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	02/23/2026

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 0656

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record review, observation, interview, and video review, the facility failed to ensure effective care planned interventions were created and implemented following new on-set of wandering and/or elopement associated behaviors, in which Resident #1 attempted on multiple occasions to exit the facility and voiced intent to exit the facility in the future. At the time of the survey, there were 8 residents in the secured unit at risk of eloping.

It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.10(c)(3) (Comprehensive Care Plans) at a scope and severity of J.

The IJ began 01/13/2026 at 6:03 AM, when Resident #1 voiced intent to leave the facility by exiting out of the window. There were no interventions put in place to address exit seeking behaviors.

The Administrator and Director of Nursing were notified of the IJ on 02/20/2026 at 2:30 PM. A removal plan was requested. The removal plan was accepted by the State Agency on 02/22/2026 at 11:56 AM.

The findings include:

A review of an admission Record revealed Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included traumatic brain injury, cerebral infarction (stroke), and altered mental status.

The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/2026 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated the resident was cognitively intact. The MDS also indicated Resident #1 was independent with ambulation.

A review of a BIMS dated 02/19/2026 revealed Resident #1 scored a 2, which indicated the resident had moderately impaired cognition.

A review of Resident #1's Care Plan, initiated on 08/25/2025, revealed the resident needed to be on the secured unit related to traumatic brain injury and elopement risk. Care Plan interventions included providing therapeutic activity such as reminiscing theme kit activities, touch therapy, and doll therapy as needed. The Care Plan interventions also included for staff to administer and monitor the effectiveness and side effects of medication as ordered. No additional interventions had been added after the date of 08/25/2025 to address new onset behaviors or elopement attempts identified at

(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: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	later dates. Review of the Medication Administration Record (MAR) with a start date of 02/05/2026 revealed a physician order for [a sedative medication] 25 mg, to be given at bedtime related to irritability, anger, and altered mental status. Another physician order for [an antidepressant] with a start date of 11/20/2025 indicated to give 5mg in the morning related to irritability and anger. The MAR also included a physician order with a start date of 04/22/2025 which indicated staff were to monitor antidepressant medication for changes in mental status and insomnia every day and every night. A review of Progress Notes, dated 01/13/2026 at 6:03 AM, revealed Resident #1 was up all night walking the halls. Resident #1 refused to go to bed and was going in and out of other residents' rooms. The resident's sibling was contacted and asked to talk to Resident #1 about voicing that they did not live in the facility. The sibling talked to the resident, but nothing changed. Resident #1 indicated they were going to get out of the window. There were no interventions put in place to provide guidance to facility staff in identifying and/or addressing exit seeking behaviors. A review of a Progress Note dated 01/13/2026 at 3:02 PM, revealed Resident #1 had been seeking elopement since returning from a home visit. Resident #1 admitted to staff the desire to leave and had been looking for ways to get out. Staff had tried to redirect Resident #1 with no success. The Progress Note also indicated when staff went out of a locked door Resident #1 followed the staff out the locked doors. The resident verbalized to staff that the resident was not staying in the facility and showed force when the staff tried to get Resident #1 back on the unit. There were no interventions put in place to address the exit seeking behaviors. A review of a Progress Note dated 01/13/2026 at 6:29 PM, revealed Resident #1 was talking loudly and being aggressive towards staff. The resident stated the desire to get out of the facility. Resident #1's sibling was called, and the resident calmed down shortly after talking with sister. An elopement assessment was completed. There were no interventions put in place to prevent exit seeking or address the aggressive behaviors. A review of a Progress Note dated 02/17/2026 at 4:25 AM, revealed LPN #9 was notified at 4:25 AM that Resident #1's window was busted and the resident was not in the facility. The nurse checked the secure unit and the perimeter for Resident #1. The nurse notified the Administrator at 4:28 AM that Resident #1 had busted the window in the room in which they resided and had eloped from the facility. Police were notified at 4:30 AM. Police found and returned the resident to the facility at 5:05 AM. A full body audit was completed upon return, with no injuries noted to Resident #1. The immediate intervention was identified as searching for the resident and getting the resident back to the facility safely. A review of an elopement assessment dated [DATE] indicated Resident #1 was able to ambulate independently without an assistive device. The resident had evidence of following staff, peers, and/or strangers. Upon return from a home visit the resident had been up wandering the halls and standing beside the locked exit doors. Resident #1 had followed staff out trying to exit the facility. A [City] Police Department Incident Report, dated 02/17/2026 at 4:31 AM, indicated the police department received a call on 02/17/2026 at approximately 4:31AM, related to a missing person. At approximately 4:50 AM, the police were advised that Resident #1 was possibly on the south end of town in an apartment complex. The police received a call from a citizen stating Resident #1 was almost struck by their vehicle as they were going to work. At approximately 5:00 AM, Resident #1 was found and (continued on next page)

