ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

September 22, 2022

Justin Hoover, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. Hoover:

On September 14, 2022 a Complaint Investigation 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 deficieny cited.

Theresa Forrest, LPN, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6235**
email to Theresa.Forrest@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.

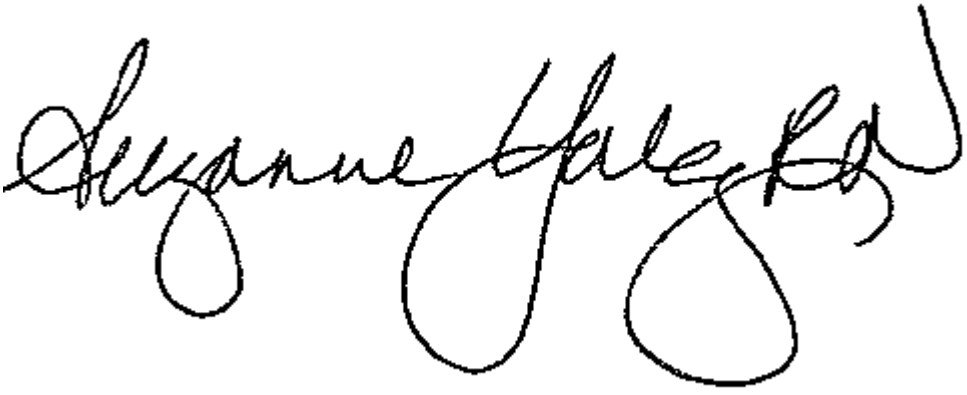
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action or the requirement for timely submission of an acceptable plan of correction. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative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

Please submit your request to:

IDR/IIDR Program Coordinator
Health Facilities Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Phone: 501-661-2201
Fax: 501-661-2165
ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Sincerely,



DPSQA/Office of Long Term Care
Survey & Certification Section

tf

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #AR00028818 was substantiated, all or in part, with deficiencies cited at N128, N142, N147, N188, N189 and N207. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on record review, the facility failed to ensure a physical restraint did not result in injury for 1 (Client #1) of 1 sampled client who received a head injury during a physical restraint. The findings are: 1. Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) report dated 8/30/22, documented, "...Date &	N 128		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 128	Continued From page 1	N 128		

[and] Time Actually Placed in Restraint; Date: 8/30/22; Time: 1425 [2:25 p.m.]; Date & Time Removed from Restraint: 8/30/22; Time: 1430 [2:40 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] 8/30/22; Time: 1420 [2:20 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give detailed justification for restraint: R [Resident] kicking, slapping and biting staff refusing to follow direction, could not calm down... Face To Face Assessment With RN [Registered Nurse] one Hour From Initiation of ESI Event... 5. Describe any complications resulting from intervention: Hematoma to back of her head. 6. List any revisions for the resident's plan of care, treatment, or services: Sent to ER [Emergency Room] [Hospital]...Description of injuries: R had silver dollar size hematoma on R [right] lower occipital lobe @ [at] base; Description of Treatment: APRN [Advanced Practice Registered Nurse] notified resident sent to [Hospital] for CT [computed tomography] scan of head..."

b. The Nursing Progress Note, dated 08/30/22 at 3:15 p.m. documented, "Resident [Client #1] was refusing outside. She refused all redirects. Nurse came out to talk to her. She became aggressive trying to bite, slap, and kick staff members. She was then placed in a restraint at 1425 [2:25 p.m.] and released from restraint at 1430 [2:30 p.m.]. Resident received a hematoma to the right side of the back of head. Resident given ice pack. Nurse assessed and per APRN orders, sent to [Hospital] for screening..."

c. The [Hospital] After Visit Summary dated 8/30/22 received from the Director of Risk Management on 9/12/22 at 10:52 a.m. documented, "...Reason for Visit: head injury, fall,

