not prove the care was actually completed for the resident and the resident's needs were not neglected. A review of facility Staff In-Service Sheet with a written title of Charting for Nursing Staff, dated 03/11/2026 and completed by the ADON, revealed instructions to chart the following assigned tasks: meals, bowel movements, grooming, skin changes, and resident concerns must be documented properly and in a timely manner. The in-service also revealed that accurate documentation is essential for resident care, communication and facility compliance.A review of a facility Staff In-Service Sheet with a written title of Accurate Charting dated 04/12/2026 and completed by the ADON, revealed that continued incorrect charting may result in disciplinary actions. A review of Staff In-Service Sheet with a written title of Charting dated 05/07/2026 and completed by the ADON revealed, All charting is completed accurately, honestly and before end of shift. Chart all assigned tasks correctly including showers, bowel movements, meals, grooming, skin changes and any refusals or concerns. Documentation must reflect the care that was provided to the residents. Incomplete or incorrect charting can affect resident care and facility compliance. A review of an in-service dated 04/29/2026, revealed [staff were to] assist [resident name] as needed and every two hours with all ADL care. If refusal occurred staff should inform the nurse. A second resident specific in-service dated 04/29/2026 indicated [Resident #2] was to get up every day for all meals except breakfast even on weekends unless refused.A review of a facility policy titled, Activities of Daily Living (ADLs) dated 03/2018 indicated, Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation), elimination (toileting), dining (meals and snacks).