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	03/27/2025

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 - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 49689 50682 Based on observation, record review, and interview, the facility failed to ensure that activities of daily living (ADL) were performed, and nail care was completed for 2 (Resident #9 and Resident #49) residents of 8 sampled residents reviewed for ADLs. The findings are: A review of the facility policy Activities of Daily Living, Supporting revised in March 2025, indicated that Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. A review of an Admission Record indicated the facility admitted Resident #9 with diagnoses that included: stroke, type 2 diabetes, unsteadiness on feet, anxiety disorder, and protein-calorie malnutrition. A review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 03/02/2025, indicated that Resident #9 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impact). Section GG marked for upper extremity limited range of motion on one side and was marked as a substantial/maximal assist for personal hygiene. A review of Resident #9 ' s Care Plan initiated on 10/06/2024 indicated the resident was at risk for impaired skin integrity with a goal of skin to remain intact; an activity of daily living performance self-care deficit with a goal of will remain clean and well-groomed daily. An intervention included: resident is totally dependent on one staff member for personal hygiene and for staff to check nail length and trim as necessary; and limited physical mobility with a goal to remain free of complications from immobility including contractures. Interventions that included: resident is non-weight bearing and the resident is completely dependent on staff for locomotion with Geri chair. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	On 03/25/2025 at 3:05 PM, this surveyor observed Resident #9 sitting next to the nurses' station. Resident #9 stated [pronoun] was hurting and pointed to [pronoun] left hand. This surveyor observed the resident ' s left hand was contracted with the second and third digit embedded into Resident #9's palm. The surveyor asked Resident #9 if they had any interventions for their left hand. Resident #9 shook their head to indicate no. On 03/25/2025 at 3:08 PM, during an interview, Licensed Practical Nurse (LPN) #7 stated they were familiar with Resident #9. LPN #7 described the resident ' s left hand as, contracted with skin and food matter present. LPN #7 stated, Resident #9 often eats with their hands. LPN #7 ran a cotton applicator between the fingers and the palm of Resident #9 ' s left hand and stated that there was an odor and it needs to be cleaned. LPN #7 stated, contractures should be cleaned and dried daily to prevent skin breakdowns. LPN #7 described nails as: long, dirty, and digging into the resident's palm. LPN #7 stated that nails should be trimmed and cleaned weekly by the nurse, for a diabetic. On 03/25/2025 at 3:30 PM, during an interview, Certified Nursing Assistant (CNA) # 8 stated they were familiar with Resident #9. CNA #8 described Resident #9' s left hand as contracted while lifting fingers. This surveyor observed white and yellow matter underneath the fingertips of the second and third fingers. CNA #8 grimaced and coughed and stated there was food matter, white matter, and the nails were digging into the palm. CNA #8 turned away from the resident, grimaced, and stated the odor can take your breath away. This surveyor noted the odor as strong and unpleasant. Resident #9 exhibited a painful expression while fingers were lifted and stated, it hurts. CNA #8 stated they did not believe interventions were in place as resident refuses. CNA #8 stated cleaning a contracture should be done daily and was unsure of when Resident #9 ' s was last cleaned. CNA #8 stated the negative outcome of not cleaning a contracture could be potential skin breakdown. CNA #8 described the resident ' s nails as long, dirty, and digging into the palm. CNA #8 stated nails should be cleaned and trimmed during bath days or as needed. CNA #8 stated Resident #9 was a diabetic, and their nails should have been reported to the nurse. On 03/25/2025 at 3:40 PM, during an interview, the Administrator stated nail care should be done as needed or on shower days. The Administrator stated it was for hygiene and to prevent skin breakdown, especially with a contracture. On 03/26/2025 at 9:30 AM, during an interview, LPN #7 notified this surveyor that after yesterday's findings, the staff cleaned Resident #9 ' s contracture and an order for wound care was created. On 03/27/2025 at 8:00 AM, during an interview, the Assistant Director of Nursing (ADON) stated Resident #9 was hospice and it was on the hospice care plan to use a rolled cloth or gauze to left hand; not a splint, related to pain/discomfort. The ADON stated if something was not bothering the resident, it was not addressed since Hospice was for comfort measures. The ADON then stated, it is hard to tell, placing something in their hand might have been painful to them, but they should have tried to prevent the nail from causing skin breakdown in their hand. A review of the Admission Record revealed Resident #49 was admitted with diagnoses that included: obesity, type 2 diabetes, hypertension, and chronic kidney