STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045178	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piggott Healthcare & Senior Living, LLC	450 S 9th Ave Piggott, AR 72454

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interviews, facility document review, and facility policy review, it was determined that the facility failed to provide a financial record or quarterly statement to the resident or resident's representative for the resident's funds account. This deficient practice has the potential to affect 14 residents placing their personal funds in the trust of the facility.Based on record review and interviews, it was determined that the facility failed to provide a financial record or quarterly statement to the resident or resident's representative for the resident's funds account. This deficient practice has the potential to affect 14 residents placing their personal funds in the trust of the facility. The findings include: On 09/04/2025 at 4:36 PM, Business Office Manager (BOM) provided a facility document titled Personal Funds Receipts. She reported they do not have quarterly statements available for the residents with personal funds kept by the facility. The Personal Funds Receipts document contained information regarding the resident's personal funds listed, which did not include receipts. The document listed the residents' name, cash withdrawal, and amount of transaction. During an interview, the BOM stated, We do not send out quarterly statements. She reported she was not aware quarterly statements for resident funds were to be sent to the resident or the resident representative. She reported that the facility does not have a local bank and if a resident requested money, she filled out a slip and verified with the resident or representative that it was correct and then the resident or representative gets the money. She indicated the resident would write a check made out to cash and the facility took the checks to the closest bank and then the cash would go back into the petty cash at the facility. She reported she did not like the way resident funds were set up, but the facility does not have a local bank to use for cashing checks. She reported that the facility would try to find a better way of handling resident funds. A review of admission packet indicated if the facility accepted custody of a resident's personal funds, the resident may take funds from the resident's account and accurate records shall be kept of all disbursements. On 09/09/2025 at 9:10 AM, during an interview, the Assistant Director of Nursing stated, I don't have anything to do with resident funds. On 09/09/2025 at 9:48 AM, during an interview, the Director of Nursing indicated she does not have a role in handling a resident's personal funds. On 09/09/2025, during an interview, the Administrator reported that residents request petty cash from the BOM. She indicated she was not sure how the money was repaid by the residents. When asked if she was aware checks were written out to cash, taken to the local bank and cashed by employees she (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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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported she was recently made aware of the process. She indicated she did not consider that practice to be a proper accounting principle. She reported a resident's funds absolutely should never be mixed with employees' funds. She indicated the facility will find a more appropriate method as soon as possible.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility policy review, it was determined the facility failed to report an alleged violation and investigation of the alleged violation involving supervision to the proper state agency within the allotted time frame for 2 (Resident # 35 and Resident #13) of 2 sampled residents reviewed for accidents/supervision and resident abuse. The deficient practice had the potential to lead to harm for Resident #35 due to repeated elopements into an unsafe environment for the resident. The deficient practice could cause a possible delay of care with the potential of more harm to Resident #13. Based on interview, record review, and facility policy review, it was determined the facility failed to report an alleged violation, and the investigation outcome of the alleged violation, involving supervision and abuse to the proper state agency within the allotted time frame for one (Resident # 35) of two residents reviewed. The findings include: A review of Resident #35's Face Sheet indicated the facility admitted Resident #35 on 11/08/2023 with diagnoses which included anoxic brain damage (a condition that occurs when the brain is deprived of oxygen causing brain damage), anxiety disorder, depression, congestive heart failure (a condition where the heart cannot pump blood effectively), and hypertension (high blood pressure). A review of the quarterly Minimum Data Set with an Assessment Reference Date of 02/10/2025 indicated Resident #35 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The assessment revealed the resident had fluctuated behaviors for disorganized thinking and altered level of consciousness and that the resident was ambulatory. A review of Resident #35's Care Plan Report, revealed the resident had an identified behavioral symptom of exit seeking tendencies with the potential for elopement and identified behavioral symptoms of exit seeking behaviors and experienced unrealistic thoughts dated 03/10/2024. Interventions dated 03/10/2024 included staff should observe resident and inform nurse for signs of restlessness or looking for exits and observe resident for safety and try to redirect resident when exit seeking. A review of Resident #35's Elopement/Wandering Risk Assessment dated 09/03/2024 indicated the resident was at risk for elopement. A review of a Progress Note dated 10/21/2024, indicated a Housekeeping Aide (unidentified) notified