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N 128	Continued From page 2 blurred vision; Diagnoses: Injury of head, initial encounter; Concussion without loss of consciousness, initial encounter..." d. The Nursing Progress Note dated 08/30/22 at 7:15 p.m. documented, "Resident returned from [Hospital] at 1915 [7:15 p.m.] accompanied by [facility] staff members. Diagnosis: "Injury of head, initial encounter. Concussion without loss of consciousness, initial encounter..." 2. The facility Policy on Emergency Safety Interventions received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...II. Policy: ...Physical restraints and seclusions shall be utilized in a way that is humanitarian and caring and used in a way in which the resident's rights, dignity, well-being and safety are assured... Physical restraint or seclusion must not result in harm or injury to the resident...F. Serious Injury: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else..."	N 128		
N 142	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation	N 142		

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N 142	Continued From page 3 with staff. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time and failed to ensure a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #1) of 1 sampled client. The findings are: 1 Client #1 was admitted on 11/30/21 and had a diagnosis of Post Traumatic Stress Disorder. a. The Emergency Safety Intervention Justification Progress Note dated 7/29/22 documented, "...Date & [and] Time Restraint Order Received from MD [Medical Doctor]; Date: 07/29/22; Time: 1226 [12:26 p.m.] ...Date & Time Chemical Restraint Order Received from MD: Date: 07/29/22; Time: 1226... Medication Administered: Thorazine/Benadryl 50/50 mg [milligrams]..." 2. The Emergency Safety Intervention Justification Progress Note dated 8/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 8/3/22; Time: 1659 [4:59 p.m.]; Date & Time Removed from Restraint: Date: 8/3/22 Time: 1702 [5:02 p.m.]; Date & Time Restraint Order Received from MD: Date: 8/3/22 Time: 1625 [4:25 p.m.]; Type of Restraint Used: Standing 2 Person; resident Behavior: Please give detailed Justification for restraint: Resident was being aggressive toward staff kicking, hitting pinching nurses. APRN [Advanced Practice Registered Nurse] in nurse's station and R	N 142		

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N 142	Continued From page 4	N 142		

[Resident] was screaming through the window at nurse's station. R refusing to follow directives and ongoing aggression... Chemical Restraint: Date & Time Chemical Restraint Order Received from MD Date: 8/3/22 Time: 1635 [4:35 p.m.]; Date & Time Nurse Actually Administered Chemical Restraint Date: 8/3/22 Time: 1702 [5:02 p.m.]; Medication Administered: Benadryl/Thorazine Dosage 50/50... After trying to process c [with] resident without success and ongoing aggression to staff and nurses by kicking, hitting, biting and trying to take nurse's items on then chemical given at this time for safety..."

a. The physical restraint was ordered at 4:25 p.m. and the chemical restraint was ordered at 4:35 p.m. The client was placed in a physical restraint at 4:59 p.m., thirty four minutes after the physical restraint was ordered. The chemical restraint was administered at 5:02 p.m., three minutes after being placed in a physical restraint. The client was released after the chemical restraint was administered. The ESI (Emergency Safety Intervention) progress note documented, "...Resident Behavior at Time of Release: Calm-crying & remorseful..."

b. On 9/14/22, at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "On 8/3/22 the ESI report documented the order for a physical restraint was received at 4:25 p.m. and the order for a chemical restraint was received at 4: 35 p.m. Documentation indicated the client was placed in a physical restraint thirty four minutes after the order was received. The chemical restraint was administered three minutes after being placed in a physical restraint. Was that appropriate?" She stated, "No." The DON was asked, "What should have happened?" She

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stated, "The restraint should have been longer." The Director of Risk Management stated, "Should have done physical, given a little time to work and if it doesn't call the physician for further orders." The Surveyor asked the DON, "The ESI report documented the resident's behavior at the time of release was calm, crying, remorseful. The chemical was given at 1702 and she was released at 1702. Was that enough time for the chemical restraint to have taken effect?" She stated, "No." The Director of Risk Management stated, "She would still be released, but she wouldn't have been calm."