disease. (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 - Some	A review of the annual MDS with an ARD of 3/11/2025, indicated Resident #49 had a Brief Interview for Mental Status (BIMS) of 5 which indicated severe cognitive impairment. A review of Section GG was not marked for limited range of motion upper extremity and marked one for dependent on staff for personal hygiene. Section O was not marked for restorative therapy. A review of the Behavior Symptoms Task for Resident #49 was not marked for refusals of care for the last 14 days. A review of the Nail Care Task for Resident #49 indicated on 2/2/23/25, was marked as not applicable, on 3/2/25 marked no, 3/9/25 and 3/23/25 were marked yes. A review of the Care Plan initiated on 4/15/23, indicated Resident #49 had an activity of daily living (ADL) self-care deficit with a goal to remain clean and well-groomed daily, with an intervention stated resident was a max assist with personal hygiene and skin inspections weekly, report changes to nurse. On 03/24/2025 at 11:53 AM, this surveyor observed Resident #49 had a contracted left hand with no interventions in place. Resident #49 attempted to open left hand and could not open it fully. This surveyor observed food matter and skin flakes present in the contracted part of the resident ' s left hand. This surveyor observed the resident ' s finger nails were long, thick, and had dark matter under them. On 03/24/2025 at 3:00 PM, Surveyor observed Resident #49 had a contracted left hand, with no interventions in place and nail care had not been performed. Surveyor attempted an interview with Resident #49 and observed that they could answer simple questions. When asked about contracture they stated, it hurts. Resident #49 attempted to open left hand and could not open it fully. On 03/25/2025 at 8:30 AM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place and nail care had not been performed. On 03/25/2025 at 3:40 PM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place and nail care had not been performed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2025 at 10:30 AM, during an interview, the Rehab Director (RD) stated they were familiar with Resident #49. The RD stated they last had Resident #49 on the caseload in 2023 and did not remember them having a contracture. The RD described the resident ' s left hand as contracted. The resident ' s fingers were sticking together with skin flakes and food matter in their left hand. This surveyor observed the RD jump back when describing hand. The RD then stated they noted an odor in the contracted hand. This surveyor observed the odor was strong and unpleasant. The RD stated since the resident was able to lift their fingers, it could be splinted still. The RD stated that Resident #49' s nails were long and thick with matter under them, and they needed to be clipped. The RD stated nail care should be performed on bath days or on an as needed basis, to prevent skin breakdown and for hygiene. The RD stated Resident #9 ' s contracture had not been reported to the RD as worsening, and the RD did not know Resident #49 had a contracture. The RD stated Resident #49's left hand had worsened and there were no interventions in place. The RD stated, there is a system breakdown. Contractures are not being reported to me and not being cared for as they should be. The RD stated contractures should be cleaned daily and dried, with interventions in place to prevent worsening. The RD then stated, the negative outcome has occurred with both residents. Resident #9 has a worsened contracture with skin breakdown and Resident #49 has a worsened contracture that was not known about. On 03/26/2025 at 10:40 AM, during a concurrent interview and observation, this surveyor observed Restorative Nurses Assistant (RNA) #9 attempt to clean Resident #49's left hand and put in a hand roll. RNA #9 used wipes, and Resident #49 complained of pain. RNA #9 decided to attempt again later. RNA #9 stated the contracture was closed up and food was on the fingers. It was dry and flaky. RNA #9 reported concern it could contract further and lead to skin breakdown. RNA #9 stated the process was to clean and dry the left hand daily, then add a handroll or splint to prevent irritation or skin breakdown. RNA #9 described Resident #49' s nails as long, thick, and needing trimmed. On 03/26/2025 at 11:15 AM, this surveyor observed RNA #9 and RNA #10 attempt to clean Resident #49 ' s contracted hand by washing it in a basin. RNA #9 and RNA #10 were carefully washing and drying the resident ' s left hand. The RNAs appeared to be working slowly to help Resident #49 with contracted left hand. Resident #49 was complaining of pain and drawing back from staff members. This surveyor observed RNA #10 grimace a bit and state there was a bit of an odor. RNA #10 stated there was food matter and dry skin flakes in the contracture. RNA #10 eased a washcloth into the resident ' s contracted left hand as an intervention.