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

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	transported back to the facility. Resident #1 informed the police that [the resident] was walking to find family. The police were informed that Resident #1 had gotten out of [the resident's] room by throwing an end table through the window. A review of an OLTC Witness Statement Form, dated 02/17/2026 from Certified Nurse Assistant (CNA) #1 revealed, [Resident # 1] was coming in and out of [the resident's] room the early part of the shift. [Resident #1] asked what time it was, and best of my knowledge I think it was around 9:30 PM to 10:00 PM. [Resident #1] went back to [the resident's room] room and was not seen again until [the resident] arrived back to the facility. During an interview on 02/18/2026 at 11:13 AM, the Director of Nursing (DON) indicated CNA #1 reported that she fell asleep during her shift and did not hear the window break when Resident #1 left the facility. During a telephone interview with CNA #1 on 02/18/2026 at 1:52 PM, CNA #1 revealed Resident #1 had been trying to start a fight with another resident for two days, prior to the elopement CNA #1 indicated Resident #1 asked what time it was at approximately 9:30 PM. Resident #1 went back to [the resident's] room, and the CNA did not go back to check on [the resident]. CNA #1 stated the resident usually went back and forth out of [the resident's] room through the night, and staff does not normally go back to [the resident's] room to check on [Resident #1]. CNA #1 indicated Licensed Practical Nurse (LPN) #6 was coming back from break and noticed one of the windows were broken. The staff then went to each room, and realized Resident #1 was not in bed. CNA #1 indicated that Resident #1 was missing between 3:30 AM and 4:00 AM. CNA #1 indicated staff went out the door screaming for the resident, everything got out of control, and she could not recall what happened after that. CNA #1 indicated the police escorted the resident back to the facility, and she was not informed where the resident was found, nor had she asked where [the resident] went when leaving the facility because she did not want to upset them. CNA #1 indicated she usually does not get a break and sometimes cannot go to the bathroom because there is no one to relieve her. CNA #1 stated she was sitting in the third room doorway, located approximately three doors down from Resident #1's bedroom on the other side of the hall, and did not hear the window break when Resident #1 eloped CNA #1 indicated she dozed off for about 30 minutes that night and was not sure of the time, but that she had not dozed off at the time of the resident's elopement. CNA #1 indicated that following the last time Resident #1 went out with family, the resident began trying to leave the unit. CNA #1 stated for the last three weeks there had been only one aide on the unit. They have been pulling the second aide scheduled for the unit to another unit. CNA #1 indicated her schedule was 7:00 PM-6:00 AM. During an interview on 02/18/2026 at 3:00 PM, the Administrator indicated that she watched the camera footage from the night of the elopement, which revealed CNA #1 had the hall lights off and a chair in the doorway so the camera could not see her. During a phone interview on 02/18/2026 at 3:25 PM, CNA #2 indicated that Resident #1 went home on 14-day leave. The CNA indicated during that time Resident #1 had a seizure and was confused when returned to the facility. CNA #2 indicated that Resident #1 gets up as if they are going to work every morning. CNA #2 indicated that Resident #1 goes door to door and asks how to get out. CNA #2 indicated on the night of the elopement LPN #6 had been coming back into the building when LPN #6 noticed the window had been busted out. Within an hour of the staff reporting the resident missing ,the police returned the resident to the facility, around 4:30 AM-5:00 AM. During an interview on 02/18/2026 at 4:35 PM, Resident #1 indicated they were going to do some work for the unit when they left the unit yesterday morning. The resident was not able to indicate how they got off the unit. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 02/19/2026 at 6:55 AM, CNA #3 indicated she had been employed at the facility since November of 2025 and worked on the unit from 7:00 PM-7:00 AM. CNA #3 indicated Resident #1 watched the staff to see if they are paying attention to [the resident]. CNA #3 indicated Resident #1 would walk up and down the halls. CNA #3 also indicated that the resident talked about leaving the facility, but she had never observed them trying to elope. During an interview on 02/19/2026 at 7:08 AM, CNA #4 indicated she had been employed at the facility since August 2025 and worked all halls. CNA #4 indicated that Resident #1 walked from door to door all the time, and the resident never talked about leaving the facility to [CNA #4]. The CNA indicated the resident thinking [the resident] is in prison. During a telephone interview with a [Local Police Department] Police Officer on 02/19/2026 at 8:52 AM, the officer indicated [apartment complex] was added to the police report because that was where Resident #1 almost got hit by a car. The police officer stated they (the police department) received a call from a citizen stating they almost hit Resident #1 with their car at approximately 4:50 AM. The officer indicated that Resident #1 was found by the school on 02/17/2026. The officer indicated the school was located at an address which Google maps showed to be 1.9 miles, or 42 minutes walking distance from the facility. During observations on 02/19/2026 at 12:05 PM this surveyor drove from the facility to the location where the resident was found by law enforcement. Resident #1 would have had to cross an intersection and travel areas of the road that did not have sidewalks available to arrive at that location. A review of the facility's camera footage on 02/19/2026 at 3:15 PM revealed Resident #1 was repeatedly going back and forth from the room in which they resided to the day room, to the bathroom. The resident went into their residential room at 3:12 AM and did not come back out. The camera footage was reviewed from 8:00 PM on 02/16/2026 until 5:00 AM on 02/17/2026. During an interview on 02/20/2026 at 8:33 AM, the DON indicated that Resident #1 was admitted to the secure unit because of a history of wandering. The DON indicated that she was not aware that Resident #1 had prior elopement attempts before 02/27/2026. The DON indicated that Resident #1 was not safe leaving the facility (alone, without staff). She indicated the resident was confused, and trying to reach their home in [a town approximately 55 miles from the facility]. The DON indicated to ensure Resident #1 does not elope again the resident was moved to the opposite side of the hallway on the same unit. To further prevent elopement, shatter proof mesh had been ordered for the windows but had not been installed. The resident was currently on 1:1 (supervision). The DON indicated the resident will remain 1:1 through the weekend. The DON reiterated that Resident #1 was not safe walking where they were found. During an interview on 02/20/2026 at 8:50 AM, the Administrator indicated that Resident #1 was admitted to secure unit because of behaviors, wandering, anger issues, and the resident thinking [the resident] was still in prison. The Administrator indicated she was not aware of any previous elopement attempts besides the resident walking back and forth. The Administrator reported a BIMS was completed on the resident recently, and the resident had received a score of 2, which indicated the resident had severe cognitive impairment. The Administrator indicated she had not reached out to the police officer and was not aware of where the resident was found during the elopement. The Administrator indicated that the resident was found between 4:55 AM and 5:00 AM. The Administrator indicated she was not aware the resident had voiced a plan to escape through the window. (continued on next page)