3. The Emergency Safety Intervention Justification Progress Note dated 9/10/22 documented, "...Date & Time Restraint Order Received from MD; Date: 9/10/12; Time: 0722 [7:22 a.m.] ...Date & Time Chemical Restraint Order Received from MD; Date: 9/10/22; Time 0722... Medication Administered: Benadryl 50 mg /Thorazine 50 mg..."

a. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "On 7/29/22 and 9/10/22 [Client #1] was placed in a physical restraint and then given a chemical restraint. The documentation on the ESI [Emergency Safety Intervention] report indicates the physical and chemical restraint orders were received at the same time. Should the orders for the physical and chemical restraint been given at the same time?" She stated, "No." The Surveyor asked the DON, "What is the procedure for obtaining orders for the chemical and physical restraints?" She stated, "The doctor should have been called after the restraint was not successful and de-escalating, then asked for further orders."

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N 147	Continued From page 6	N 147		
N 147	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(2) [Each order for restraint or seclusion must include] the date and time the order was obtained; and This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the documented times on the Physician's Order and the time on the Emergency Safety Intervention Report were the same for 1 (Client #1) of 1 sampled client who was placed in a physical restraint. The findings are: 1 Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) Justification Progress Note dated 7/29/22 documented, "...Date & [and] Time Actually Placed in Restraint: Date: 7/29/22; Time: 1225 [12:25 p.m.]; Date & Time Removed from Restraint: Date: 7/29/22; Time: 1232 [12:32 p.m.] Date & Time Restraint Order Received from MD [Medical Doctor]: 7/29/22; Time: 1226 (12:26 p.m.) ..." b. The Emergency Safety Intervention Physician's Order dated 7/29/22 documented, "...Date 07/29/22 Time: 1220 [12:20 p.m.] ..." The times documented on the Progress Note and the Physician's Order did not match. 2. On 9/14/22, at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "The time on the order for 7/29/22 is 1220 for the physical restraint,	N 147		

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N 147	Continued From page 7 the ESI report documented 1226. Should both the Physician's Order and ESI times match?" She stated, "Yes."	N 147		
N 188	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff involved in an emergency safety intervention were present at the client debriefing for 1 (Client #1) of 1 sampled clients. The findings are: 1. Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Justification Progress	N 188		

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N 188	Continued From page 8	N 188		

Note dated 8/3/22 documented, "...Type of Restraint Used: Standing 2 person..." The Staff Emergency Safety Intervention Debriefing, dated 8/3/22, documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it. LPN [Licensed Practical Nurse] #1, RN [Registered Nurse] #1, RN #2..." There were only two staff members listed as attending the Resident Emergency Safety Intervention Debriefing. RN #2 did not sign as attending the debriefing. There was no documentation of why RN #2 did not attend.

b. The Emergency Safety Justification Progress Note dated 9/10/22 documented, "...Type of Restraint: Standing 2 person..." The Staff Emergency Safety Intervention Debriefing dated 9/10/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it: BHA [Behavioral Health Assistant] #1, BHA #2, RN #3, RN #4..." There were only three staff members listed as attending the Resident Emergency Safety Intervention Debriefing. BHA #2 did not sign as attending the debriefing. There was no documentation of why BHA #2 did not attend.

2. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "Should all staff involved in the ESI [Emergency Safety Intervention] be at the debriefings?" She stated, "Yes."

3. The Emergency Safety Interventions policy and procedure received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...G. Physical Restraint and Seclusion Debriefing: 1. Staff involved in the emergency safety intervention as well as an

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N 188	Continued From page 9 appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (24) hours of the emergency safety intervention..."	N 188		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff involved in an Emergency Safety Intervention (ESI) were present at the staff debriefing for 1 (Client #1) of 1 sampled client. The findings are: 1. Client #1 was admitted on 11/30/21 and a had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Justification Progress Note dated 8/3/22 documented, "...Type of Restraint Used: Standing 2 person..." Staff Emergency Safety Intervention Debriefing, dated 8/3/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the	N 189		

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events that led to it. LPN [Licensed Practical Nurse] #1, RN [Registered Nurse] #1, RN #2..." There were three staff members listed as attending the Staff Emergency Safety Intervention Debriefing. RN #2 did not sign as attending the debriefing. There was no documentation of why RN #2 did not attend.

b. The Emergency Safety Justification Progress Note dated 9/10/22 documented, "...Type of Restraint: Standing 2 person..." A Staff Emergency Safety Intervention Debriefing dated 9/10/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it: BHA [Behavioral Health Assistant] #1, BHA #2, RN #3, RN #4..." There were only three staff members listed as attending the Staff Emergency Safety Intervention Debriefing. BHA #2 did not sign as attending the debriefing. There was no documentation of why BHA #2 did not attend.

2. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "Should all staff involved in the ESI be at the debriefings?" She stated, "Yes."

3. The Emergency Safety Interventions policy and procedure received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...G. Physical Restraint and Seclusion Debriefing: 1. Staff involved in the emergency safety intervention as well as an appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (24) hours of the emergency safety intervention..."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 207	Continued From page 11	N 207		
N 207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to report a serious occurrence to the appropriate agencies for 1 (Client #1) of 1 sampled client who received a head injury during a physical restraint. The findings are: 1 Client #1 was admitted on 11/30/21 and had a diagnosis of Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) report dated 8/30/22 documented, "...Date & [and]	N 207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	C 09/14/2022

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N 207	Continued From page 12	N 207		

Time Actually Placed in Restraint; Date: 8/30/22; Time: 1425 [2:25 p.m.]; Date & Time Removed from Restraint: 8/30/22; Time: 1430 [2:30 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] 8/30/22; Time: 1420 [2:20 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give detailed justification for restraint: R [Resident] kicking, slapping and biting staff refusing to follow direction, could not calm down... Face To Face Assessment With RN [Registered Nurse] one Hour From Initiation of ESI Event... 5. Describe any complications resulting from intervention: Hematoma to back of her head. 6. List any revisions for the resident's plan of care, treatment, or services: Sent to ER [Emergency Room] [Hospital]... Description of injuries: R had silver dollar size hematoma on R [right] lower occipital lobe @ [at] base; Description of Treatment: APRN [Advanced Practice Registered Nurse] notified, resident sent to [Hospital] for CT [computed tomography] scan of head..."

b. The Nursing Progress Note dated 08/30/22 at 3:15 p.m. documented, "Resident [Client #1] was refusing outside. She refused all redirects. Nurse came out to talk to her. She became aggressive trying to bite, slap, and kick staff members. She was then placed in a restraint at 1425 and released from restraint at 1430. Resident received a hematoma to the right side of the back of head. Resident given ice pack. Nurse assessed and per APRN orders, sent to [Hospital] for screening..."

c. The Nursing Progress Note dated 08/30/22 at 7:15 p.m. documented, "Resident returned from [Hospital] at 1915 [7:15 p.m.] accompanied by [facility] staff members. Diagnosis: "Injury of

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N 207	Continued From page 13	N 207		

head, initial encounter. Concussion without loss of consciousness, initial encounter..."

d. The [Hospital] After Visit Summary dated 8/30/22 received from the Director of Risk Management on 9/12/22 at 10:52 a.m. documented, "...Reason for Visit: head injury, fall, blurred vision; Diagnoses: Injury of head, initial encounter; Concussion without loss of consciousness, initial encounter..."

e. There was no documentation of a Serious Occurrence Report sent to the appropriate State agencies.

f. On 9/13/22 at 3:07 p.m., the Surveyor asked the Director of Nursing (DON), "Was the incident with [Client #1] reported to the [Agency]?" She stated, "No."

g. On 9/13/22 at 3:15 p.m., the Surveyor asked the Director of Risk Management, "Did you notify all the State agencies?" She stated, "We notified licensing, we did not notify [Agency]."

2. The facility Policy on Emergency Safety Interventions received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...F. Serious Injury: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else...G. Physical Restraint and Seclusion Debriefing: ...2. Serious Injury Occurrence: ...All serious injuries will be reported to the [Agency] and [Agency] by the end of the business day..."

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

October 6, 2022

Justin Hoover, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. Hoover:

On September 14, 2022, 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 October 14, 2022.