staff that Resident #35 was found outside near the laundry and maintenance building and it was unknown how the resident got outside. The Assistant Director of Nursing (ADON), the Director of Nursing (DON), and Administrator were notified. A review of a Progress Note dated 11/15/2025, indicated Resident #35 exited the facility via 300 hall door and was found walking down the road in front of the facility. The Progress Note indicated that the Administrator and ADON were aware of the event, and 15-minute rounding was started. A review of a Facility Event Summary Report indicated Resident #35 had an event of elopement on 11/15/2025. Evaluation of the event indicated resolved without further complications. No event was listed for elopements dated 10/21/2024, 02/24/2025 nor 03/23/2025. On 09/05/2025 at 11:40 AM, during an interview, Administrator reported she did not have a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reportable for October or November 2024 for Resident #35. A review of a Accidents and Incidents-Investigating and Reporting document indicated all incidents involving residents occurring on facility premises shall be investigated and reported to the administrator. The data to be included on the report of incident/accident form in part included the date/time the injured person's family was notified and by whom, any corrective action taken, and follow up information. The supervisor shall complete a report of incident/accident form and submit the original to the DON within 24 hours of the incident or accident. The DON shall ensure the admin receives a copy of the Report of Incident/Accident form for each occurrence. On 09/05/2025 at 4:02 PM, during a phone interview, Corporate Nurse stated she was acting as Administrator at the facility from September 2024 through May 2025. She reported she was DON and Administrator concurrently at the facility. She stated she was aware of Resident #35's elopement on 02/24/2025 and 03/23/2025 and indicated reportables were filled out for those incidents. She reported she was not aware of Resident #35's elopement on 10/21/2024 or 11/15/2024, she also stated she had posted her phone number in the facility, and no one told her about those incidents. On 09/09/2025 at 9:10 AM, during an interview, ADON reported she was aware of Resident #35's elopements on 10/21/2024 and 11/15/2024. She indicated the elopements should have been reported, and verbalized, Were they not? I am sorry. On 09/09/2025 at 9:48 AM, during an interview, the DON reported she was not aware of Resident #35's elopements on 10/21/2025 and 11/15/2025 because she was not employed at the facility at that time. She reported a reportable should have been made due to potential dangers to Resident #35 and other residents. On 09/09/2025 at 10:47 AM, during an interview, Administrator reported an event of an elopement should be reported. She reported she was not at the facility at the time of the elopements. Review of a facility policy titled, PP Abuse Prohibition Policy and Procedures, dated September 2022, indicated Abuse of any kind is strictly prohibited. Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual or because of the number of injuries either at a single point in time or over time. Examples of injuries that could indicate physical abuse include but are not limited to injuries that are non-accidental or unexplained, and fractures, sprain, and dislocations. immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury Review of a facility policy titled, PP Wandering and Elopements, dated March 2019, indicated When a resident returns to the facility, the director of nursing services or the charge nurse shall: complete and file an incident report.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure that the resident's transfer/discharge was documented in the resident's medical record, failed to provide the resident and resident representative a notice of transfer/discharge in writing, and failed to send a written copy of notice of transfer/discharge to a representative of the office of the State Long-Term Care Ombudsman for 1 Resident (R #35) of 3 residents reviewed for discharge rights. Based on record review, interviews and facility policy review, it was determined the facility failed to ensure that the resident's transfer or discharge was documented in the resident's medical record, to send a written copy of notice of transfer or discharge to the Ombudsman for one (Resident #35) of three residents reviewed. The findings include: A review of Resident #35's Face Sheet indicated the facility admitted Resident #35 on 11/08/2024 with diagnoses which included anoxic brain damage (a condition that occurs when the brain is deprived of oxygen causing brain damage), anxiety disorder, depression, congestive heart failure (a condition where the heart cannot pump blood effectively), and hypertension (high blood pressure). The face sheet indicated the resident was not responsible for self. The Census Summary within the face sheet indicated the resident was discharged from the facility on 03/23/2025 at 11:56 AM. The following areas of the Census Summary were not completed: discharged to, primary discharge diagnosis, discharge reason and condition on discharge. A review of Resident #35's Care Plan Report, indicated the resident had an identified behavioral symptom of exit seeking tendencies with the potential for elopement dated 03/10/2024. Intervention dated 03/10/2024 included staff should observe the resident and inform the nurse of signs of restlessness or looking for exits. Intervention dated 02/24/2025 included staff would monitor and assess residents' emotional well-being. Intervention dated 02/28/2025 included supervisory staff will be notified if Resident #35 verbalizes their desire to go. A review of a Progress Note dated 03/23/2025, indicated Resident #35 had an incident at the facility which concluded with Resident #35 being transported in police