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

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 02/20/2026 at 10:42, the MDS Coordinator indicated that the nurses or the CNAs inform her of changes with residents, but she was responsible for updating the care plans. The MDS Coordinator indicated no one told her about the behaviors Resident #1 had on 01/13/2026. She indicated that a care plan was in place for Resident #1 prior to the elopement. During a telephone interview on 02/20/2026 at 11:02 AM, LPN #5 indicated she talked to LPN #10 who wrote the note on 01/13/2026 indicating that Resident #1 was staring at the bathroom window. LPN #5 indicated LPN #10 informed her Resident #1 did not attempt to elope. LPN #5 indicated LPN #10 informed her that she reported the resident staring out the window to the oncoming nurse, but she could not recall if she told the Administrator. During an interview on 02/20/2026 at 3:54 PM, CNA #7 indicated that she had been employed at the facility for two years and regularly worked on the unit. The CNA indicated Resident #1 had begun exit seeking after returning from a visit with family for a few days. The CNA indicated the resident came back from a family visit, a different person. During a telephone interview with Resident #1's family member on 02/20/26 at 4:28 PM, the family member indicated Resident #1 did not receive nighttime medications for two nights during the leave of absence with family. The family member indicated the missed doses were not back-to-back, and they did not remember the names of the medications. During an interview on 02/20/26 at 5:25 PM, CNA #8 indicated Resident #1 started having behaviors when [the resident] came back from a family visit. The CNA indicated Resident #1 walked back and forth to the doors, but they had not witnessed the resident trying to get out (of the facility). CNA #8 indicated that any behaviors or elopement concerns should be charted. The CNA indicated she had not been informed to do anything different since the resident had been on 1:1. The CNA indicated that she worked with Resident #1 on Wednesday, Thursday, and Friday of this week (February 18-20, 2026). During a telephone interview on 02/23/26 at 5:42 AM, LPN #6 indicated that she was outside on break when she noticed the window (to Resident #1's room) was broken. The LPN indicated she went on the unit and asked CNA #1 to go to Resident #1's room with her. LPN #6 indicated she informed LPN #9 about the window and started searching the building then. LPN #6 indicated she charts behaviors, calls the doctor, then calls the DON when a resident is having behaviors. LPN #6 indicated that she was not aware of any behaviors that Resident #1 had since she did not work with [this resident]. During a phone interview on 02/23/26 at 5:55 PM, LPN #9 indicated one of the nurses went outside to smoke around 4:25 AM and noticed the window was broken. LPN #9 indicated Resident #1 was not on the unit, or in the parking lot. LPN #9 indicated he called the Administrator and the police and informed them that there had been an elopement. LPN #9 indicated the family was called after the Administrator arrived at the facility. LPN #9 indicated the Administrator, and the DON went out looking for Resident #1. LPN #9 indicated the police called and returned Resident #1 to the facility around 5:05 AM. LPN #9 indicated the DON is notified of changes that need to be made to the care plan by the nurses. A review of a policy titled, Wandering and Elopements, revealed if a resident is identified as at risk for wandering, elopement, or other safety issues the resident's care plan will include strategies and interventions to maintain the resident's safety. A policy titled Missing Resident, revealed it is the policy of the facility that staff who have (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	residents under their care are responsible for knowing the location of those residents. A review of an in-service report dated 02/17/2026 revealed rounding should be completed every two hours for all residents. At no time should staff be asleep during their shift. This is grounds for termination. A review of a policy titled, Recognizing Signs and Symptoms of Abuse/Neglect, revealed neglect is defined as, failure to provide goods and services as necessary to avoid physical harm. A review of a form titled, Personnel Action Form, revealed CNA #1 was terminated effective 02/17/2026. The termination reason was sleeping while on duty. Onsite Verification: The IJ was removed on 02/23/2026 at 12:31 PM. On 02/23/2026 at 8:45 AM per Plan of Removal (POR) dated 02/22/2026- Step #1 is corrective action- The facility revised Resident #1's care plan to include individualized elopement prevention interventions. Per record review the care plan was updated to include all interventions per POR. Per POR- Step #2 is identification of others with the potential to be affected. On 02/17/26 the facility completed new elopement risks assessments for residents residing on the secured unit. For any resident scoring moderate or high risk: A. On 02/20/2026, care plans were reviewed to ensure individualized elopement interventions were present. B. Environment exit safety checks completed 02/17/2026. Per record review of all residents on secured unit all care plans have been revised/updated as per POR. Per POR -Step #3: Systemic changes to ensure deficient practice does not recur: A. staff education- Beginning 02/17/2026, nursing and direct care staff received in- service education on elopement policy and missing resident procedures. B. On 02/20/2026 nursing and direct care staff were in-serviced on the following: 1. definition and examples of elopement and exit seeking behaviors. 