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49689 50682 Based on observation, record review, and interview, the facility failed to ensure that limited range of motion did not worsen for 2 residents (Resident #9 and Resident #49) of 3 sampled residents reviewed for range of motion. The findings include: A review of the facility policy Resident Mobility and Range of Motion revised in July 2024, 1. Residents will not experience an avoidable reduction in the range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. A review of the facility policy Activities of Daily Living, supporting revised in March 2025 indicated, If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. A review of an Admission Record indicated the facility admitted Resident #9 with diagnoses that included: stroke, type 2 diabetes, unsteadiness on feet, anxiety disorder, and protein-calorie malnutrition. A review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 3/2/2025, indicated that Resident #9 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impact). On Section GG marked for upper extremity limited range of motion on one side. A review of Resident #9 ' s Care Plan initiated on 10/06/2024 indicated the resident was at risk for impaired skin integrity with a goal of skin to remain intact; an activity of daily living performance self-care deficit with a goal of will remain clean and well-groomed daily. An intervention included: resident is totally dependent on one staff member for personal hygiene and for staff to check nail length and trim as necessary; and limited physical mobility with a goal to remain free of complications from immobility including contractures. Interventions that included: resident is non-weight bearing and the resident is completely dependent on staff for locomotion with Geri chair. On 03/25/2025 at 3:05 PM, this surveyor observed Resident #9 sitting next to the nurses' station. Resident #9 stated [pronoun] was hurting and pointed to [pronoun] left hand. This surveyor observed the resident ' s left hand was contracted with the second and third digit embedded into Resident #9's palm. The surveyor asked Resident #9 if they had any interventions for their left hand. Resident #9 shook their head to indicate no. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/2025 at 3:08 PM, during an interview, Licensed Practical Nurse (LPN) #7 stated they were familiar with Resident #9. LPN #7 described the left hand as contracted with skin and food matter present. LPN #7 stated Resident #9 often eats with their hands. LPN #7 ran a cotton applicator between the fingers and the palm of Resident #9 ' s left hand and stated that there was an odor and it needs to be cleaned. LPN #7 stated the nails were digging into the resident ' s palm. LPN #7 stated the negative outcome could be the resident having skin break down, infection, or the contracture freezing. On 03/25/2025 at 3:30 PM, during an interview, Certified Nursing Assistant (CNA) # 8 stated they were familiar with Resident #9. CNA #8 described Resident #9 ' s left hand as contracted. This surveyor observed white and yellow matter underneath the fingertips of the second and third finger. CNA #8 grimaced and coughed. CNA #8 stated there was food matter, white matter, and the nails had dug into the palm. CNA #8 turned away from the resident grimaced and stated, the odor can take your breath away. This surveyor noted the odor was strong and unpleasant. Resident #9 exhibited a painful expression while fingers were lifted up and stated, it hurts. CNA #8 stated they did not believe interventions were in place since resident refuses. CNA #8 stated that cleaning a contracture should be done daily. CNA #8 was unsure when the resident ' s hand was last cleaned. CNA #8 stated the negative outcome could be the contracture worsening or causing skin breakdown. On 03/25/2025 at 3:40 PM, during an interview, the Administrator stated a contracture should have interventions in place. The Administrator stated that without interventions in place a contracture could worsen and could cause skin breakdown On 03/26/2025 at 9:30 AM, during an interview, LPN #7 stated, after yesterday ' s findings for Resident #9, the staff cleaned the contracture and an order for wound care was created. On 03/26/2025 at 10:15 AM, during an interview, the Rehab Director (RD) stated they were familiar with Resident #9. The RD stated that Resident #9 was last on the caseload at the end of January. The RD stated Resident #9 was getting their core strength back and was practicing with a rolling walker. The RD stated Resident #9 could hold a rolling walker with the contracted left hand at that time. The RD described the contracture as, yes it has worsened compared to where it was when I last had [Resident #9] on caseload. The RD stated the resident never refused care with therapy or interventions for contracture. The RD stated the negative outcome could be worsening or freezing contracture and/or skin breakdown. The RD stated that Resident #9 did not have interventions in place for contracture after therapy ended. On 03/27/2025 at 8:00 AM, during an interview, the Assistant Director of Nursing (ADON) stated Resident #9 was on hospice and using a rolled cloth or gauze to left hand; not to use a splint related to pain/discomfort was on the hospice care plan. If something isn't bothering the resident, it isn't addressed since hospice is for comfort measures. The ADON then stated, it is hard to tell. Placing something in their hand might have been painful to them, but they should have tried to prevent the nail from causing skin breakdown in their hand. A review of the Admission Record indicated that Resident #49 was admitted with diagnoses that included: obesity, type 2 diabetes, hypertension, and chronic kidney disease. