

# Division of Provider Services and Quality Assurance

Office of Long Term Care PO Box 8059, Slot S404 Little Rock, AR 72203-8059 Fax: 501-682-6159



October 23, 2019

Adrienne Catalina, Administrator Piney Ridge Treatment Center, Inc 2805 E Zion Rd Fayetteville, AR 72703

Dear Ms. Catalina:

On October 11, 2019 a Complaint survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

### **Plan of Correction**

A POC must be submitted within 10 calendar days of you receipt of the Statement of **Deficiencies.** Failure to submit a POC may result in termination. Include a completion date for each deficiency cited.

Sandra Broughton, Reviewer OLTC, Survey & Certification Section PO Box 8059, Slot S404 Little Rock, AR 72201-4608 Telephone (501) **320-6182;** Fax (501) 682-6159 or email to Rodney.Raper@dhs.arkansas.gov

### Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

c. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur;

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

### **Informal Dispute Resolution**

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

Becky Bennett, Section Chief Health Facility Services Arkansas Department of Health 5800 West 10<sup>th</sup> Street. Suite 400 Little Rock, AR 72204 Fax (501) 661-2165

If you have any questions, please call Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,

Sandra Broughton, DHS Program Administrator Office of Long Term Care Survey & Certification Section

sgb

DRA cc:

file

		ID HUMAN SERVICES					FORM	): 10/23/2019 APPROVED
STATEMENT O	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTR			(X3) DATE	0. 0938-0391 SURVEY LETED
		04L117	B. WING	-		C 10/11/2019		
	ROVIDER OR SUPPLIER	•12111			DDRESS, CITY, STATE, ZIP COD	E	10/	11/2019
	NOVIDER OR SOLT EIER			2805 E ZIC		· <b>L</b>		
PINEY RIC	OGE TREATMENT CENT	ER, INC			VILLE, AR 72703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
N 000	Initial Comments		NC	00				
	is an official, legal do remain unchanged ex correction, correction space. Any discrepan citation(s) will be repo Office (RO) for referra Inspector General (O information is inadver provider/supplier, the should be notified imm	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately. ation was conducted from						
	or in part, with deficie N0209.	3618, was substantiated, all incies cited at N0131 and n compliance with §483,						
N 131	Subpart G - Conditio Psychiatric Residentia	ns of Participation for al Treatment Center ESIDENTS	N 1	31				
	Restraint and seclusion simultaneously.	on must not be used						
		ot met as evidenced by: 3618, was substantiated, all dings.						
	Based on record revie	ew and interviews, the						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/23/2019 / APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		LETED
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RI	GE TREATMENT CENTE	R. INC		:	2805 E ZION RD		
					FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 131	facility failed to ensure seclusion were not us assure the safety of 9 #4, #6, #7, #8, #9, an who were chemically seclusion. The finding 1. Resident #1 had di Dysregulation Disorde Disorder, Attention De and Reactive Attachm a. Emergency Safety Progress Note had an Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/10/1 Date & [and] Time Re 9/10/19 Time: 1236 [1 Restraint Order Rece Doctor] Date: 9/10/19 Resident Behavior/ hitting, kicking, punch SeclusionDate and Seclusion Date: 9/10/ Date & Time Remove 9/10/19 Time: 1300 [1 Restraint Order Rece Time: 1225 [12:25 p.r. Secluded related to ac calm as evidenced by kicking staff and bang Chemical Restraint D	e a chemical restraint and eed simultaneously used to of 9 (Resident #1, #2, #3, d #10) case mix residents restrained while in is are: agnoses of Disruptive Mood er, Posttraumatic Stress efficit Hyperactivity Disorder nent Disorder. Intervention Justification of X in the box next to lusion and next to Chemical Time Actually Placed in 19 Time: 1225 [12:25 p.m.] moved from Restraint Date: 2:36 p.m. Date & Time ived form MD [Medical Time: 1225 [12:25 p.m.] Aggression toward staff, ing Time Actually Placed in 19 Time: 1236 [12:36 p.m.] Aggression toward staff, ing Time Actually Placed in 19 Time: 1236 [12:36 p.m.] d from Restraint Date: :00 p.m.] Date & Time ived form MD Date: 9/10/19 n.] Resident Behavior ggression for safety, until or screaming, cussing, ing on quite room windows. ate & Time Restraint Order ate: 9/10/19 Time: 1225	N	131			

Facility ID: 3016

If continuation sheet Page 2 of 19

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
PINEY RII	DGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 131	Time: 1235 [12:35 p.r b. Emergency Safety Progress Note (had a Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/15/7 Date & Time Remove 9/15/19 Time: 1420 [2 Restraint Order Rece Time: 1415 [2:15 p.m BehaviorResident s were redirecting and the fence outside. Re Seclusion Date: 9/15/7 Date & Time Remove 9/15/19 Time: 1425 [2 Restraint Order Rece Time: 1415 [2:15 p.m BehaviorWhile in re his body around in att balance. Resident bit staff. Secluded for sa Chemical Restraint Order Received form 1415 [2:25 p.m.]. Dat Administered Chemic Time: 1420 [2:20 pm. Zyprexa/Benadryl Do mg [Benadryl] Route: While in seclusion res escalate. Resident so	<ul> <li>al Restraint Date: 9/10/19</li> <li>n.]</li> <li>Intervention Justification in X in the box next to clusion and next to Chemical</li> <li>I Time Actually Placed in 19 Time: 1400 [2:00 p.m.]</li> <li>ad from Restraint Date: 2:20 p.m.] Date &amp; Time ived form MD Date: 9/15/19</li> <li>n.] Resident tarted punching staff as they trying to guide resident from strained for safety.</li> <li>I Time Actually Placed in 19 Time: 1420 [2:20 p.m.]</li> <li>ad from Seclusion Date: 2:25 p.m.] Date &amp; Time ived form MD Date: 9/15/19</li> <li>J. Resident straint resident was jerking tempt to throw staff off staff and attempted to kick fety.</li> <li>Date &amp; Time Restraint MD Date: 9/15/19 Time: te &amp; Time Nurse Actually sal Restraint Date: 9/15/19</li> <li>J Medication administered: sage: 10 mg [Zyprexa]/50 IM Resident Behavior sident behavior continued to</li> </ul>	N	13.			

Facility ID: 3016

If continuation sheet Page 3 of 19

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L117	B. WING_				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER		•	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
	OGE TREATMENT CENTE			2	2805 E ZION RD		
					FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 131	Continued From page times, punches wall. ( administered for safe The progress note wa on 9/16/19. 2. Resident #4 had di Depressive Disorder, Disorder, Autism Spe a. Emergency Safety Progress Note had ar Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/6/19 Date & Time Remove 9/10/19 Time: 1245 [7 Restraint Order Rece Time: 1248Reside flipping filing cabinets	e 3 Chemical restraint ty. as signed by the physician agnoses of Major Oppositional Defiant ctrum, and Child Neglect. Intervention Justification to X in the box next to clusion and next to Chemical Time Actually Placed in D Time: 1240 [12:40 p.m.] of from Restraint Date: 12:45 p.m.] Date & Time ived form MD Date: 9/6/19 int Behavior Resident c, rolling in the carpet and acher's phone, kicking staff		131	DEFICIENCY)		
	Seclusion Date: 9/6/1 Date & Time Remove 9/10/19 Time: 1300 [7 Date & Time Restrain Date: 9/10/19 Time: 1 Resident BehaviorV continued to try and the calling her a whore, s Chemical Restraint1 Received form MD Date Date & Time Nurse Action	ad from Restraint Date: 1:00 p.m.] 1:00 p.m.] 1:00 rder Received form MD 1:248. Vhile in restraint resident rip staff and spit on staff Iammed body into staff. Date & Time Restraint Order ate: 9/6/19 Time: 1248.					

