STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045430	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Brinkley	1214 North Main Brinkley, AR 72021

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, it was determined that the facility failed to prevent resident to resident abuse for two (Resident #1 and Resident #3) of four residents reviewed for abuse. The findings include: Resident #1: A review of Resident #1’s admission Record indicated the facility admitted the resident on 07/25/2024, with diagnoses which included metabolic encephalopathy (brain dysfunction) and Parkinson’s disease, with dyskinesia (involuntary muscle movements). A review of Resident #1’s quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/2025, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #1 required substantial/maximal assistance when using a manual wheelchair. A review of Resident #1’s Care Plan, revised on 05/28/2025, indicated the resident was at risk for wandering. Further review of Resident #1’s Care Plan indicated the resident crawled on their hands and knees in the hallways and rooms at times. Resident #1’s Care Plan included interventions that directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. A review of Resident #1’s Order Summary Report revealed an order, with a start date of 11/14/2024, for staff to monitor the resident for agitation and an increase in elopement, delusions, hallucinations, psychosis, and aggression. Resident #1’s Order Summary Report also revealed the resident had an order for hospice, dated 01/16/2025. Resident #2: A review of Resident #2’s admission Record indicated the facility admitted the resident on 02/28/2025, with diagnoses which included Alzheimer’s disease, adjustment disorder with disturbance of conduct, dementia with agitation, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, and hallucinations. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #2’s quarterly MDS with an ARD of 06/04/2025, revealed a BIMS score of 03, which indicated the resident had severe cognitive impairment. Resident #2’s MDS also revealed the resident was independent for transfers. A review of Resident #2’s Care Plan, revised on 03/14/2025, indicated the resident had delirium or an acute confusional episode relate to Alzheimer’s, dementia, mild neurocognitive disorder with behavioral disturbance. Incident: A review of an “OLTC [Office of Long-Term Care] Incident and Accident Report,” dated 03/16/2025, indicated Resident #1 was attempting to crawl into Resident #2’s room and was kicked in the face by Resident #2. Both residents resided on the men’s behavioral unit. The residents were separated immediately. Resident #2 was placed on 1:1 observation, while Resident #1 was sent to the emergency room. A review of an OLTC Witness Statement, dated 03/16/2025, indicated Certified Nursing Assistant (CNA) #8 heard a commotion in the hall while she was in the nurse’s station. She walked out in the hallway and saw Resident #2 trying to push their door closed and kicking Resident #1, who was crawling on the floor. CNA #8 indicated Resident #1 was attempting to crawl into Resident #2’s room, so she immediately separated them and called the nurse. A review of an OLTC Witness Statement, dated 03/16/2025, indicated Licensed Practical Nurse (LPN) #9 observed Resident #2 trying to push their door closed while kicking Resident #1, who was on the floor crawling. She indicated that when she arrived, Resident #1 had an injured nose and skin tears. LPN #9 revealed that she provided care, contacted hospice, and sent Resident #1 to the emergency room. A review of Resident #1’s emergency room Records, dated 03/16/2025, revealed the resident was crawling into another patient’s room and was kicked in the head and face multiple times with steel toe boots. Resident #1’s emergency room Records also revealed the resident had contusions of the nose, scalp, head, and part of the neck, with a deviation and laceration to their nose, and bruising to their left hip. During an interview on 07/15/2025 at 10:15 AM, CNA #7 indicated she always worked on the secure unit, and there were usually 13-15 residents that resided there. During a phone interview on 07/15/2025 at 11:10 AM, CNA #8 revealed she was working the secure unit by herself and stated, when she was coming out of a resident room she saw Resident #1 going into Resident #2’s room, and Resident #2 kicked Resident #1. She stated that Resident #2 liked to be by themselves and was placed in a room by themselves as an intervention for their behavior, upon admission. CNA #8 revealed Resident #2 had a bedroom door that opened at the top, and the resident had left the door open. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 07/16/2025 at 12:20 PM, LPN #9 revealed Resident #1 was in the family room on the unit, crawling around on the floor. [Resident #1’s] nose was bleeding when I saw [pronoun]. She revealed there were no interventions put in place to prevent Resident #1 from going into another resident’s room. LPN #9 stated CNA #8 was in another resident’s room when the incident happened. She indicated Resident #1 crawled around the unit a lot. LPN #9 also indicated that at the time of the incident there was only one staff member on the unit. She revealed she felt there was not enough staff to take care of the residents on the locked unit, and revealed the intervention, after the incident, was for Resident #2 to keep their door closed. During an interview on 07/15/2025 at 1:55 PM, the Administrator revealed Resident #2 was admitted to the facility with behaviors. She further revealed that she received a referral from Resident #2’s previous facility that the resident had only one incident and had been on 1:1 observation with no further incidents. The Administrator stated the referral indicated Resident #2 had attacked another resident with no injuries and was put on the unit in a room by themselves. She revealed that a half door was put on Resident #2’s room to keep other residents from going in. The Administrator confirmed that