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:**Theresa Forrest at 501-320-6235 or email to theresa.forrest@dhs.arkansas.gov.**

Sincerely,

Rodney Ryser for
Theresa Forrest, Reviewer
DPSQA/Office of Long Term Care
Survey & Certification Section

tf

APOC
10/06/2022
RR

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

PRINTED: 09/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #AR00028818 was substantiated, all or in part, with deficiencies cited at N128, N142, N147, N188, N189 and N207. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000	Submission of this plan of correction is not an admission by the facility that all citations are true.	
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on record review, the facility failed to ensure a physical restraint did not result in injury for 1 (Client #1) of 1 sampled client who received a head injury during a physical restraint. The findings are: 1. Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) report dated 8/30/22, documented, "...Date &	N 128	N128 Step1: On 08/30/2022, Senior Leadership was notified about the injury that occurred during the restraint on 08/30/2022. Corrective Action measures were taken. On LPN's next scheduled work shift after the injury occurrence, Director of Nursing met with the LPN involved in the restraint to provide counseling and additional education regarding improving communication during he release of a restraint, this was done to ensure physical restraints do no result in injury. Step 2: by date of 09/20/2022, the Director of Nursing/Designee identified 50 ESIs in he past 30 days by record review to ensure he clients were not affected by checking to ensure physical restraints do not result in injury with any negative findings corrected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 10/6/22

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.

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N 128	Continued From page 1 [and] Time Actually Placed in Restraint; Date: 8/30/22; Time: 1425 [2:25 p.m.]; Date & Time Removed from Restraint: 8/30/22; Time: 1430 [2:40 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] 8/30/22; Time: 1420 [2:20 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give detailed justification for restraint: R [Resident] kicking, slapping and biting staff refusing to follow direction, could not calm down... Face To Face Assessment With RN [Registered Nurse] one Hour From Initiation of ESI Event... 5. Describe any complications resulting from intervention: Hematoma to back of her head. 6. List any revisions for the resident's plan of care, treatment, or services: Sent to ER [Emergency Room] [Hospital]...Description of injuries: R had silver dollar size hematoma on R [right] lower occipital lobe @ [at] base; Description of Treatment: APRN [Advanced Practice Registered Nurse] notified resident sent to [Hospital] for CT [computed tomography] scan of head..." b. The Nursing Progress Note, dated 08/30/22 at 3:15 p.m. documented, "Resident [Client #1] was refusing outside. She refused all redirects. Nurse came out to talk to her. She became aggressive trying to bite, slap, and kick staff members. She was then placed in a restraint at 1425 [2:25 p.m.] and released from restraint at 1430 [2:30 p.m.]. Resident received a hematoma to the right side of the back of head. Resident given ice pack. Nurse assessed and per APRN orders, sent to [Hospital] for screening..." c. The [Hospital] After Visit Summary dated 8/30/22 received from the Director of Risk Management on 9/12/22 at 10:52 a.m. documented, "...Reason for Visit: head injury, fall,	N 128	N128 (Cont.) Step 3: On 09/14/2022, The Director of Nursing provided written education to all nursing staff to ensure physical restraints fo not result in injury. Step 4: The Director of Nursing/Designee Will monitor to ensure physical restraints do 101 result in injury by checking all ESI documentation the next business day for 8 weeks or until compliance is verified by OLTC. Completion Date: 10/14/2022	

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N 128	Continued From page 2 blurred vision; Diagnoses: Injury of head, initial encounter; Concussion without loss of consciousness, initial encounter..." d. The Nursing Progress Note dated 08/30/22 at 7:15 p.m. documented, "Resident returned from [Hospital] at 1915 [7:15 p.m.] accompanied by [facility] staff members. Diagnosis: "Injury of head, initial encounter. Concussion without loss of consciousness, initial encounter..." 2. The facility Policy on Emergency Safety Interventions received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...II. Policy: ...Physical restraints and seclusions shall be utilized in a way that is humanitarian and caring and used in a way in which the resident's rights, dignity, well-being and safety are assured... Physical restraint or seclusion must not result in harm or injury to the resident...F. Serious Injury: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else..."	N 128		
N 142	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation	N 142	N142 Step 1: By 09/20/2022, the Director of Nursing checked to ensure A. order for physical and chemical restraints are not received at the same time B. physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint for Client #1 Step 2: By 09/20/2022 the DON/Designee identified 8 clients by record review to ensure they were not affected by checking to ensure A. order for physical and chemical restraint are not received at the same lime. B. physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint with any negative findings to be corrected.	