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			3	COMF	PLETED
		04L117	B. WING				C / <b>11/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10.	11/2010
	OGE TREATMENT CENTE				2805 E ZION RD		
					FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 131	Route: IM Residen continued to throw ob staff The progress note wa on 9/6/19 at 3:00 p.m 3. Resident #6 had di Trauma and Stressor Intellectual Functionin a. Emergency Safety Progress Note (had a Restraint, next to Sec Restraint, next to Sec Restraint Date: 9/15/7 Date & Time Remove 9/15/19 Time: 1555 [3 Restraint Order Rece Time: 1546 Reside throwing cups on the peer to where resider staff intervene and go SeclusionDate and Seclusion Date: 9/15/7 Date & Time Remove 9/15/19 Time: 1625 [4 Date & Time Seclusio Date: 9/15/19 Time: Resident BehaviorV was shoving his body the restraint.	<ul> <li>ion administered:</li> <li>iosage 100 mg/100 mg</li> <li>t Behavior Resident</li> <li>ijects at staff and threaten</li> <li>as signed by the physician</li> <li>agnoses of Unspecified</li> <li>related Disorder, Borderline</li> <li>ng, and Physical Abuse.</li> <li>Intervention Justification</li> <li>n X in the box next to</li> <li>clusion and next to Chemical</li> <li>1 Time Actually Placed in</li> <li>19 Time: 1546 (3:46 p.m.)</li> <li>id from Restraint Date:</li> <li>3:55 p.m.] Date &amp; Time</li> <li>ived form MD Date: 9/15/10</li> <li>nt Behavior Resident was</li> <li>unit which upset one of his</li> <li>ht tried to fight the peer but</li> <li>to thit by resident.</li> <li>Time Actually Placed in</li> <li>(19 Time: 1555</li> <li>ed from Seclusion Date:</li> <li>4:25 p.m.]</li> <li>on Order Received form MD</li> <li>1546</li> <li>While in restraint resident</li> <li>against staff trying to break</li> </ul>	N	13			
	Date: 9/15/19 Time: Resident BehaviorV was shoving his body the restraint.	1546 Vhile in restraint resident					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RI	DGE TREATMENT CENTE	R, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 131	Order Received form 1546 Date & Time Nur Chemical Restraint D. [3:50 p.m.] Medication Thorazine/Benadryl D IMResident Behavi resident started bangi over and over, refusin behavior" The progress note wa on 9/20/19. b. Emergency Safety Progress Note (had a Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/19/1 Date & Time Remove 9/19/19 Time: 1928 [7 Restraint Order Rece Time: 1925 [7:25 p.m Resident was in dayro peers. They were both then both became ver continued trying to fig separated. Resident v and others as he keep SeclusionDate and Seclusion Date: 9/19/ Date & Time Remove 9/19/19 Time: 1945 [7 Date & Time Restrain Date: 9/19/19 Time: 1945 [7	MD Date: 9/15/19 Time: rse Actually Administered ate: 9/15/19 Time: 1550 n Administered; Dosage 50 mg/50 mg Route: orWhile in time out room ing his head into the wall ng to regain control of his as signed by the physician Intervention Justification n X in the box next to clusion and next to Chemical 1 Time Actually Placed in 19 Time: 1920 [7:20 p.m.] d from Restraint Date: 7:28 p.m.] Date & Time ived form MD Date: 9/15/10 n.] Resident Behavior bom, horseplaying with h antagonizing each other ry aggressive. Resident ht peer and they had to be was restrained for his safety p kicking peer. Time Actually Placed in 19 Time: 1928 d from Seclusion Date: 7:45 p.m.] t Order Received form MD 1925 While resident was being	N	131			

Facility ID: 3016

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/23/2019 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY PLETED
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING	·		C
		04L117	B. WING				_ 11/2019
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY RI	DGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
N 131	Continued From page	≥ 6	Í N	131	1		
		ging his head in the wall		-			
		Date & Time Restraint Order ate:  9/19/19 Time: 1925					
	Date & Time Nurse A						
	[7:27 p.m.] Medication	n Administered" sage: 10mg/50 mg Route:					
	IM Resident Behav	viorWhile resident was still					
		continued kicking, hitting head into the wall. An order					
		om MD (Medical Doctor) on					
		Intervention Justification In X in the box next to					
		clusion and next to Chemical					
		l Time Actually Placed in 19 Time: 2351 [11:51 p.m.]					
	Date & Time Remove	ed from Restraint Date:					
		12:05 a.m.] Date & Time ived form MD Date: 2/21/19					
	Time: 2356 [11:56 p.	m.] Resident					
		n room screaming, climbing ly finding items to harm self					
	with. Resident becam	e aggressive and began to					
	allack any stan that th	ried to process or intervene.					
	SeclusionDate and Seclusion Date: 9/22/	I Time Actually Placed in					
	Date & Time Remove	ed from Seclusion Date:					
	9/22/19 Time: 0023 [1	12:23 a.m.] on Order Received form MD					
	Date: 9/21/19 Time: 2	2356.					
		Resident beating own head, e clothing around own neck,					

Facility ID: 3016

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/23/2019 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RI	DGE TREATMENT CENTE	ER, INC					
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	_ r	FAYETTEVILLE, AR 72703 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
N 131	Continued From page	97	N	131			
	took all object resider allowed to calm in sec	nt could harm self with and clusion.					
	Restraint Order Rece	Date & Time Chemical ived form MD Date: 9/21/19					
	Time: 2356 Date &T Administered Chemic Time: 0001 [12:01 a.	al Restraint Date: 9/22/19					
		ine/Benadryl Dosage:					
	• •	e: IMResident Behavior and kick staff spitting and					
	scratching at staff wh	en they blocked his blows,					
	kicking in restraint rep head on walls and flo	peatedly. Bashing his own ors"					
	This progress note wa on 9/22/19 at 10:00 a	as signed by the physician .m.					
	4. Resident #7 had di Trauma and Stressor	agnoses of Unspecified Related Disorder,					
	Non-parental Child Se	exual Abuse.					
		tervention Justification					
	Progress Note (had a Restraint, next to Sec Restraint.	n X in the box next to clusion and next to Chemical					
	Restraint Date: 9/18/	e and Time Actually Placed in 19 Time: 0820 [8:20 a.m.] ed from Restraint Date:					
		3:23 a.m.] Date & Time					
	Restraint Order Rece	ived form MD Date: 9/18/19					
	Resident pounding fis	.] Resident Behavior #1. st and kicking windows and on. Refused verbal redirect."					
		and Time Actually Placed in					
		19 Time: 0900 [9:00 a.m.] d from Restraint Date:					

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		04L117	B. WING				C / <b>11/2019</b>
NAME OF P	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
PINEY RI	DGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 131	9/18/19 Time: 0907 [S Restraint Order Rece Time: 0903 [9:03 a.m Resident attacked per hitting and kicking. Seclusion Date: 9/18/ Removed from Seclus 0937 [9:37 a.m.] Date & Time Seclusio Date: 9/18/19 Time: 0 Resident BehaviorF and pull against staff. safety following chem Chemical RestraintI Received form MD Da [9:05 a.m.] Date & Tim Administered Chemica Time: 0903 Medicatio Zyprexa/Benadryl Do Route: IM Resident E to calm Attacked staff re-escalated. Refused This progress note wa on 9/18/19 at 10:00 a 5. Resident #8 had di Stress Disorder, Chro Impulse Control, Com Deficit Hyperactivity E a. Emergency Safety Progress Note (had a	<ul> <li>9:07 a.m.] Date &amp; Time ived form MD Date: 9/18/19</li> <li>.] Resident Behavior#2. ers and staff, punching,</li> <li>Time Actually Placed in (19 Time: 0907 Date &amp; Time sion Date: 9/18/19 Time:</li> <li>on Order Received form MD 0903 Resident continued to push Resident was secluded for nical restraint.</li> <li>Date &amp; Time Restraint Order ate: 9/18/19 Time: 0905 he Nurse Actually sal Restraint Date: 9/18/19 on Administered: sage: 10 [mg]/50 [mg] Behavior Resident unable and peers when he d direction"</li> <li>as signed by the physician .m.</li> <li>agnoses of Posttraumatic onic. Unspecified Disruptive, duct Disorder and Attention Disorder.</li> <li>Intervention Justification</li> </ul>	N	131			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		04L117	B. WING _				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RI	OGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 131	"RestraintDate and Restraint Date: 9/28/ Date & Time Remove 9/28/19 Time: 1746 [5 Restraint Order Rece Time: 1745 [5:45 p.m Resident was on the to one of his peers on the this peer as staff tried resident to stop. He w continue on chasing p peer, he slapped staff Restrained for safety. SeclusionDate and Seclusion Date: 9/28/ Removed from Seclusio Date: 9/28/19 Time: 1 Resident BehaviorV started to cuss and ki in CPI [Crisis Prevent then started to slam h stop. Secluded for saf Chemical RestraintI Restraint Order Rece Time: 1745 Date & Tim Administered Chemic Time: 1750 [5:50 p.m Benadryl/Zyprexa Doo IM/IM Resident Behav kick the two staff that refusing to regain con body"	<ul> <li>Time Actually Placed in 19 Time: 1740 [5:40 p.m.] d from Restraint Date: 5:46 p.m.] Date &amp; Time ived form MD Date: 9/28/19</li> <li>J Resident Behavior unit aggressively chasing the unit, attempting to choke to intervene and redirect yould cuss at the staff and beer threatening to choke his f and kicked peer.</li> <li>Time Actually Placed in 19 Time: 1746 Date &amp; Time sion Date: 9/28/19 Time:</li> <li>Order Received form MD 745</li> <li>When in restraint, resident ck the two staff that had him ion Intervention] restraint timself into staff refusing to fety.</li> <li>Date &amp; Time Chemical ived form MD Date: 9/28/19 ne Nurse Actually al Restraint Date: 9/28/19</li> <li>J. Medication Administered: sage: 50 mg/10mg Route viorContinued to cuss and had him in a restraint throl over his emotions and</li> </ul>	N	131			