Resident #1 crawled and Resident #2’s door was opened. She verified CNA #8 was not available to always monitor Resident #1, since she was the only staff on the unit, and Resident #1 was seen on the camera trying to push Resident #2’s door open. The Administrator confirmed Resident #1 had been crawling around the unit since they were admitted . Resident #3: A review of Resident #3’s admission Record revealed the facility admitted Resident #3 on 04/22/2025, with diagnoses which included focal traumatic brain injury (TBI), stroke, convulsions, high blood pressure, anger, and altered mental status. A review of Resident #3’s Care Plan revealed the resident had an activities of daily living self-care deficit related to short term memory loss and behavioral issues. Resident #3’s Care Plan also revealed the resident had impaired cognitive function related to TBI and stroke. The Care Plan indicated Resident #3 needed assistance with shaving. The Care Plan did not indicate Resident #3 resided on the secure unit. A review of Resident #3’s admission MDS with an ARD revealed a BIMS score of 11, which indicated moderate cognitive impairment. A review of Resident #3’s Order Summary Report did not reveal an order indicating the resident required residence on the secure unit. Resident #7: A review of Resident #7’s admission Record revealed the facility admitted the resident on 11/02/2024, with diagnoses which included schizophrenia, major depressive disorder, and generalized anxiety disorder. A review of Resident #7’s quarterly MDS with an ARD of 04/30/2025, revealed a BIMS of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #7’s Care Plan revealed the resident was admitted to the secure unit due to schizophrenia, anxiety, and being an elopement risk. Incident: A review of an Office of Long Term Care (OLTC) Incident and Accident Report (I&A) with a discovery date of 06/27/2025 at 10:45 AM revealed a “Summary of Incident” that included, “Administrator notified by Ombudsman that [Resident #3] reported to [family member] that “[Resident #7] hit [Resident #3] in the head.” Resident had been transported on 06/27/2025 to ED (emergency department) for abrasion to top of the head that had been addressed previously…” In Section 762-Findings and Actions Taken, the facility documented, “After thorough investigation, the facility could not conclude whether a resident-to-resident event had occurred. However, based on the assessment of the resident and hospital paperwork…[Resident #3] did not have any identified injuries…Conclusion: On 06/27/2025, after being sent out to the ED for assessment of the abrasion, resident returned to the facility with no new orders or injuries noted. While the facility cannot rule out a potential unwitnessed resident altercation, there is no evidence of resident abuse or resultant injury.” During an interview on 07/15/2025 at 8:35 AM, the Administrator stated the incident with the razor cut on Resident #3’s head initially happened on 06/22/2025. The facility did not enter the incident on the Incident & Accident (I&A) log because they did not think anything had happened between the two residents and no allegations were made at that point. During an interview on 07/15/2025 at 1:57 PM, the Administrator stated on 06/22/2025, CNA #2 heard a “commotion” and went to identify the source. CNA #2 found Resident #3 with blood on their head. The Administrator stated later, Resident #7 was seen ambulating down the hall with a razor in hand. The Administrator stated CNA #1 had just gotten back from lunch and Resident #7 gave CNA #1 the razor. The Administrator stated, We thought Resident #7 attempted to help Resident #3 shave Resident #3’s head. The Administrator stated, I thought the razor was one of the facility razors and thought a staff member might have left the razor in the room or in someone’s room. The Administrator stated on the morning of 06/23/2025, I discovered the Incident Report had not been completed. The Administrator stated they had not completed an I & A report for this incident because the nurse was responsible for completing the report, but when it was discovered the report had not been completed, then the Director of Nursing (DON) should have completed it. During a follow-up interview on 07/15/2025 at 4:27 PM, the Administrator stated, I had come out to the facility early on 06/23/2025, when the first incident happened and had a soft file on the incident. A review of the Administrator’s Soft File report, revealed CNA #2 provided a written statement that indicated CNA #2 heard a commotion and went into the residents’ room. Resident #3 was standing by their bed with blood on their head, while Resident #7 was standing by their own bed. A photo of Resident #3’s head was included, with a visible cut. A Skin Check, dated 06/23/2025, identified a six-centimeter laceration to Resident #3 scalp. During an interview on 07/14/2025 at 12:28 PM, Resident #3 told this surveyor that Resident #7 hit them with a piece of iron and cut their head. This surveyor observed a scabbed over linear laceration on the top of Resident #3’s head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/14/2025 at 1:23 PM, the Director of Nursing (DON) stated the incident on 06/22/2025 was unwitnessed. The DON stated once the staff heard “the commotion,” CNA #2 went to check on the issue and saw a cut on Resident #3’s head. The DON stated that CNA #2 also saw Resident #7 had a razor, so staff took it and put it up. The DON stated there were little spots of blood on the floor beside Resident #3’s bed. The DON revealed Resident #3’s injury was treated with steri-strips, and there was no bruising or complaints following the incident. The DON stated they did not find any metal objects in the resident’s room, We did find razors, but could not say the other resident did it or if Resident #3 did it themself. The DON revealed Resident #3 was sent to the hospital on [DATE]. A review of ED Nurse Documentation dated 06/27/2025 at 8:15 AM, revealed Resident #3 stated they were struck over the head with a piece of