custody to the local emergency room for evaluation and assessment. A review of a Police Department Incident Report dated 03/23/2025 indicated Resident #35 was in police custody and transported by police to the emergency room for a medical evaluation. The report indicated Resident #35 was medically cleared at the emergency room and the resident was transported by police to a different hospital and placed on the lockdown unit. A review of a Hospital Record dated 03/23/2025 indicated Resident #35 arrived at the hospital emergency room via law enforcement on 03/23/2025 at 12:29 PM, with a chief complaint of the need for a psychiatric evaluation. The assessment revealed anoxic brain injury with aggressive behavior and the plan indicated that the resident would be transferred to a different hospital for behavioral health. The record stated, facility called and states that Corporate Nurse will not accept patient back into facility until they have a psych eval, facility was requesting (behavioral hospital) be contacted. A medical doctor accepted the resident as a patient at [behavioral hospital] on 03/23/2025 at 3:07 PM. Resident #35 was transferred via law enforcement to [behavioral hospital]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #35's Transition of Care/Discharge Summary indicated no data. A review of Resident #35's Electronic Health Record (EHR) revealed no discharge summary. A review of Resident #35's Physician Orders, revealed no discharge order for Resident #35. During a phone interview on 09/04/2025 at 8:19 AM, the Regional Ombudsman indicated they were not receiving notification of transfers or discharges from the facility at that time. They indicated they were aware of the transfer of Resident #35 due to being informed by a complainant. They added they were not aware if the resident returned to the facility after the transfer. During a phone interview on 09/05/2025 at 8:31 AM, the psychiatric hospital Social Clinic Director indicated Resident #35 was admitted to the facility on [DATE] after being discharged from the emergency room. The director indicated that the Corporate Nurse of the facility indicated that the facility would not accept Resident #35 back into the facility. The director reported that the resident was not given 30-day notice from the facility and that Resident #35 was placed with a different long-term care facility. During an interview on 09/09/2025 at 9:48 AM, the Director of Nursing (DON) indicated the facility discharge process should include documentation of the location the resident was discharged , a discharge order from their Medical Doctor (MD), and an inventory of the resident's returned belongings. She indicated the facility does not send any documentation to the resident's MD, but the MD does fax an order for discharge to the facility. She reported Care Plans and medications could be printed, and the facility should have called the resident's representative to inform them they could pick those documents up at the facility. She indicated she did not believe the ombudsman would receive notice from the facility of a resident's discharge. DON indicated necessary emergency room transfer information would be documented in the Progress Notes and in the digital form of the discharge summary. She indicated that if the discharge information was not documented in the resident's electronic health chart it would mean someone failed to properly document the discharge. During an interview on 09/09/2025 at 10:47 AM, the Administrator indicated the facility discharge process included receiving a discharge order from the resident's MD. She reported the resident's Progress Notes would contain the resident's current status, any Durable Medical Equipment needs that were addressed, any community needs that had been set up, the disposition of the resident's inventory, the transportation details and a notification would be sent to the Ombudsman about the resident's discharge. She reported there should be documentation of a discharge summary given to the receiving facility and there should be documentation of an MD discharge order. She indicated that if the discharge information was not documented in the residents chart it would mean someone failed to properly document the discharge. A review of a facility policy titled, Admission, Transfer, and Discharge Register, revision date June 2008, indicated, Our facility maintains an admission, transfer and discharge register. The policy indicated the medical records office maintained a current admission, transfer and discharge register which should contain the reason for the transfer or discharge, a discharge summary and the place the resident was transferred or discharged to.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure Care Plans were person-centered for two residents (Resident #4 and #35) of 12 residents reviewed. The Findings include: Resident #4 A review of Resident #4's admission Record indicated, the facility currently admitted Resident #4 on 09/01/2023 and last returned on 07/11/2025, with diagnoses which included recurrent major depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), hypokalemia (low potassium levels), hemiplegia (partial to total paralysis on one side of the body), hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, hypertension (high blood pressure), hyperlipidemia (high cholesterol), dysuria (difficulty urinating), and constipation (infrequent or difficult bowel movements). A review of Resident #4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025, indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. A review of Resident #4's, Care Plan, revised 08/27/2025, indicated the resident had problems regarding hypertension, left sided hemiplegia and taking. The Care Plan did not have medication interventions for antihypertensives, anxiolytics, statins, diuretics, supplemental medications, laxatives, or antipsychotic medications. Resident #4 had insulin care