Facility ID: 3016

If continuation sheet Page 10 of 19

		ID HUMAN SERVICES				FORM	D: 10/23/2019 MAPPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY RID	DGE TREATMENT CENT	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 131	Continued From page	e 10	N	131	1		
	Progress Note (had a	Intervention Justification n X in the box next to lusion and next to Chemical					
	Restraint Date: 10/6/ a.m.]Date & Time Rei 10/6/19 Time: 0813 [8 Restraint Order Rece Time: 0810 [8:10 a.m BehaviorResident in aggression toward per Resident attempted to	moved from Restraint Date: 3:13 a.m.]Date & Time ived form MD Date: 10/6/19 n.] Resident n bedroom, Physical eer and staff members. o punch peer. Staff stepped s. Resident proceeded to ro staff members.					
	Seclusion Date: 10/6/ Date & Time Remove 10/6/19 Time: 0840 [8 Date & Time Seclusio Date:10/6/19 Time: 0 Continued physical as	d from Seclusion Date: 3:40 a.m.] on Order Received form MD 0810 Resident Behavior ggression while restrained. a staff member. Resident					
	Received form MD Da Date &Time Nurse Ac Chemical Restraint D [8:12 a.m.] Medication [mg]/Benadryl 50 [mg Resident Behavior towards staff. Resident	Date & Time Restraint Order ate: 10/6/19 Time: 0810 stually Administered ate: 10/6/19 Time: 0812 n Administered: Zyprexa 10 ] Dosage: 10/50 Route: IM Continued aggression nt kicking the quite room windows. Medicine given for					

Facility ID: 3016

If continuation sheet Page 11 of 19

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	10/23/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	GE TREATMENT CENTE				2805 E ZION RD		
	GE TREATMENT CENTE	ER, INC			FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 131	Continued From page	÷ 11	N ·	131			
	Dysregulation Disorde and Stressor Related Hyperactivity Disorde Child Sexual Abuse, C Encounter; academic and Encounter for Me Perpetrator of Non-pa Emergency Safety Int Progress Note (had a	agnoses of Disruptive Mood er, Other Specified Trauma Disorder; Attention Deficit r, Combined Presentation; Confirmed, Subsequent or Educational Problem; ental Health Services for arental Child sexual Abuse. tervention Justification n X in the box next to clusion and next to Chemical					
	Restraint Date: 9/21/1 Date & Time Remove 9/21/19 Time:1925 [7 Restraint Order Rece Time 1918 [7:18 p.m.] peer on the unit repea threaten and fight, pu Seclusion Date & T	Time Actually Placed in a 19 Time: 1917 [7:17 p.m.] 2d from Restraint Date: 25 p.m.] Date & Time ived from MD Date: 9/21/19 ] Fist fighting c [with] a atedly, going back to nch over and over again. Time Actually Placed in 19 Time: 1925 Date & Time					
	removed from Seclus 1940 [7:40 p.m.] Date Received from MD Da Chemical Restraint	ion Date: 9/21/19 Time: & Time Seclusion Order ate: 9/21/19 Time: 1918. Date & Time Chemical ived from MD Date: 9/21/19					

Facility ID: 3016

If continuation sheet Page 12 of 19

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/23/2019 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		04L117	B. WING				C 11/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RID	OGE TREATMENT CENTE	R, INC			805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
N 131	Actually Administered 9/21/19 Time: 1924 [7 Administered: Thoraz mg/100 [mg] Route: II [Resident] fighting wit kicking, biting and scr This progress note wa on 9/22/19 at 10:00 a 7. Resident #3 had di Dysregulation Disorde Disorder; Attention De Combined Presentatio Suspected, Subseque Neglect, Confirmed, S Emergency Safety Int Progress Note (had a Restraint, next to Sec Restraint. "Restraint Date & T Restraint Date: 9/22/1 Date & Time Remove 9/22/19 1119 [11:19 a Order Received from Time:1109 [11:09 a.m from one of his staff a and over as he was b the pen. R then threat pen. R was restrained Seclusion Date & Tim Seclusion Date & Tim Seclusion Date & Tim Received from MD 9/2/	Chemical Restraint Date: (24 p.m.] Medication ine/Benadryl Dosage: 100 M Resident Behavior h staff in restraint, shoving, atching in restraint" as signed by the physician m. agnoses of Disruptive Mood er; Posttraumatic Stress efficit Hyperactivity Disorder, on; Child Sexual Abuse, ent Encounter; and Child Subsequent Encounter. ervention Justification n X in the box next to lusion and next to Chemical Time Actually Placed in 9 Time 1110 [11:10 a.m.] d from Restraint Date: a.m.] Date & Time Restraint MD Date: 9/22/19 .]R [Resident] took a pen nd started hitting staff over eing redirected to give up ten to stab staff with the I for safety. e Actually Placed in 19 1120 [11:20 a.m.] Date & Seclusion 9/22/19 1145 me Seclusion Order	N	131			

Facility ID: 3016

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L117	B. WING_			C 10/11/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PINEY RIC	OGE TREATMENT CENTE	ER, INC			805 E ZION RD FAYETTEVILLE, AR 72703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 131	kill them refusing to re Chemical Restraint D Restraint Order Rece Time: 1120 Date & Tii Administered Chemic Time: 1119 [11:19 a.m Zyprexa 10 [mg]/Bena Route: IM Residen staff and nurse while regaining control of et 8. Resident #9 had di Spectrum Disorder; U Stressor Related Diso Health Services for P Child Sexual Abuse; O Confirmed, Subseque Physical Abuse, Conf Encounter. Emergency Safety Int Progress Note (had a Restraint, next to Sec Restraint. "Restraint Date & T Restraint Date:9/29/1 p.m.] Date & Time Re 9/29/19 Time: [unable Restraint Ordered fro [12:16 p.m.] Reside with a peer because f free time ball. So R th face which caused per intervene and remove	ver and over threatening to egain control of behavior. ate & Time Chemical ived from MD Date: 9/22/19 me Nurse Actually al Restraint Date: 9/22/19 n.] Medication Administered: adryl Dosage 10/50 [mg] t Behavior Continued to kick threatening to kill staff not motions and behavior." agnoses of Autism Inspecified Trauma and order; Encounter for Mental erpetrator of Non-parental Child Sexual Abuse, ent Encounter; and Child irmed, Subsequent rervention Justification n X in the box next to Jusion and next to Chemical Time Actually Placed in 9 Time: 1210 pm [12:10 emoved from Restraint Date: a to determine] Date & Time m MD 9/29/19 1216 pm ent Behavior R was upset he felt that a peer poop his irew his ball in his peers per to try fight R but staff	N	131				

Facility ID: 3016

If continuation sheet Page 14 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/23/2019 MAPPROVED
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			LETED C
		04L117	B. WING				_ 11/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RID	OGE TREATMENT CENTE	ER, INC			805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
N 131	Continued From page 14		N	131			
	Seclusion Date 9/2 Date and Time Remo 1250 [12:50 p.m.]. Da Order Received from 1216 Resident Bel be aggressive with sta kicking at the time out Chemical Restraint Restraint Order Rece Time 1216 Date & Tir Administered Chemic Time 1221 [12:21 p.m Zyprexa/ Benadryl Do IM/IM Resident Bel time out room while c peers. Refusing to rea was trying to process 9. Resident #10 had of Mood Dysregulation I Hyperactivity Disorde Child Physical Abuse Encounter; Child Sex Subsequent Encounter Mild.	29/19 Time 1221 [12:21 p.m.] ved from Seclusion 9/29/19 ate and Time seclusion MD Date: 9/29/19 Time: haviorR was continuing to aff and yelling cussing and t room door Date & Time Chemical ived from MD Date: 9/29/19 me Nurse Actually cal Restraint Date 9/29/19 m.] Medication Administered: bsage: 10mg/50 mg Route havior Kicking door in ussing and threatening his gain control even as staff him down." diagnoses of Disruptive Disorder; Attention Deficit r, Combined Presentation;					
		clusion and next to Chemical					
	Restraint Date: 9/22/ Date & Time Remove 9/22/19 Time: 1743 [ Restraint Order Rece	Fime Actually Placed in 19 Time: 1740 [5:40 p.m.] 2d from Restraint Date: 5:43 p.m.] Date & Time ived from MD Date: 9/22/19 .] Resident Behavior					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L117	B. WING			C 10/11/2019		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEY RI	OGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 131	Resident tried busted get to outside, then w turned to staff. Threat stab them with a peno person standing restra on door et window Seclusion Date 9/22/7 /#2 1743 [5:43 p.m.]. Seclusion 9/22/19 Tin 1810 [6:10 p.m.]. Date Reseident Behavior room several times. A to bust out west outsis seclusion room. Slam window [with] fist. door Resecluded following 100 mg IM for Dyscor Chemical Restraint Restraint Order Rece Date & Time Nurse A Chemical Restraint D [5:43 p.m.] Medication Benadryl Dosage: 50/ Resident Behavior et kicking seclusion roo Threatening staff. Pos 10. On 10/11/19 at 9:1 Nursing was asked, " use of a physical rest chemical restraint?" S to self and others. I w policy." She was ask	through west unit trying to rent to seclusion room and tening et [and] positioning to cil. Resident placed in 2 aint after continued beating Time Actually Placed in 19 Time #1 1730 [5:30 p.m.] Date & Time Removed from ne #1 1740 [5:40 p.m.] / #2 e and Time Seclusion Order ate: 9/22/19 Time: 1735 Resident broke into laundry angry. Posturing staff. Tried de door but then walked into imed door and started hitting or then locked. #2 Thorazine 50 et Benadryl ntrol for safety until calm. Date & Time Chemical ived from MD 9/22/19 1735 ctually Administered ate 9/22/19 Time: 1743 n Administered: Thorazine/ /100 [mg] Route: IM Continued aggression hitting oom door et window. sturing."	N	13				