2. early warning signs requiring interventions. 3. Requirements to notify nurse/administrator/DON of new or increased behaviors. C. On 02/20/2026 nurse management responsible for updating care plans were in-serviced on: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. Mandatory care plan revision following behavior changes with individualized interventions. D. On 02/19/2026, shatter-resistant film was ordered for front-facing secured unit windows and will be installed by facility maintenance director when received. Invoice from [online vendor] given to show that shatter-resistant film was ordered and per-tracking order the shatter-resistant film is due to arrive on 02/24/2026. Per POR Step #4: Monitoring: A. DON/Designee will review the 24-hour report three times weekly for four weeks to identify new or increasing exit-seeking behaviors. B. DON/Designee will complete weekly audits of five residents for four weeks to identify: 1. Elopement risk assessments completed. 2. Individualized interventions are present. 3. Documentation reflects staff implementation. After 4 weeks, audits will decrease to monthly for two months, then transition to routine QAPI monitoring. Per interim DON all unit resident's records were reviewed on Friday and will review the 5 resident charts on every Friday. The DON completed 24-hour monitoring over the weekend and will monitor 3 times a week. Calendar was reviewed to show when she monitored the 24-hour report with no negative findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure increased supervision was provided by staff during periods of increased exit seeking behaviors for one (Resident #1) of four sampled residents reviewed for elopement. The lack of effective supervision resulted in Resident #1 eloping from the facility, and the facility staff being unaware of the residents' whereabouts. At the time of the survey, there were eight residents residing on the locked unit. The findings are: A review of an admission Record revealed Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses of traumatic brain injury, cerebral infarction, and altered mental status. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/2026 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact. The MDS also included that Resident #1 was independent with ambulation. A review of a BIMS dated 02/19/2026 revealed Resident #1 scored a 2 which indicated the resident had moderately impaired cognition A review of Resident #1's Care Plan, initiated on 08/25/2025, revealed the resident needed to be on the secured unit related to traumatic brain injury and elopement risk. Care Plan interventions included providing therapeutic activity such as reminiscing theme kit activities, touch therapy, and doll therapy as needed. The Care Plan interventions also included for staff to administer and monitor the effectiveness and side effects of medication as ordered. Review of the Medication Administration Record(MAR) with a start date of 02/05/2026 revealed a physician order for [a sedative medication] 25 mg, to be given at bedtime related to irritability and anger, altered mental status. Another physician order for [an antidepressant] with a start date of 11/20/2025 indicated to give 5mg in the morning related to irritability and anger. The MAR also included a physician order with a start date of 04/22/2025 which indicated staff were to monitor antidepressant medication for changes in mental status and insomnia every day and every night. A review of Progress Notes, dated 01/13/2026 at 6:03 AM, revealed Resident #1 was up all night walking the halls. Resident #1 refused to go to bed and was going in and out of other residents' rooms. The resident's sibling was contacted and asked to talk to Resident #1 about voicing that they did not live in the facility. The sibling talked to the resident, but nothing changed. Resident #1 indicated they were going to get out of the window. A review of a Progress Note dated 01/13/2026 at 3:02 PM, revealed Resident #1 had been seeking elopement since returning from a home visit. Resident #1 reported to staff the desire to leave and that the resident had been looking for ways to get out. Staff had tried to redirect Resident #1 with no success. The Progress Note also indicated when staff went out of a locked door Resident #1 followed the staff out the locked doors Resident #1 verbalized to the staff that [the resident] was not staying in the facility and showed force when the staff was trying to get the resident back on the unit. A review of a Progress Note dated 01/13/2026 at 6:29 PM, revealed Resident #1 was talking loudly and being aggressive towards a staff member. The resident reported wanting to get out of the facility. Resident #1's sibling was called, and the resident calmed down shortly after talking with sibling. An elopement assessment was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Progress Note dated 02/17/2026 at 4:25 AM, revealed LPN #9 was notified at 4:25 AM that Resident #1's window was busted and the resident was not in the facility. The nurse checked the secure unit and the perimeter for the resident. The Nurse then notified the administrator at 4:28 AM that Resident #1 had busted the window in the room in which the resident resided and had escaped. Police were notified at 4:30 AM. Police found resident and returned the resident to the facility