planned on 08/27/2025, a review of active orders indicated Resident #4 was not on any insulin medications. During an interview on 09/09/2025 at 9:10 AM, the Assistant Director of Nursing (ADON) stated that honesty, proper procedure, comfort of the resident, and safety of employees plays a part of expectations for staff with correctly documenting in the care plan. The ADON verified that the care plan drives the care of the resident. During an interview on 09/09/2025 at 9:48 AM, the Director of Nursing (DON) stated that medications should be on the care plan to keep an eye out for serious adverse reactions. During an interview on 09/09/2025 at 12:42 PM, Licensed Practical Nurse (LPN) #1 verified that medications should be on the care plan and that it was important to have medications on the care plan due to it allowing us to look up any signs or symptoms within the care plan. During an interview on 09/09/2025 at 3:26 PM, the DON verified that there was not a staff member who was completely responsible for the care plans. The DON verified that the following classifications of medication and interventions were not on the care plan for Resident #4: antihypertensives, anxiolytics, statins, diuretics, supplements, laxatives, or other antipsychotic medications. During an interview on 09/09/2025 at 10:58 AM, the Administrator indicated that it was expected that the care plan be completed correctly and timely. The Administrator verified that medications as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	well as the signs and symptoms of the medications should be documented in the Care Plan. She verified that it was a huge part of the resident's care. She confirmed that the purpose behind the care plan was, so staff knew how to take care of the residents. She verified that the Care Plan needed to be updated quarterly or with any change of condition. Resident #35 A review of Resident #35's Face Sheet indicated the facility admitted Resident #35 on 11/08/2024 with diagnoses which included anoxic brain damage (a condition that occurs when the brain is deprived of oxygen causing brain damage), anxiety disorder, depression, congestive heart failure (a condition where the heart cannot pump blood effectively), and hypertension (high blood pressure). A review of Resident #35's Care Plan dated 03/10/2025, indicated Resident #35 had a behavioral symptom of potential for elopement and exit seeking tendencies. Resident #35 had attempted elopements or elopements documented on 10/21/2024, 11/15/2024, 02/24/2025 and 03/23/2025. Interventions dated 02/24/2025 included to monitor and assess the residents' emotional well-being. No other updates, no new interventions and no indication of elopements dated 10/21/2024, 11/15/2024 and 03/23/2025 [DD1] were documented in the Care Plan. On 09/09/2025 at 9:10 AM during an interview, the ADON reported a resident's care plan should be updated quarterly, annually, and if a resident has a change in condition. She indicated Resident #35's care plan should have been updated each time he attempted to elope, eloped, or had any wandering behaviors. On 09/09/2025 at 9:48 AM during an interview, the DON reported Resident #35's care plan should have been updated with each elopement attempt. 09/09/2025 at 10:47 AM during an interview, the Administrator reported a resident's care plan should be updated quarterly and with any change of condition. She reported an attempted elopement would be considered a change of condition. She indicated when a new approach did not work, a new approach would be needed. The Administrator stated, I want to say we are actively going through each care plan and have been since I started here in June. During an interview on 09/09/2025 at 3:48 PM, the ADON reviewed and verified Resident #35's care plan for elopement risk and interventions had been updated one time after the 02/24/2025 elopement but had not been updated after the other elopements or elopement attempts. A review of a facility policy titled, Care Plan dated 2001 indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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, record review, and facility document review it was determined that the facility failed to ensure a safe environment as free of accident hazards and each resident receives adequate supervision to prevent accidents for 3 (Resident #35, Resident #8, and Resident #3) of 3 residents reviewed for accidents and supervision. Based on observations, interviews, record review, and facility policy review it was determined that the facility failed to ensure a safe environment was free of accident hazards and each resident received adequate supervision to prevent accidents for one (Resident #35) of three residents reviewed. The findings include: A review of Resident #35's Face Sheet indicated the facility admitted Resident #35 with diagnoses that included brain damage that occurs when the brain is deprived of oxygen, anxiety disorder, depression, congestive heart failure, and high blood pressure. A review of the quarterly MDS, with an ARD of 02/10/2025, revealed Resident #35 had a BIMS score of 8 which indicated the resident had moderate cognitive impairment and had fluctuated behaviors for disorganized thinking and altered level of consciousness. The MDS also revealed Resident #35was ambulatory. A review of Resident #35's Care Plan Report revealed the resident had identified behavioral symptoms of exit seeking tendencies with the potential for elopement, identified behavioral symptoms of exit seeking behaviors and experienced unreal thoughts dated 03/10/2024. A Care Plan intervention dated 03/10/2024, indicated staff should observe resident and inform nurse for signs of restlessness or looking for exits and observe resident for safety and try to redirect resident when exit seeking. Intervention dated 02/24/2025 indicated staff would monitor and assess resident's emotional well-being. Intervention dated 02/28/2025 