Facility ID: 3016

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		04L117	B. WING		10	C )/11/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PINEY RID	DGE TREATMENT CENTE	ER, INC		2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 131	simultaneously."		N 1			
N 209	FACILITY REPORTIN CFR(s): 483.374(b)(3		N 2	09		
	the serious occurrence State Medicaid agence Protection and Advoce name of the person to reported. A copy of the maintained in the resi	in the resident's record that we was reported to both the by and the State designated acy system, including the bowhom the incident was the report must be dent's record, as well as in lent report logs kept by the				
		t met as evidenced by: 3618, was substantiated, all dings.				
	failed to ensure a seri maintained in the clin reference for 2 of 2 (F	Residents #11 and #12) of ho had a serious occurrence				
	"8/9/19 - Resident [Re playing with 10 other monitoring them one and started climbing i another fence and clin [Resident #11] come turned around and sta to come down. [Resid connect or catch on th jumped down, he was	eporting Form documented, esident #11] was outside residents and two staff were resident ran to one fence t. [Resident #11] then ran to mbed it. Staff requested down immediately and he arted sliding down the fence lent #11's] left arm started to he fence link. He then s knocked to the ground hded on his left arm. He				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L117	B. WING			C 10/11/2019		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PINEY RID	OGE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 209	reported immediate p and helped him inside seen by his PCP [Prir was at the facility see MD [Medical Doctor] of [Resident #11's] pain #11] was brought via treated for left elbow if fracture. Splint applied for pain and appointm MD for X-rays and ca the Office of Long Ter Disability Rights of Ar by fax on 8/12/19 at 9 2. A Serious Injury Re "9/10/19 - Resident [F outside during recreat climbed part way up a hand on the top of fer and went to nurse's s and left hands washe water. 1 x [by] 1/8 inc dressing applied for p [Resident #12] to be t evaluation. 2 sutures will be removed 9/20/ follows up 9/11/19, or antibiotic ointment." T and DRA were notified a.m. 3. On 10/11/19 at 9:00 Nursing was asked if the resident's chart th	ain. Nurses came to him a where he was immediately mary Care Physician] who ing routine patients. PCP ordered 911 to be called as was extreme. [Resident ambulance to [hospital] and injury with effusion - an early d, order for Tylenol of Motrin hent made for orthopedic st." The form documented m Care (OLTC) and kansas (DRA) were notified to 24 a.m. aporting Form documented, Resident #12]was playing tional time. Resident a fence and caught right nce. Resident came down tation immediately. Right d thoroughly with soap and h laceration present, gauze ressure. MD orders aken to [hospital] for placed on right hand that 19. Primary care physician ders over the counter triple The form documented OLTC d by fax on 9/12/19 at 10:57 B a.m., the Director of there was documentation in at notifications were made encies. The Director of just keep the fax and	N	209				

Facility ID: 3016

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		04L117	B. WING					
	ROVIDER OR SUPPLIER	ER, INC		2805	EET ADDRESS, CITY, STATE, ZIP CODE 5 E ZION RD 'ETTEVILLE, AR 72703			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 209	4. The Policy: Emerge provided by the Direc 9:11 a.m. documente OccurrenceThis for resident's medical rec	ency Safety Interventions tor of Nursing on 10/10/19 at	N	209				

Facility ID: 3016

If continuation sheet Page 19 of 19



### **Division of Provider Services and Quality Assurance**

Office of Long Term Care PO Box 8059, Slot S404 Little Rock, AR 72203-8059 Fax: 501-682-6159



November 7, 2019

Adrienne Catalina, Administrator Piney Ridge Treatment Center, Inc 2805 E Zion Rd Fayetteville, AR 72703

Dear Ms. Catalina:

On October 11, 2019, we conducted a complaint investigation survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by November 06, 2019.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer at (501)320-6182.

Sincerely,

Redney Reper for Sandra Broughton, Reviewer

Sandra Broughton, Reviewer Survey & Certification Section Office of Long Term Care

sb

TEMENT	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	1			e Survey Pleted C
		04L117	B. WING		10	0 //11/2019
AME OF PF	ROVIDER OR SUPPLIER	<u> </u>			REET ADDRESS, CITY, STATE, ZIP CODE	
INEY RID	GE TREATMENT CENT	ER, INC			NOSEZION RD AYETTEVILLE, AR 72703	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
N 000	Initial Comments	1 (Otale m date of Deficiencies)	N	000	N131 PROTECTION OF RESIDENTS Step #1	11/06/1
	is an official, legal do remain unchanged ex correction, correction space. Any discrepar citation(s) will be repr Office (RO) for referra Inspector General (O information is inadve provider/supplier, the should be notified im	IG) for possible fraud, If tently changed by the State Survey Agency (SA) mediately. ation was conducted from		•	Corrective Action: On, 10/23/2019, upon notification of deficient practice, the DON observed/ checked (to verify no restraint or seclusion moving forward was administered simultaneously) to ensure chemical restraint and Seclusion is not used simultaneously to assure the safety of resident #1, #2, #3, #4, #6, #7, #8, #9, and #10. No additional negative findings were found. Step #2	
N 131	or in part, with deficie N0209. The facility was not in Subpart G - Conditio Psychiatric Resident PROTECTION OF R CFR(s): 483.356(a)(4	ESIDENTŚ 4)	Ν	131	Identification of others with the potential of being affected: On, 10/23/19, DON through Emergency safety intervention log and immediately identified 18 residents in the last 90 days who had the potential to be affected from the deficient practice by (Don reviewed each emergency safety intervention listed with chemical restraint and seclusion used simultaneously) DON observed/ checked to ensure chemical restraint and seclusion is not used simultaneously in future to determine if those residents	
		ot met as evidenced by: 3618, was substantiated, all			were affected. Any negative findings were corrected immediately.	
		iew and interviews, the				
~ ~	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TILE Director of Nursing	(X6) DATE
/ deficienc	y statement ending with an i				e excused from correcting providing it is determined that iomes, the findings stated above are disclosable 90 days	

Facility ID: 3016

						FORM	APPROVE	ΞD
STATEMENT (	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
	CONNECTION	04L117	A. BUILD B. WING			с	l	
	ROVIDER OR SUPPLIER	046117	B. WING			10/11/2019		
NAME OF PI	ROMDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		1	
PINEY RIC		ER, INC		1	805 E ZION RD AYETTEVILLE, AR 72703		 <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	V
N 131	seclusion were not us assure the safety of 9 #4, #6, #7, #8, #9, an who were chemically seclusion. The finding 1. Resident #1 had di Dysregulation Disord Disorder, Attention D and Reactive Attachm a. Emergency Safety Progress Note had an Restraint, next to Sec Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/10/ Date & [and] Time Re 9/10/19 Time: 1236 [ Restraint Order Rece Doctor] Date: 9/10/19 Resident Behavior hitting, kicking, punch SeclusionDate and Seclusion Date: 9/10 Date & Time Remove 9/10/19 Time: 1300 [ Restraint Order Rece Time: 1225 [12:25 p.] Secluded related to a calm as evidenced b kicking staff and ban Chemical Restraint D	e a chemical restraint and sed simultaneously used to 9 of 9 (Resident #1, #2, #3, rd #10) case mix residents restrained while in gs are: agnoses of Disruptive Mood er, Posttraumatic Stress eficit Hyperactivity Disorder nent Disorder. Intervention Justification n X in the box next to clusion and next to Chemical d Time Actually Placed in 19 Time: 1225 [12:25 p.m.] emoved from Restraint Date: 12:36 p.m. Date & Time sived form MD [Medical 9 Time: 1225 [12:25 p.m.] Aggression toward staff, ning d Time Actually Placed in /19 Time: 1236 [12:36 p.m.] ed from Restraint Date: 1:00 p.m.] Date & Time sived form MD Date: 9/10/19 m.] Resident Behavior aggression for safety, until y screaming, cussing, ging on quite room windows.	N		Step #3 To ensure deficient practice does not recur: On 10/16/2019, 11/06/2019, the DC Designee in-serviced nurses to ensu- chemical restraint and seclusion is r- used simultaneously. The Emergence Safety Intervention policy was also updated to ensure no seclusion or r- is administered simultaneously. If n- not present he or she has been or wi- in-serviced prior to working next sh The nursing department competence checklists were also updated to ensu- competency monitoring. Step #4 Monitoring: DON and administrative assistant to DON will monitor to ensure chemi- restraint and Seclusion is not used simultaneously by observation and documenting on emergency safety intervention checklist, each business weekly for 8 weeks or until complia- verified by OLTC. Any negative fin- will be corrected immediately and I- notified. Completion Date: 11/06/2019	N/ re not cy estraint urse ill be hift. cy tre o the cal s day nce is dings		
FORM CMS-25	67(02-99) Previous Versions Ob		<u>l</u> V11	F	acility ID: 3016 If conti	nuation shee	et Page 2 of	f 19