iron by Resident #7, due to Resident #7 believing Resident #3 had taken their belongings. The document described the mechanism of injury as a blow from an iron pipe. A review of a form titled, CT (computed topography) Head Without IV Contrast, dated 06/27/2025 at 8:55 AM, revealed an impression that indicated, “Acute linear fracture visualized through the anterior and posterior wall of the left front sinus extending into the superior left ethmoid sinuses, superior segment of the medial left orbital wall, and superiorly into the lower anterior left frontal bone.” This indicated there was a fresh, straight-line break in the front left sinus bone. The crack extended into nearby areas, including part of the bone between the eyes, the inside edge of the left eye socket, and the lower front part of the left forehead bone. During a phone interview on 07/15/2025 at 10:33 AM, Resident #3’s family member stated on 06/27/2025, the facility notified them the resident was being sent to the hospital because they had a cut on their head due to being shaved. Resident #3’s family member stated they were told it happened when the resident, or the resident’s roommate [Resident #7], tried to shave Resident #3’s head, and cut the resident’s head. The family member stated the DON told them they believed the resident had been digging into the cut on their head, making it bleed. Resident #3’s family member stated Resident #3 told them that Resident #7 had hit Resident #3 in the head with a pipe, because the Resident #7 thought Resident #3 stole their things. During a follow-up phone interview on 07/15/2025 at 12:31 PM, Resident #3’s family member said Resident #3 did not have an electric razor, and initially they were told the residents cut was caused by a regular razor. During Resident #3’s Care Plan meeting on 06/30/2025, they were told Resident #3’s cut was caused by an electric razor. The family member said the facility was “assuming everything,” and could not explain definitively what had occurred. During an interview on 07/15/2025 at 11:17 AM, CNA #2 stated they worked the secure unit the night Resident #3 sustained the cut to the top of the head, which CNA #2 confirmed was not the same day Resident #3 was sent to the hospital. CNA #2 said, I heard a commotion and went to check what it was and found [Resident #3 and Resident #7] standing by their own beds, and [Resident #3] had blood on them. CNA #2 stated the incident was around 9:00 -10:00 PM, and revealed the nurse came and evaluated Resident #3 and later found a razor, which looked like the ones the facility provided. CNA #2 stated they did not know how Resident #3 got the razor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 07/15/2025 at 3:54 PM, LPN #5 said CNA #2 came and told them Resident #3 was bleeding and that Resident #7 had hit Resident #3. LPN #5 said both Resident #7 and Resident #3 reported that Resident #7 had struck Resident #3, but no one witnessed it. LPN #5 said they completed a paper I & A report per instructions provided by the DON. LPN #5 said no one else saw the report and did not remember passing on this information in report, but the I&A report was left at the nurse’s station. LPN #5 said, I wanted to send the resident out just because [pronoun] was hit on the head, but the Administrator told me not to send resident out. LPN #5 revealed they were asked to backdate the I & A report in the computer. During an interview on 07/15/2025 at 4:50 PM, LPN #4 said LPN #5 did not leave a paper I & A report on 06/23/2025. LPN #4 revealed they did not remember if neurological checks were done. LPN #4 and this surveyor looked in the computer system and no neurological checks were found for Resident #3 on 06/22/2023. During a phone interview on 07/16/2025 at 4:06 PM, the Medical Director (MD) stated the facility informed them that Resident #3 had sustained an abrasion to the top of the head while trying to shave. The MD could not remember the date they were notified of the incident, but said it was before July 1st. The MD stated they had seen the laceration and had determined the wound did not have any soft tissue injury or bruising like you would expect if the resident had been hit with an iron bar. The MD said it appeared to be from a razor cut, with a linear opening like a razor. The MD stated, If the resident had been hit with an iron bar, the wound would be popped open from pressure like popping open a lemon or orange. A review of a policy titled, “Abuse, Neglect, Exploitation and Misappropriation Prevention Program, ” revised April 2025, indicated residents have the right to be free from abuse, this includes abuse from other residents. A review of a policy tiled, “Resident Rights,” revised February 2021, indicated federal and state laws guaranteed certain basic rights to all residents of this facility. These rights included the resident’s right to: be free from abuse and neglect. An in-service training regarding abuse and dealing with behaviors on the unit was completed on 03/16/2025. Following the March 16, 2025 incident involving Residents #1 and #2, the following was completed on or before 03/26/2025: Residents were immediately separated Resident #2 was placed on 1:1 observation A half-door was installed on Resident #2's room to prevent entry by other residents These interventions remained in place and effective as confirmed by the Administrator during the survey Staff educated on abuse Immediate incident investigating and reporting protocols were followed (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1 expired on hospice prior to the survey Following the June 22, 2025 incident involving Residents #3 and #7, the following was completed on or before 06/27/2025: Immediate safety interventions were implemented Increased safety rounds were instituted Sharp objects were removed from resident areas Staff educated on abuse Immediate incident investigating and reporting protocols were followed The survey team was able to verify the facility had performed the aforementioned corrections via interview and record review.