at 5:05 AM. A full body audit was completed upon return, with no injuries noted to the resident. The immediate intervention listed was for staff to search for the resident and get the resident back to the facility safely. A review of an elopement assessment dated [DATE] indicated that Resident #1 was able to ambulate independently without an assistive device. The resident had a history of following staff, peers, and/or strangers. Upon return from a home visit the resident had been up wandering the halls and standing beside the locked exit doors. Resident #1 had followed staff out trying to exit the facility. A [City] Police Department Incident Report, dated 02/17/2026 at 4:31 AM, indicated the police department received a call on 02/17/2026 at approximately 4:31 AM, related to a missing person. At approximately 4:50 AM the police were advised that Resident #1 was possibly on the south end of town in an apartment complex. The police received a call from a citizen stating Resident #1 was almost struck by their vehicle as they were going to work. At approximately 5:00 AM Resident #1 was found and transported back to the facility. Resident #1 informed the police that they were walking to find family. The police were informed that Resident #1 had gotten out of their room by throwing an end table through the window. A review of an OLTC Witness Statement Form, dated 02/17/2026 from Certified Nurse Assistant (CNA) #1 revealed, Resident # 1 was coming in and out of [the resident's] room the early part of the shift. Resident #1 asked what time it was, and best of my knowledge I think it was around 9:30 PM to 10:00 PM. Resident #1 went back to [the resident's] room and was not seen again until [the resident] arrived back to the facility. During an interview on 02/18/2026 at 11:13 AM the Director of Nursing (DON) indicated CNA #1 reported that she fell asleep during her shift and did not hear the window break when Resident #1 left the facility. During a telephone interview with CNA #1 on 02/18/2026 at 1:52 PM, the CNA revealed Resident #1 had been trying to start a fight with another resident for two days (prior to the elopement). CNA #1 indicated Resident #1 asked what time it was at approximately 9:30 PM. Resident #1 went back to the resident's room, and the CNA did not go back to check on [the resident]. CNA #1 stated, the resident usually goes back and forth out of [the resident's] room through the night, and the staff does not normally go back to the room to check on the resident. CNA #1 indicated Licensed Practical Nurse (LPN) #6 was coming back from break and noticed one of the windows was broken. The staff went to each room, and then realized Resident #1 was not in bed. CNA #1 indicated that the resident went missing between 3:30 AM and 4:00 AM. The CNA indicated staff went out the door screaming for the resident, everything got out of control, and she could not recall what happened after that. CNA #1 indicated the police escorted the resident back to the facility, and she was not informed where the resident was found. The CNA indicated that she usually does not get a break and sometimes cannot go to the bathroom because there is no one to relieve her. The CNA indicated that she did not hear the window break when Resident #1 eloped. The CNA indicated that she was sitting in the third room doorway, approximately three doors down from Resident #1's room ,on the opposite side of the hall, near the nurse's station. CNA #1 stated that she dozed off for about 30 minutes that night, and was not sure of the time, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but she had not dozed off at the time the resident eloped. CNA #1 indicated the last time Resident #1 went out with family the resident had tried to leave the unit. The CNA indicated for the last three weeks there had been only one aide on the unit. The facility administration had been pulling the second aide scheduled for the unit to another unit. CNA #1 indicated that her schedule was 7:00 PM-6: 00 AM. During an interview on 02/18/25 at 3:00 PM, the Administrator indicated that she watched the camera footage which revealed CNA #1 had the hall lights off and a chair in the doorways so the camera could not see her. During a phone interview on 02/18/2026 at 3:25 PM, CNA #2 indicated Resident #1 went home on 14-day leave. The CNA indicated was confused when returned to the facility. CNA #2 indicated that Resident #1 gets as if going to work every morning. The CNA indicated that Resident #1 goes door to door and asks how to get out. CNA #2 indicated on the night of the elopement LPN #6 was coming back into the building when she noticed the window had been busted out. Within an hour of the staff reporting the resident missing, the police returned the resident to the facility, around 4:30 AM-5:00 AM. The DON indicated that Resident #1 was not safe walking in the area they were found. During an interview on 02/18/2026 at 4:35 PM, Resident #1 indicated they were going to do some work for the unit when they left the unit yesterday morning. The resident was not able to indicate how they got off the unit. During an interview on 02/19/2026 at 6:55 AM, CNA #3 indicated she had been employed at the facility since November of 2025 and worked on the unit from 7:00 PM-7:00 AM. The CNA indicated Resident #1 watched the staff to see if they are paying attention to [the resident]. CNA #3 indicated Resident #1 would walk up and down the halls. CNA #3 also indicated that the resident talked about leaving the facility, but she had never observed them