		D HUMAN SERVICES					PRINTED: 1 FORM AF OMB NO. 09	PROVED	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI				(X3) DATE SUR COMPLET	VEY	
		04Ļ117	B. WIN	۹G		-	C 10/11/2019		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u>.</u>	1	
	GE TREATMENT CENT	ER. INC			2805 E ZION RD				
					FAYETTEVILLE, AR 727	/03		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PR	id Refix Tag	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)	-	(X5) OMPLETION DATE	
N <sup>.</sup> 131	Continued From and								
	Continued From page			N 13	1				
	Time: 1235 [12:35 p.r	al Restraint Date: 9/10/19 n.]							
· ·		Intervention Justification In X in the box next to							
	- ·	lusion and next to Chemical						 	
t.	Restraint Date: 9/15/ Date & Time Remove 9/15/19 Time: 1420 [2 Restraint Order Rece Time: 1415 [2:15 p.n BehaviorResident s	started punching staff as they							
	the fence outside. Re	-							
	Seclusion Date: 9/15 Date & Time Remove 9/15/19 Time: 1425 [2 Restraint Order Rece Time: 1415 [2:15 p.m								
	his body around in at	estraint resident was jerking tempt to throw staff off staff and attempted to kick fety.							
	Order Received form 1415 [2:25 p.m.]. Da Administered Chemic	Date & Time Restraint MD Date: 9/15/19 Time: te & Time Nurse Actually cal Restraint Date: 9/15/19							
	Zyprexa/Benadryl Do mg [Benadryl] Route	] Medication administered: sage: 10 mg [Zyprexa]/50 IM Resident Behavior sident behavior continued to							
	escalate. Resident se	creaming, slams head							
	against wall, kicks se	clusion room door multiple				-	·		
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: 056	W11		Facility ID: 3016	If cont	inuation sheet F	Page 3 of 19	

Facility ID: 3016

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		MEDICAID SERVICES				IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				RE SURVEY
		04L117	B. WING		1	C 0/11/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE	1
PINEY RIC	OGE TREATMENT CENT	ER, INC		05 E ZION RD NYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
N 131	Continued From page	e 3	N 131			
,	times, punches wall. administered for safe	Chemical restraint				
1	The progress note wa on 9/16/19.	as signed by the physician				
		iagnoses of Major Oppositional Defiant ectrum, and Child Neglect.				
	Progress Note had a	Intervention Justification n X in the box next to clusion and next to Chemical				
	Restraint Date: 9/6/1 Date & Time Remove 9/10/19 Time: 1245 [ Restraint Order Reco Time: 1248Reside flipping filing cabinets	d Time Actually Placed in 9 Time: 1240 [12:40 p.m.] ed from Restraint Date: 12:45 p.m.] Date & Time eived form MD Date: 9/6/19 ent Behavior Resident s, rolling in the carpet and eacher's phone, kicking staff I resident.				
	Seclusion Date: 9/6/ Date & Time Remove 9/10/19 Time: 1300 [ Date & Time Restrain Date: 9/10/19 Time: Resident Behavior continued to try and	ed from Restraint Date: 1:00 p.m.] nt Order Received form MD				
	Received form MD D Date & Time Nurse A	Date: 9/6/19 Time: 1252				
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: 0\$6	W11 Fac	cility ID: 3016	If continuation	sheet Page 4 of 19

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	LETED
	,	04L117	B. WING				11/2019
	ROVIDER OR SUPPLIER	ER, INC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 805 E ZION RD AYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
N 131	Route: IM Residen continued to throw of staff The progress note wa on 9/6/19 at 3:00 p.m 3. Resident #6 had d Trauma and Stressor Intellectual Functionin a. Emergency Safety Progress Note (had a Restraint, next to Sea Restraint, next to Sea Restraint, next to Sea RestraintDate and Restraint Date: 9/15/ Date & Time Remove 9/15/19 Time: 1555 [ Restraint Order Rece Time: 1546 Reside throwing cups on the peer to where reside staff intervene and ge Seclusion Date: 9/15/ Date & Time Remove 9/15/19 Time: 1625 [ Date & Time Seclusio Date: 9/15/19 Time: Resident Behavior <sup>1</sup>	ion administered: Dosage 100 mg/100 mg it Behavior Resident ojects at staff and threaten as signed by the physician i. iagnoses of Unspecified related Disorder, Borderline ng, and Physical Abuse. Intervention Justification an X in the box next to clusion and next to Chemical d Time Actually Placed in 19 Time: 1546 (3:46 p.m.) ed from Restraint Date: 3:55 p.m.] Date & Time eived form MD Date: 9/15/10 ent Behavior Resident was unit which upset one of his nt tried to fight the peer but ot hit by resident. I Time Actually Placed in /19 Time: 1555 ed from Seclusion Date: 4:25 p.m.] on Order Received form MD	N	131			
Ĺ	Chemical Restraint .	Date & Time Restraint		_			

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Event ID: 0S6W11

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Facility ID: 3016

If continuation sheet Page 5 of 19

		ID HUMAN SERVICES				FORM	: 10/23/2019 APPROVED . <u>093</u> 8-0391
STATEMENT (	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE S COMPL	
ļ		04L117	B. WING			10/:	; 11/2019
NAME OF P	ROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RID	GE TREATMENT CENTE	ER, INC			2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 131	<ul> <li>1546 Date &amp;Time Nu Chemical Restraint D [3:50 p.m.] Medicatio Thorazine/Benadryl D IMResident Behavi resident started bang over and over, refusin behavior"</li> <li>The progress note wa on 9/20/19.</li> <li>Emergency Safety Progress Note (had a Restraint, next to Sec Restraint, next to Sec RestraintDate and Restraint Date: 9/19/ Date &amp; Time Remove 9/19/19 Time: 1928 [ Restraint Order Rece Time: 1925 [7:25 p.n. Resident was in dayr peers. They were bot then both became ve continued trying to fig separated. Resident and others as he kee SeclusionDate and Seclusion Date: 9/19 Date &amp; Time Remove 9/19/19 Time: 1945 [ Date &amp; Time Restrain Date: 9/19/19 Time: Resident Behavior</li> </ul>	MD Date: 9/15/19 Time: rse Actually Administered late: 9/15/19 Time: 1550 in Administered; Dosage 50 mg/50 mg Route: iorWhile in time out room ing his head into the wall ing to regain control of his as signed by the physician Intervention Justification an X in the box next to clusion and next to Chemical d Time Actually Placed in 19 Time: 1920 [7:20 p.m.] ed from Restraint Date: 7:28 p.m.] Date & Time eived form MD Date: 9/15/10 in.] Resident Behavior oom, horseplaying with th antagonizing each other ery aggressive. Resident ght peer and they had to be was restrained for his safety ep kicking peer. Time Actually Placed in /19 Time: 1928 ed from Seclusion Date: 7:45 p.m.] int Order Received form MD	Ν	13			

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Facility ID: 3016

If continuation sheet Page 6 of 19

I. 1

		ID HUMAN SERVICES				FORM	): 10/23/2019 1 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIÓN NUMBER:	1 · ·		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		04L117	B. WING	ə			C   11/2019
NAME OF P	ROVIDER OR SUPPLIER	• <u> </u>		s	TREET ADDRESS, CITY, STATE, ZIP CODE		1
				28	805 E ZION RD		
PINETRIL	OGE TREATMENT CENT	ER, INC		F.	AYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
N 131	Secluded for his safe Chemical Restraint Received form MD D Date & Time Nurse A Chemical Restraint D [7:27 p.m.] Medicatio Zyprexa/Benadryl Do IM Resident Behave being restrained, he of staff and banging his to give IM received fr call" c. Emergency Safety Progress Note (had a Restraint, next to Sec Restraint, next to Sec Restraint. "RestraintDate and Restraint Date: 9/21/ Date & Time Remove 9/22/19 Time: 0005 [ Restraint Order Rece Time: 2356 [11:56 p. BehaviorResident i on bed and repeated with. Resident becan attack any staff that t Seclusion Date: 9/22 Date & Time Remove 9/22/19 Time: 0023 [ Date & Time Seclusio Date: 9/21/19 Time:	ging his head in the wall ty. Date & Time Restraint Order ate: 9/19/19 Time: 1925 actually Administered Date: 9/15/19 Time: 1927 in Administered" bage: 10mg/50 mg Route: viorWhile resident was still continued kicking, hitting head into the wall. An order from MD (Medical Doctor) on Intervention Justification an X in the box next to clusion and next to Chemical d Time Actually Placed in 19 Time: 2351 [11:51 p.m.] ed from Restraint Date: 12:05 a.m.] Date & Time eived form MD Date: 2/21/19 .m.] Resident in room screaming, climbing ly finding items to harm self ne aggressive and began to tried to process or intervene. d Time Actually Placed in /19 Time: 0005 ed from Seclusion Date: 12:23 a.m.] on Order Received form MD 2356.	P	I 131			
	screaming trying to ti	Resident beating own head, ie clothing around own neck,					
FURIN GIVIS-25	67(02-99) Previous Versions Ob	solete Event ID: 056	WV 1 1	Fa	acility ID: 3016 If con	nunuation she	eet Page 7 of 1