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the annual MDS with an ARD of 3/11/2025, indicated that Resident #49 had a Brief Interview for Mental Status (BIMS) of 5 which indicated severe cognitive impairment. A review of Section GG was not marked for limited range of motion upper extremity and marked one for dependent on staff for personal hygiene. Section O was not marked for restorative therapy. A review of the Behavior Symptoms Task for Resident #49 was not marked for refusals of care for the last 14 days. A review of the Nail Care Task for Resident #49 indicated on 2/2/23/25, was marked as not applicable, on 3/2/25 marked no (not provided), 3/9/25 and 3/23/25 were marked yes. A review of the Care Plan initiated on 4/15/23, indicated that Resident #49 had an activity of daily living self-care deficit with a goal to remain clean and well-groomed daily, with an intervention stated resident was a max assist with personal hygiene and skin inspections weekly, report changes to nurse. On 03/24/2025 at 11:53 AM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place. This surveyor attempted an interview with Resident #49 and observed they could answer simple questions. When asked about contracture they stated it hurts. Resident #49 attempted to open their left hand and could not open it fully. This surveyor observed, while the resident ' s left hand was opened, food matter and skin flakes were in the contracture. On 03/24/2025 at 3:00 PM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place. On 03/25/2025 at 8:30 AM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place. On 03/25/2025 at 3:40 PM, this surveyor observed Resident #49 had a contracted left hand, with no interventions in place. On 03/26/2025 at 10:30 AM, during an interview, the Rehab Director (RD) stated they were familiar with Resident #49. The RD stated they last had Resident #49 on the caseload in 2023 and did not remember the resident having a contracture. The RD described the left hand as contracted. The fingers were sticking together with skin flakes and food matter in the hand. This surveyor observed the RD jump back. When describing the hand, the RD stated they noted an odor in the contracted left hand. This surveyor observed the odor as strong and unpleasant. The RD stated that with how the resident lifted the fingers, it could be splinted still. The RD stated that Resident #9 ' s contracture had not been reported as worsening to them, and they did not know Resident #49 had a contracture. The RD stated that Resident #49's left hand had worsened and there were no interventions in place. The RD stated that there is a system breakdown. Contractures are not being reported to me and not being cared for as they should be. The RD stated contractures should be cleaned daily and dried with interventions in place to prevent worsening. The RD then stated, the negative outcome had occurred with both residents. Resident #9 had a worsened contracture with skin break down and Resident #49 had a worsened contracture that was not known about. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2025 at 10:40 AM, during a concurrent interview and observation, this surveyor observed Restorative Nurses Assistant (RNA) #9 attempt to cleaned Resident #49's hand and put in a hand roll. RNA #9 used wipes. Resident #49 complained of pain and staff decided to attempt at a later time. RNA #9 stated the contracture was closed up, food was on the resident ' s fingers, and it was dry and flaky. RNA #9 stated a negative outcome could be that Resident #49' s left hand could contract further and could lead to skin breakdown. RNA #9 stated the process was to clean and dry the contracture daily, then add a handroll or splint to prevent irritation or skin breakdown. On 03/26/2025 at 11:15 AM, this surveyor observed RNA #9 and RNA #10 attempt to clean Resident #49 ' s contracted left hand by washing it in a basin. RNA #9 and RNA #10 appeared to be carefully washing and drying the resident ' s left hand. RNA #9 and RNA #10 worked slowly to help Resident #49 with the contracted left hand. Resident #49 was complaining of pain and drawing back from staff members. This surveyor observed RNA #10 grimaced a bit, then stated there was a bit of an odor. RNA #10 stated there was food matter and dry skin flakes in the contracture. RNA #10 eased a washcloth into the resident ' s contracted left hand, as an intervention.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49689 Based on observation, facility record review and interview, the facility failed to ensure food was in the proper form for the residents, affecting six residents with orders for pureed diets in the facility. The findings include: A review of the facility policy QRT Food Palatability issued on 9/1/2021 indicated that Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. A review of the Recipe Pureed Chicken Pot Pie indicated Blend until smooth adding liquid/thickener needed to obtain a pudding like consistency. On 03/25/2025 at 10:35 AM, this surveyor observed Dietary [NAME] (DC) #2 add 8 four-ounce scoops of chicken pot pie to the food processor. When the chicken pot pie was placed in the stainless-steel bin after being pureed, this surveyor observed chunks of carrots, chicken, and peas in the puree. DC #2 stated that consistency should be pudding like for pureed