indicated supervisory staff will be notified if resident verbalizes their desire to go. A review of Resident #35's Elopement/Wandering Risk assessment dated [DATE], indicated the resident was at risk for elopement. A review of Resident #35's Progress Note dated 10/21/2024, indicated a housekeeping aide notified staff that Resident#35 was found outside near the laundry/maintenance building and it was unknown how the resident got outside. The Assistant Director of Nursing (ADON), Director of Nursing (DON), and Administrator were notified. A review of a Progress Note dated 11/15/2025, indicated Resident #35 exited the facility via the 300-hall door and was found walking down the road in front of the facility. The note indicated the Administrator and ADON were aware of the event, and 15-minute rounding was started. A review of the Facility Event Summary Report indicated Resident #35 had an event of elopement on 11/15/2025.An evaluation of the event indicated resolved without further complications. There were no events listed for elopement dated 10/21/2024, 02/24/2025 nor 03/23/2025. A review of an Incident Report dated 02/24/2025, indicated staff observed Resident #35 crawl (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through the smoke [NAME] wall. The staff requested assistance, and other staff went outside to look for resident. The Corporate Nurse drove her car to the area and the resident rode back to the facility without further incident. Resident was placed on 15-minute checks for 24 hours, faded to 30-minute checks next 24 hours. A review of Resident #35's Progress Note dated 03/23/2025 indicated Resident #35 exited through the dining room door to outside of the facility at approximately 11:30 AM. Resident #35 was witnessed by staff exiting the dining room door and followed resident outside. The Progress Note indicated the resident punched and kicked staff during the altercation. The incident at facility concluded with resident being taken from facility in police custody to an emergency room for evaluation and assessment. A review of a Police Department Incident Report dated 03/23/2025, revealed Resident #35 was in police custody and transported by police to the emergency room for a medical evaluation. The report indicated Resident #35 was medically cleared at the emergency room and the resident was transported by police to a different hospital and placed on the lockdown unit. An observation on 09/04/2025 at 2:38 PM, revealed the dining room door was an exit-delay door with a sign posted EXIT-DELAYED EGRESS PUSH UNTIL ARLARM SOUNDS. DOOR CAN BE OPENED IN 15-30 SECONDS. During an interview on 09/08/2025 at 2:24 PM, the Medical Director reported he was aware Resident#35 had found ways out of the facility such as the resident had found outdoor codes or figured another way outside, he added the resident was pretty smart. He reported he was not aware the police were called during the 03/23/2025 attempted elopement. Review of a facility policy titled, Wandering and Elopements, dated March 2019, indicated The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If a resident is missing, initiate the elopement/missing resident emergency procedure, if the resident was not authorized to leave, initiate a search of the building(s) and premises. When the resident returns to the facility, the director of nursing services or charge nurse shall examine the resident for injuries, contact the attending physician and report findings and conditions of the resident, notify the resident's legal representative (sponsor), notify search teams that the resident has been located, complete and file an incident report, and document relevant information in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045178	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piggott Healthcare & Senior Living, LLC	450 S 9th Ave Piggott, AR 72454

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, document review, and interviews the facility failed to ensure staffing information was complete and was not missing information, to ensure staffing information was accurate and current, and to maintain the posted daily nurse staffing data for a minimum of 18 months. The deficient practice had the potential to affect all residents.Based on observations, record review and interviews the facility failed to ensure staffing information was complete and accurate, and failed to maintain the posted daily nurse staffing data for a minimum of 18 months. The findings include: During an observation on 09/03/2025 at 1:49 PM, this surveyor observed a staffing schedule for CNAs and nurses for the month of September 2025 in a glass case on the wall near the main front door entrance and in a glass case on the wall near the common area front door During an observation on 09/03/2025 at 1:52 PM, outside of the Administrators (AD) office, this surveyor observed a staffing schedule for nurses for the month of September 2025. A review of the posted nursing and CNA schedules on 09/03/2025, the schedules for the CNAs and nurses did not contain the facility name, the date, the facility census nor the total number and actual areas worked per shift for licensed and unlicensed staff responsible for resident care. During an interview on 09/04/2025 at 10:42 AM, the AD reported that she was not aware that she needed to keep up with staffing assignments. She stated No, I do not keep up with the regulated staffing assignments. We don't post the staffing, and we do not keep up with where each nurse or CNA is working for each day they are working. During an interview on 09/09/2025 at 9:48 AM, the Director of Nursing indicated she indicated the staffing sheets should contain the staff's name, the hall they are assigned to and if the staff was working the day or night shift. She indicated it is important for the staffing sheets to contain all required components to ensure family members can know who was taking care of their family member.