trying to elope. During an interview on 02/19/2026 at 7:08 AM, CNA #4 indicated she had been employed at the facility since August 2025 and she worked all halls. The CNA indicated that Resident #1 walked from door to door all the time, and the resident never talked about leaving the facility [to CNA #4]. The CNA indicated the resident thinks [the resident] is in prison. During a telephone interview with a [Local Police Department] Police Officer on 2/19/2026 at 8:52 AM, the officer indicated [the apartment complex] was added to the police report because that was where Resident #1 almost got hit by a car. The police officer stated they received a call from a citizen stating they almost hit Resident #1 with their car at approximately 4:50 AM. The officer indicated that Resident #1 was found by the school on 02/17/2026. The officer indicated the school was located at an address Google maps showed to be 1.9 miles, or 42 minutes walking distance from the facility. During observations on 02/19/2026 at 12:05 PM this surveyor drove from the facility to the location where the resident was found by law enforcement. Resident #1 would have had to cross an intersection and travel areas of the road that did not have sidewalks available to arrive at that location. A review of the facility's camera footage on 02/19/2026 at 3:15 PM revealed Resident #1 was repeatedly going back and forth from the room in which they resided to the day room, to the bathroom. The resident went into their residential room at 3:12 AM and did not come back out. The camera footage was reviewed from 8:00 PM on 02/16/2026 until 5:00 AM on 2/17/2026. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/2026 at 8:33 AM, the DON indicated that Resident #1 was admitted to the secure unit because of a history of wandering. The DON indicated that she was not aware that Resident #1 had prior elopement attempts before 02/27/2026. The DON indicated that Resident #1 was not safe leaving the facility. She indicated the resident was confused, and trying to reach their home in [a town approximately 55 miles from the facility]. The DON indicated to ensure Resident #1 does not elope again the resident was moved to the opposite side of the hallway on the same unit. To prevent elopement shatter proof mesh was ordered for the windows but had not been installed. The resident was currently on 1:1 (supervision). The DON indicated the resident will remain 1:1 through the weekend. During an interview on 02/20/2026 at 8:50 AM, the Administrator indicated that Resident #1 was admitted to secure unit because of behavior, wandering, anger issues, and the resident thinking[the resident] was still in prison. The Administrator indicated she was not aware of any previous elopement attempts besides the resident walking back and forth. The Administrator reported a BIMS was completed on the resident recently, and that the resident had a score of 2 which indicated the resident had severe cognitive impairment. The Administrator indicated she had not reached out to the police officer and was not aware of where the resident was found during the elopement. The Administrator indicated that the resident was found between 4:55 AM and 5:00 AM. The Administrator indicated she was not aware the resident voiced a plan to escape through the window. During an interview on 02/20/2026 at 10:42 the MDS Coordinator indicated that the nurses or the CNA's informs her of changes with residents, and she was responsible for updating the care plan. The MDS Coordinator indicated no one told her about the incident Resident #1 had on 01/13/2026. She indicated that a care plan was already in place before Resident #1 eloped. During a telephone interview on 02/20/2026 at 11:02 AM, LPN #5 indicated she spoke with the nurse that wrote the note on 01/13/26 and the nurse indicated that Resident #1 was staring at the bathroom window. LPN #5 indicated the nurse told her Resident #1 did not attempt to elope. LPN #5 indicated the nurse said she reported the resident staring out the window to the oncoming nurse, but she could not recall if she told the Administrator. During an interview on 02/20/2026 at 3:54 PM, CNA #7 indicated that she had been employed at the facility for two years and regularly worked on the unit. The CNA indicated Resident #1 had begun exit seeking after returning from a visit with family for a few days. The CNA indicated the resident came back from a family visit, a different person. During a telephone interview with Resident #1's family member on 02/20/26 at 4:28 PM, the family member indicated that Resident #1 did not receive nighttime medications for two nights during the leave of absence with family. The family member indicated the missed doses were not back-to-back, and they did not remember the names of the medications. During an interview on 02/20/26 at 5:25 PM, CNA #8 indicated Resident #1 started having behaviors when [the resident] came back from a family visit. The CNA indicated Resident #1 walked back and forth to the doors, but CNA #8 had not witnessed the resident trying to get out. The CNA indicated that any behaviors or elopement concerns should be charted. CNA #8 indicated she had not been informed to do anything different since the resident had been on 1:1. The CNA indicated that she worked with Resident #1 on Wednesday, Thursday, and Friday of this week (February 18-20, 2026). During a telephone interview on 02/23/26 at 5:42 AM, LPN #6 indicated she was outside on break when (continued on next page)

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