	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES			FORM APPRØV OMB NO. 0938-03
ATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		04L117	B. WING		C 10/11/2019
NAME OF PI	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PINEY RIC	DGE TREATMENT CENT			E ZION RD ETTEVILLE, AR 72703	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETIC
N 131	Continued From page took all object resider allowed to calm in se	nt could harm self with and	N 131		
	Restraint Order Rece Time: 2356 Date & T Administered Chemic Time: 0001 [12:01 a Administered: Thoraz 100mg/100 mg Rout Resident began to hi scratching at staff wh	cal Restraint Date: 9/22/19 .m.] Medication zine/Benadryl Dosage: e: IMResident Behavior t and kick staff spitting and then they blocked his blows, peatedly. Bashing his own			
	This progress note w on 9/22/19 at 10:00 a	vas signed by the physician a.m.			
	4. Resident #7 had d Trauma and Stresso Non-parental Child S				
	Progress Note (had a	itervention Justification an X in the box next to clusion and next to Chemical			
	Restraint Date: 9/18/ Date & Time Remove 9/18/19 Time: 0823   Restraint Order Rect Time: 0825 [8:25 a.n Resident pounding fi	e and Time Actually Placed in (19 Time: 0820 [8:20 a.m.] ed from Restraint Date: 8:23 a.m.] Date & Time eived form MD Date: 9/18/19 n.] Resident Behavior #1. ist and kicking windows and ion. Refused verbal redirect."			
	Restraint Date: 9/18/	e and Time Actually Placed in /19 Time: 0900 [9:00 a.m.] ed from Restraint Date:			

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMP	LETED
		04L117	B. WING				C 11/2019
	ROVIDER OR SUPPLIER	ER, INC		280	REET ADDRESS, CITY, STATE, ZIP CODE 5 E ZION RD YETTEVILLE, AR 72703	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 131	Restraint Order Rece Time: 0903 [9:03 a.m Resident attacked per hitting and kicking. SeclusionDate and Seclusion Date: 9/18 Removed from Seclu 0937 [9:37 a.m.] Date & Time Seclusio Date: 9/18/19 Time: 1 Resident BehaviorI and pull against staff safety following chem Chemical Restraint Received form MD D [9:05 a.m.] Date & Tim Administered Chemic Time: 0903 Medicatio Zyprexa/Benadryl Do Route: IM Resident to calm Attacked staff re-escalated. Refuse This progress note w on 9/18/19 at 10:00 a 5. Resident #8 had of Stress Disorder, Chr Impulse Control, Con Deficit Hyperactivity a. Emergency Safety Progress Note (had	9:07 a.m.] Date & Time eived form MD Date: 9/18/19 n.] Resident Behavior#2. eers and staff, punching, Time Actually Placed in /19 Time: 0907 Date & Time usion Date: 9/18/19 Time: on Order Received form MD 0903 Resident continued to push Resident continued to push Resident was secluded for nical restraint. Date & Time Restraint Order bate: 9/18/19 Time: 0905 me Nurse Actually cal Restraint Date: 9/18/19 on Administered: bsage: 10 [mg]/50 [mg] Behavior Resident unable ff and peers when he ad direction" vas signed by the physician a.m. liagnoses of Posttraumatic onic. Unspecified Disruptive, nduct Disorder and Attention	N	131			

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 3016

If continuation sheet Page 9 of 19

						RINTED: 10/2 FORM APPR	ROVED
STATEMENT O	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	T	MB NO. 0938 X3) DATE SURVE COMPLETED	
1	·	04L117	B. WING_		_	C 10/11/201	9
	ROVIDER OR SUPPLIER	ER, INC		STREET ADDRESS, CITY, S 2805 E ZION RD FAYETTEVILLE, AR 72			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)	COMP	(5) LETION ATE
N 131	Restraint Date: 9/28/ Date & Time Remove 9/28/19 Time: 1746 [ Restraint Order Rece Time: 1745 [5:45 p.m Resident was on the one of his peers on the this peer as staff tried resident to stop. He w continue on chasing peer, he slapped staf Restrained for safety Seclusion Date: 9/28 Removed from Seclus 1800 [6:00 p.m.] Date & Time Seclusio Date: 9/28/19 Time: Resident BehaviorV started to cuss and k in CPI [Crisis Prevent then started to slam I stop. Secluded for safety Chemical Restraint Restraint Order Rece Time: 1745 Date & Ti Administered Chemic Time: 1750 [5:50 p.m Benadryl/Zyprexa Do IM/IM Resident BehaviorV	d Time Actually Placed in (19 Time: 1740 [5:40 p.m.] ed from Restraint Date: 5:46 p.m.] Date & Time eved form MD Date: 9/28/19 A Resident Behavior unit aggressively chasing he unit, attempting to choke d to intervene and redirect would cuss at the staff and peer threatening to choke his if and kicked peer. d Time Actually Placed in /19 Time: 1746 Date & Time usion Date: 9/28/19 Time: on Order Received form MD 1745 When in restraint, resident ick the two staff that had him tion Intervention] restraint himself into staff refusing to afety. Date & Time Chemical eived form MD Date: 9/28/19 me Nurse Actually cal Restraint Date: 9/28/19 n.] Medication Administered: osage: 50 mg/10mg Route aviorContinued to cuss and t had him in a restraint ntrol over his emotions and	N	131			
	67(02-99) Previous Versions Ob			Facility ID: 3016		ation sheet Page	10 of 10

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		ID HUMAN SERVICES MEDICAID SERVICES						RINTED: FORM	APPRO	OVED
OF	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION		X3) DATE S COMPLI	URVEY	
		04L117		B. WING _				C 10/1	1/2019	
PRO	VIDER OR SUPPLIER	•			S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	-		1
					28	805 E ZION RD				1
IDGI	E TREATMENT CENT	ER, INC			F/	AYETTEVILLE, AR 72703				
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		id Prefi) Tag	x	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE	E	(X5) COMPLE DAT	TON
ı c	Continued From page	e 10		<b>N</b> 1	131					
P	Progress Note (had a	Intervention Justification an X in the box next to clusion and next to Chemical								-
F a 1 F T E a F b P	Restraint Date: 10/6/ a.m.]Date & Time Re 10/6/19 Time: 0813 [ Restraint Order Rece Time: 0810 [8:10 a.r BehaviorResident i aggression toward po Resident attempted t	emoved from Restraint Date: 8:13 a.m.]Date & Time eived form MD Date: 10/6/19 n.] Resident n bedroom, Physical eer and staff members. to punch peer. Staff stepped ts. Resident proceeded to wo staff members.								
S C 1 C C F	Seclusion Date: 10/6 Date & Time Remove 10/6/19 Time: 0840 [ Date & Time Seclusion Date:10/6/19 Time: 0 Continued physical a Resident was kicking	ed from Seclusion Date:	,							
F C (1 [1	Received form MD D Date &Time Nurse A Chemical Restraint I [8:12 a.m.] Medicatio [mg]/Benadryl 50 [mg Resident Behavior towards staff. Reside	Date & Time Restraint Order Date: 10/6/19 Time: 0810 ctually Administered Date: 10/6/19 Time: 0812 on Administered: Zyprexa 10 g] Dosage: 10/50 Route: IM Continued aggression ent kicking the quite room e windows. Medicine given fo								
[ <sup>1</sup> [ <sup>1</sup> t c s	[8:12 a.m.] Medicatio [mg]/Benadryl 50 [mg Resident Behavior towards staff. Reside door. Banging on the	on Administered: Zyprexa 10 g] Dosage: 10/50 Route: IM Continued aggression ent kicking the quite room e windows. Medicine given fo	r 		Fa	acility ID: 3016		If continu	If continuation sheet	If continuation sheet Page

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-		D HUMAN SERVICES MEDICAID SERVICES				FORM	10/23/2019 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SU COMPLE	JRVEY
		04L117	B. WING			-	/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RI	OGE TREATMENT CENT	ER, INC			05 E ZION RD YETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 131	Continued From page	ə 11	N	131			
	Dysregulation Disord and Stressor Related Hyperactivity Disorde Child Sexual Abuse, Encounter; academic and Encounter for Me Perpetrator of Non-pa	agnoses of Disruptive Mood er, Other Specified Trauma Disorder; Attention Deficit r, Combined Presentation; Confirmed, Subsequent e or Educational Problem; ental Health Services for arental Child sexual Abuse. tervention Justification					
	Restraint, next to Sea Restraint. "Restraint "Date & Restraint Date: 9/21/ Date & Time Remove 9/21/19 Time:1925 [7 Restraint Order Rece Time 1918 [7:18 p.m peer on the unit repe						
	Seclusion Date & Seclusion Date 9/21/ removed from Seclus 1940 [7:40 p.m.] Date Received from MD D Chemical Restraint Restraint Order Rece	Inch over and over again. Time Actually Placed in 19 Time: 1925 Date & Time sion Date: 9/21/19 Time: e & Time Seclusion Order ate: 9/21/19 Time: 1918. . Date & Time Chemical sived from MD Date: 9/21/19 n.] Date & Time Nurse					
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: 056	W11	Fac	lity ID: 3016 If continu	uation sheet	Page 12 of 19