diets. On 03/25/2025 at 10:45 AM, this surveyor observed DC #2 add 9 four-ounce scoops of broccoli and cauliflower in the food processor. DC #2 added approximately 1 and 1/2 cups of vegetable broth to the food processor while blending the vegetables. When the vegetable blend was added to the stainless-steel bin, this surveyor observed there were chunks of vegetables and the blend was watery in consistency. On 03/25/2025 at 12:04 PM, during a concurrent interview and observation, Certified Nursing Assistant (CNA) #4 and CNA #5 passed trays in the assisted dining room. This surveyor observed CNA #4 setting up a tray to assist a resident with eating. CNA #4 described the chicken pot pie puree to have chunks of chicken and vegetables. CNA #4 stated it seemed thin in consistency and could be a choking hazard. CNA #4 described the broccoli and cauliflower puree blend as watery with chunks in it. CNA #5 was setting up another resident. While mixing the chicken pot pie puree, CNA #5 stated it was a thin consistency with chunks of chicken and vegetables in it. CNA #5 stated that purees needed to be a certain consistency to prevent choking. CNA #5 stated that the broccoli and cauliflower puree blend was watery with chunks in it. This surveyor observed a large piece of broccoli in the puree. On 03/24/2025 at 12:30 PM, during an interview, DC #2 was cleaning up the line and described the puree for the vegetable blend as watery and thin. DC #2 stated that the chicken pot pie had some vegetable chunks in it. DC #2 then stated that the pureed consistency needed to be pudding-like to prevent choking for the residents. On 03/24/2024 at 12:40 PM, during an interview, the Dietary Manager stated that people could choke if the food was not the right consistency, they would not get the right nutrition, and they could aspirate the food too.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49689 Based on observations, facility record review and interview, the facility failed to ensure that cross contamination did not occur during lunch service for one out of one kitchen. The findings include: A review of the facility policy Quick Resource Tool: Safe Food Handling issued on 9/1/2021, indicated 1. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. On 3/24/2025 at 11:06 AM, the 4-ounce scoop for the cream of corn fell into the pan. DC #1 pulled it out, using ungloved hands and touching the food in the process. DC #1 then took the scoop to the dishwasher. This surveyor observed pieces of cream of corn on tips of fingers on both hands. On 3/24/2025 at 11:15 AM, while observing lunch service, DC #2 touched the inside of the bowl before adding baked beans. On 3/24/2025 at 11:20 AM, while observing lunch service, DC #3 touched the middle of the plate before adding food. On 3/24/2025 at 11:22 AM, while observing lunch service, DC #2 touched the inside of the bowl before adding cream of corn. A bowl of cream corn spilled on top of the serving line. When DC #1 cleaned it up, a bowl of cream corn fell into the baked beans. DC #1 took tongs and removed the black bowl from the baked beans. DC #1 then took a different bowl and scoop and scooped the cream corn out of the baked beans. This surveyor observed the full lunch service. The dietary staff used this same stainless-steel pan of baked beans for the residents in the building. On 3/24/2025 at 11:25 AM, this surveyor observed DC #3 touch the middle of the plate before adding food. On 03/24/2025 at 11:28 AM, this surveyor observed DC #2 prepare guest trays utilizing foam take out containers. When adding baked beans and cream of corn to the guest tray, the top of the foam container touched the cream of corn. This surveyor observed cream of corn on top of the guest tray when it was added to the hall cart. On 3/24/2025 at 11:30 AM, this surveyor observed DC #1, by the fryer, toasting bread, using ungloved hands to add three or four pieces of bread to the toaster at a time. After toasting the bread, DC #1 used one ungloved hand to hold the bread still while cutting it in half. DC #1 then added the bread to the stainless-steel bin, with their ungloved hands. DC #1 continued to make bread using the same process, while serving trays for lunch service. No hand hygiene was performed before this occurred. On 3/24/2025 at 11:32 AM, this surveyor observed DC #3 touch the middle of the plate before adding food. (continued on next page)

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	03/27/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/2025 at 11:59 AM, this surveyor observed DC #2 pouring juice into a container of pork ribs from a pan. During the pour, the bottom of the stainless-steel pan touched the pork ribs inside the container. DC #3 served the ribs afterwards for the last two hall carts. On 3/24/2025 at 12:30 PM, during an interview, DC #2 stated that touching the inside of dishes, and touching the food in general was cross contamination, and that could cause sickness from germs in the food. On 03/24/2025 at 12:40 PM, during an interview, the Dietary Manager stated that any cross contamination could cause people to get sick, anything on your hands could get transferred to the food. On 03/27/2025 at 8:35 AM, during an interview, DC #2 stated you should not touch dishes because hands might be dirty. DC #2 stated that they could spread infection if sick, or hands are dirty.