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1 PRINTED: 10/23/2019

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				1		PPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(	<u>DMB_NO. (</u>	<u>0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SU COMPLE	
		04L117	B. WING				C 10/11	/2019
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PINEY RIC	GE TREATMENT CENTI	ER, INC			805 E ZION RD AYETTEVILLE, AR 72703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	XI	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	- 1	(X5) COMPLETION DATE
N 131	<ul> <li>9/21/19 Time: 1924 [ Administered: Thoraz mg/100 [mg] Route: I [Resident] fighting wi kicking, biting and sc</li> <li>This progress note w on 9/22/19 at 10:00 a</li> <li>7. Resident #3 had d Dysregulation Disord Disorder; Attention D Combined Presentati Suspected, Subsequ Neglect, Confirmed,</li> <li>Emergency Safety In Progress Note (had a Restraint, next to Ser Restraint.</li> <li>"Restraint Date &amp; Restraint Date: 9/22/ Date &amp; Time Remove 9/22/19 1119 [11:19 Order Received from Time: 1109 [11:09 a.n from one of his staff and over as he was I the pen. R then threa pen. R was restraine</li> <li>Seclusion Date &amp; Tir Seclusion Date 9/22/ Time Removed from</li> </ul>	d Chemical Restraint Date: 7:24 p.m.] Medication zine/Benadryl Dosage: 100 IM Resident Behavior th staff in restraint, shoving, ratching in restraint" vas signed by the physician a.m. liagnoses of Disruptive Mood ler; Posttraumatic Stress Deficit Hyperactivity Disorder, ion; Child Sexual Abuse, lent Encounter; and Child Subsequent Encounter. Attervention Justification an X in the box next to clusion and next to Chemical Time Actually Placed in 19 Time 1110 [11:10 a.m.] ed from Restraint Date: a.m.] Date & Time Restraint h MD Date: 9/22/19 n.]R [Resident] took a pen and started hitting staff over being redirected to give up aten to stab staff with the	N	131				
L	Received from MD 9	/22/19 1109 Resident a restraint R started kicking						
FORM CMS-25	67(02-99) Previous Versions Ob	solete Event ID: 056	5W11	Fa	acility ID: 3016	If continu	ation sheet	Page 13 of 19

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		MPLETED
		04L117	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		10/11/2019
	ONDER OR SOLITEIER			2805 E ZION RD		1
INEY RID	GE TREATMENT CENT	ER, INC		FAYETTEVILLE, AR 72703		1
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u>ID</u>	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	
N 131	Continued From page	- 12				
N 131			N 13			i
		ver and over threatening to				
	kill them refusing to r	egain control of behavior.				
	Chamical Bostraint C	ate & Time Chemical				ł
		eived from MD Date: 9/22/19				
	Time: 1120 Date & Ti					
		cal Restraint Date: 9/22/19				
		n.] Medication Administered:				
Z R s'		adryl Dosage 10/50 [mg]				1
		t Behavior Continued to kick				E E
		threatening to kill staff not				
		motions and behavior."				
	0 0					
	8. Resident #9 had d	iagnoses of Autism				
	Spectrum Disorder; l	Jnspecified Trauma and		•		
	Stressor Related Dis	order; Encounter for Mental				i
		Perpetrator of Non-parental				1
	Child Sexual Abuse;					
		ent Encounter; and Child				
	Physical Abuse, Con	firmed, Subsequent				
	Encounter.					
	Emorgonay Sofaty In	ton option Justification				
		tervention Justification an X in the box next to				
		clusion and next to Chemical				1
	Restraint.					
	"Restraint Date &	Time Actually Placed in	ļ			
		19 Time: 1210 pm [12:10	1			
	p.m.] Date & Time R	emoved from Restraint Date:				
		e to determine] Date & Time				1
		om MD 9/29/19 1216 pm				
		lent Behavior R was upset				
		he felt that a peer poop his				
		hrew his ball in his peers				
		eer to try fight R but staff				
		ed peer but R started				
	punching staff in the	face while trying to get to	1	1		1 +

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						FORM	10/23/2019 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	<u> </u>			<u>_OMB NO.</u>	0938-0391
		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	· · · · · ·			(X3) DATE S COMPL	
		04L117	B. WIN	G		C 10/1	1/2019
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		1
				2	805 E ZION RD		·
	GE IREAIMENT CENTE	ER, ING		F	AYETTEVILLE, AR 72703		ļ ļ
(X4) ID	SUMMARY ST				PROVIDER'S PLAN OF CORRECTIO		(X5)
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TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION	N) TA	١G	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
	·				DEFICIENCY)		
N 131	Continued From page	e 14	.   1	N 131			
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			-				j j
			/19 -				
							1
ļ			nd				
	kicking at the time ou	t room door					
	kicking at the time out room door						l l
			40				
1		· · · · · · · · · · · · · · · · · · ·	/19				i
	•	•	a				
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							1
]			nis			1	i i
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							i
	9. Resident #10 had	diagnoses of Disruptive					-
			n;				
Į –						ļ	i i
		er; and Intellectual Disat	oility.				
	Mild.						Ì
1							
	AN OF CORRECTION       IDENTIFICATION NUMBER         OF PROVIDER OR SUPPLIER       04L117         OF PROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMATION FOR AND THE REGULATORY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)         131       Continued From page 14         Seclusion Date 9/29/19 Time 1221 [12:2         Date and Time Removed from Seclusion 9/1250 [12:50 p.m.]. Date and Time seclusion 0/1250 [12:50 p.m.]. Date and Time seclusion 0/1216 Resident BehaviorR was contin be aggressive with staff and yelling cussing		lical			1	
	"Restraint Date &	Time Actually Placed in					
			.1				
			-				
1	-		2/19				ļ
l			-				
FORM CMS-25	67(02-99) Previous Versions Ob	· · · · · · · · · · · · · · · · · · ·	ent ID:0S6W11	 F:	acility ID: 3016 If con	tinuation sheet	Page 15 of 19

CENTER	S FOR MEDICARE &	MEDICAID SERVICE	<u>s</u>			<u> </u>	OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	BED.	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE S COMPLE	
		04L117		B. WING _			C 10/1 <sup>-</sup>	1/2019
NAME OF PI	ROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RID	GE TREATMENT CENT	ER, INC				05 E ZION RD YETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	ULL	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLET(ON DATE
N 131	get to outside, then w turned to staff. Threa stab them with a pen- person standing restr on door et window Seclusion Date & <sup>-</sup> Seclusion Date 9/22/ /#2 1743 [5:43 p.m.]. Seclusion 9/22/19 Tir 1810 [6:10 p.m.]. Dat Received from MD D Resident Behavior room several times. A to bust out west outsi seclusion room. Slam window [with] fist. doo Resecluded following 100 mg IM for Dysco Chemical Restraint Restraint Order Rece Date & Time Nurse A	through west unit tryi rent to seclusion room tening et [and] position cil. Resident placed in aint after continued be Time Actually Placed i 19 Time #1 1730 [5:30 Date & Time Remove ne #1 1740 [5:40 p.m te and Time Seclusion ate: 9/22/19 Time: 173 Resident broke into la Angry. Posturing staff. ide door but then walk med door and started or then locked. #2 1 Thorazine 50 et Ben ntrol for safety until ca . Date & Time Chemic sived from MD 9/22/19 actually Administered	and ning to 2 eating n 0 p.m.] of from ] / #2 Order 35 aundry Tried red into I hitting adryl hm. cal 0 1735	N 1	131			
	[5:43 p.m.] Medicatio Benadryl Dosage: 50 Resident Behavior et kicking seclusion r Threatening staff. Po 10. On 10/11/19 at 9: Nursing was asked, ' use of a physical resischemical restraint?'' to self and others. In policy.'' She was ask	sturing." 03 a.m., the Director 'What is your criteria f	azine/ n hitting of or the tharm the cal					
FORM CMS-25	She stated, "No, they 67(02-99) Previous Versions Ob	y should not be used	Event ID:0S6W11		Fac	cility ID: 3016 If contin	nuation sheet	Page 16 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/23/2019

FORM APPROVED

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED		
04L117		04L117	B. WING	B. WING			C 10/11/2019		
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 805 E ZION RD AYETTEVILLE, AR 72703				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLE DATE	TION	
N 131 N 209	simultaneously."		N 13 N 209		Step #1		11/06/		
	failed to ensure a sei maintained in the clir reference for 2 of 2 ( case mix residents w report. The findings a 1. A Serious Injury R "8/9/19 - Resident [R playing with 10 other monitoring them one and started climbing another fence and cl [Resident #11] come turned around and si to come down. [Resi connect or catch on jumped down, he wa	iew and interview, the facility rious occurrence report was nical record for easy Residents #11 and #12) of <i>r</i> ho had a serious occurrence			On, 10/23/2019, the DON through looking at serious occurrence binde the past 90 days immediately identi residents who had the potential to b affected from the deficient practice charts of these 3 residents were chee verify each notification and documentation was currently place chart) Administrative assistant to th DON observed/checked to ensure s occurrence report was maintained i clinical record for easy reference to determine if those residents were af Any negative findings were correcte immediately.	fied 3 be by (the cked to d in the ne erious in the ffected.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0\$6W11

Facility ID: 3016

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         04L117         NAME OF PROVIDER OR SUPPLIER         PINEY RIDGE TREATMENT CENTER, INC			(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE COMF	SURVEY   SURVEY   PLETED   L
		B. WING S 2 F		11/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
N 209	and helped him insid seen by his PCP [Pri was at the facility see MD [Medical Doctor] [Resident #11's] pair #11] was brought via treated for left elbow fracture. Splint applie for pain and appointr MD for X-rays and c the Office of Long Te Disability Rights of A by fax on 8/12/19 at 2. A Serious Injury R "9/10/19 - Resident ] outside during recrea climbed part way up hand on the top of fe and went to nurse's and left hands wash water. 1 x [by] 1/8 in dressing applied for [Resident #12] to be evaluation. 2 sutures will be removed 9/20 follows up 9/11/19, c antibiotic ointment." and DRA were notific a.m. 3. On 10/11/19 at 9:1 Nursing was asked i the resident's chart 1 to the appropriate age	bain. Nurses came to him e where he was immediately mary Care Physician] who eing routine patients. PCP ordered 911 to be called as a was extreme. [Resident ambulance to [hospital] and injury with effusion - an early ed, order for Tylenol of Motrin ment made for orthopedic ast." The form documented arm Care (OLTC) and rkansas (DRA) were notified 9:24 a.m. reporting Form documented, Resident #12]was playing ational time. Resident a fence and caught right ence. Resident came down station immediately. Right ed thoroughly with soap and ch laceration present, gauze pressure. MD orders taken to [hospital] for a placed on right hand that 0/19. Primary care physician orders over the counter triple The form documented OLTC ed by fax on 9/12/19 at 10:57	N 209	Step #3 To ensure deficient practice doe recur: On 11/06/2019, the DON in-ser nursing staff present and will in any nurse unable to attend prior next shift to work to ensure seri occurrence report is maintained clinical record for easy reference Step #4 Monitoring: Administrative assistant to DOI monitor to ensure serious occur report is maintained in the clini for easy reference by observatio documenting on serious occurr checklist, each business day for or until compliance is verified b Any negative findings will be co immediately and DON notified Completion Date: 11/06/2019	viced -service to their ous in the e. N will rence cal record n and ence 8 weeks y OLTC. rrected	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 3016

If continuation sheet Page 18 of 19

	S FOR MEDICARE &	(X1) PROVIDER/SUPP IDENTIFICATION.	LIER/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION			(X3) DATE S COMPL	ETED
	·	04L1	17	B. WING				C 10/1	1/2019
	ROVIDER OR SUPPLIER	ER, INC	· · · ·	28	REET ADDRESS, 105 E ZION RD AYETTEVILLE,		CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PR( (EACH	OVIDER'S PLAN	DF CORRECTION CTION SHOULD BE O THE APPROPRIA NCY)		(X5) COMPLETION DATE
N 209	Continued From page 4. The Policy: Emerg provided by the Direc 9:11 a.m. documente Occurrence This f resident's medical re- (Emergency Safety In form."	ency Safety Interv tor of Nursing on d, "Serious Injury orm is to be filed in cord following the	10/10/19 at n the ESI	N 209		· ·	· · · · · · · · · · · · · · · · · · ·		
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED R-C 11/26/2019	
		04L117	B. WING			
	OVIDER OR SUPPLIER		1	ET ADDRESS, CITY, STATE, ZIP CODE E ZION RD		
INEY RID	GE TREATMENT CEN	11ER, INC	FAY	ETTEVILLE, AR 72703		· • · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{N 000}	Initial Comments		{N 000}			
	is an official, legal remain unchanged correction, correcti space. Any discrep citation(s) will be n Office (RO) for refe Inspector General information is inad	567 (Statement of Deficiencies) document. All information must except for entering the plan of on dates, and the signature bancy in the original deficiency eported to the Dallas Regional erral to the Office of the (OIG) for possible fraud. If vertently changed by the the State Survey Agency (SA) immediately.				
	for all deficiencies deficiencies have noncompliance wa	ucted on November 26, 2019 cited on October 11, 2019. All been corrected, and no new as found. The facility is in Il regulations surveyed.				
					,	
Ĭ,						
BORATORY	DIRECTOR'S OR PROVID	Catallina	IRE	CEO	[2	(X6) DATE 3. 19

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# **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building		DATE OF RE	VISI	Г
04L117 <sub>Y1</sub>	B. Wing	Y2	11/26/2019	1	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		1	
PINEY RIDGE TREATMENT CENTER, INC		2805 E ZION RD		Ì	
		FAYETTEVILLE, AR 72703			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM		DATE	ITEM	DATE
Y4	Y5	Y4	, 	Y5	Y4	Y5
ID Prefix N0131	Correction	ID Prefix N0209	Э	Correction	ID Prefix	Correction
483.356(a)(4)	Completed	Reg. #	74(b)(3)	Completed	Reg. #	Completed
LSC	11/06/2019			11/06/2019	LSC	
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #		Completed	Reg. #	Completed
LSC	· ,					······································
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #		Completed	Reg. #	Completed
LSC		LSC		-	LSC	
	· · ·					
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #		Completed	Reg. #	Completed
LSC	· · · · · · · · · · · · · · · · · · ·			-	LSC	
ID Prefix	Correction	ID Prefix		Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #		Completed	Reg. #	Completed
LSC				 -	LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY	DATE 11/27/19	SIGNATURE OF	SURVEYOR	tt RR	DATE 11/27/19
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/11/2019					NCIES. WAS A SUMMARY ) SENT TO THE FACILITY	
Form CMS - 2567B (09/9	2) EF (11/06)		Page 1 of 1		EVENT ID	0S6W12

#### CHANGES TO SURVEY

### Facility Name: Piney Ridge Treatment Center, Inc.

#### Survey Date: <u>10/11/19</u>

Please review the changes below, then sign this form and fax back to the reviewer to indicate you are aware of and have approved the changes.

Team Leader: Dian Elliott Reviewer: Sandra

Team Members: Norma Rushing and Dennis Adams

Changes & Rationales: Delete N0147 no failed practice and Delete N0170 no failed practice.

#### Spoke with Norma and Dennis and they are ok with this decision.

Deletion of one or more tags and/or a significant change in scope and severity must be discussed with, and the change form signed by, at least 3 of the following: (Sandra Broughton, Lori Hobbs, Cecilia Vinson, Cephas Beene-Cooper, Melody Jones-Blackwell). Surveyor signatures should be obtained prior to the 2567 being sent out; when this is not possible, reviewer will document the date/time of verbal approval from the surveyor and have the surveyor sign the form as soon as possible.

Signatures (Supervisory Personnel)

Date

As designated surveyor, I have consulted with the team members and we concur with the changes.

Orma Kushing RN Date: 10/23/19 Surveyor Signature:

Incomplete, Inaccurate or Missing Survey forms? Yes / No



### Division of Provider Services and Quality Assurance Office of Long Term Care

PO Box 8059, Slot S404 Little Rock, AR 72203-8059 Fax: 501-682-6159



December 3, 2019

Adrienne Catalina, Administrator Piney Ridge Treatment Center, Inc 2805 E Zion Rd Fayetteville, AR 72703

Dear Ms. Catalina:

During the revisit conducted on November 26, 2019, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. A CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to Sandra Broughton at (501) 682-6159 or email to Sandra.Broughton@dhs.arkansas.gov as soon as possible.

If you have any questions please contact your reviewer at 501-320-6182.

Sincerely, Dandua Beauton

Sandra Broughton, DHS Program Administrator Office of Long Term Care Survey and Certification Section

sgb

cc: file

		D HUMAN SERVICES MEDICAID SERVICES			FOF	M APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		04L117	B. WING			R-C 1/ <b>26/2019</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PINEY RID	GE TREATMENT CENTE	ER, INC		2805 E ZION RD FAYETTEVILLE, AR 72703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 00	0}		
	is an official, legal door remain unchanged ex- correction, correction space. Any discrepan- citation(s) will be report Office (RO) for referrat Inspector General (O information is inadver provider/supplier, the should be notified imman A revisit was conduct for all deficiencies cite deficiencies have been	IG) for possible fraud. If tently changed by the State Survey Agency (SA) nediately. ed on November 26, 2019 ed on October 11, 2019. All en corrected, and no new bund. The facility is in				
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE		(X6) DATE

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.

PRINTED: 12/03/2019