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N 142	Continued From page 3 with staff. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time and failed to ensure a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #1) of 1 sampled client. The findings are: 1 Client #1 was admitted on 11/30/21 and had a diagnosis of Post Traumatic Stress Disorder. a. The Emergency Safety Intervention Justification Progress Note dated 7/29/22 documented, "...Date & [and] Time Restraint Order Received from MD [Medical Doctor]; Date: 07/29/22; Time: 1226 [12:26 p.m.] ...Date & Time Chemical Restraint Order Received from MD: Date: 07/29/22; Time: 1226... Medication Administered: Thorazine/Benadryl 50/50 mg [milligrams]..." 2. The Emergency Safety Intervention Justification Progress Note dated 8/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 8/3/22; Time: 1659 [4:59 p.m.]; Date & Time Removed from Restraint: Date: 8/3/22 Time: 1702 [5:02 p.m.]; Date & Time Restraint Order Received from MD: Date: 8/3/22 Time: 1625 [4:25 p.m.]; Type of Restraint Used: Standing 2 Person; resident Behavior: Please give detailed Justification for restraint: Resident was being aggressive toward staff kicking, hitting pinching nurses. APRN [Advanced Practice Registered Nurse] in nurse's station and R	N 142	N142 (Cont.) Step 3: On 09/14/2022, the Director of Nursing provided written education to the nursing staff that A. order for physical and chemical restraints are not received at the same time B. physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint. Step 4: Auditing and Monitoring: the Director of Nursing/Designee will monitor: A. order for physical and chemical restraints are not received at the same time B. physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint the next business day for 8 weeks or until compliance is verified by QLTC. Completion Date: 10/14/2022	

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N 142	Continued From page 4 [Resident] was screaming through the window at nurse's station. R refusing to follow directives and ongoing aggression... Chemical Restraint: Date & Time Chemical Restraint Order Received from MD Date: 8/3/22 Time: 1635 [4:35 p.m.]; Date & Time Nurse Actually Administered Chemical Restraint Date: 8/3/22 Time: 1702 [5:02 p.m.]; Medication Administered: Benadryl/Thorazine Dosage 50/50... After trying to process c [with] resident without success and ongoing aggression to staff and nurses by kicking, hitting, biting and trying to take nurse's items on then chemical given at this time for safety..." a. The physical restraint was ordered at 4:25 p.m. and the chemical restraint was ordered at 4:35 p.m. The client was placed in a physical restraint at 4:59 p.m., thirty four minutes after the physical restraint was ordered. The chemical restraint was administered at 5:02 p.m., three minutes after being placed in a physical restraint. The client was released after the chemical restraint was administered. The ESI (Emergency Safety Intervention) progress note documented, "...Resident Behavior at Time of Release: Calm-crying & remorseful..." b. On 9/14/22, at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "On 8/3/22 the ESI report documented the order for a physical restraint was received at 4:25 p.m. and the order for a chemical restraint was received at 4: 35 p.m. Documentation indicated the client was placed in a physical restraint thirty four minutes after the order was received. The chemical restraint was administered three minutes after being placed in a physical restraint. Was that appropriate?" She stated, "No." The DON was asked, "What should have happened?" She	N 142		

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N 142	Continued From page 5 stated, "The restraint should have been longer." The Director of Risk Management stated, "Should have done physical, given a little time to work and if it doesn't call the physician for further orders." The Surveyor asked the DON, "The ESI report documented the resident's behavior at the time of release was calm, crying, remorseful. The chemical was given at 1702 and she was released at 1702. Was that enough time for the chemical restraint to have taken effect?" She stated, "No." The Director of Risk Management stated, "She would still be released, but she wouldn't have been calm." 3. The Emergency Safety Intervention Justification Progress Note dated 9/10/22 documented, "...Date & Time Restraint Order Received from MD; Date: 9/10/12; Time: 0722 [7:22 a.m.] ...Date & Time Chemical Restraint Order Received from MD; Date: 9/10/22; Time 0722... Medication Administered: Benadryl 50 mg /Thorazine 50 mg..." a. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "On 7/29/22 and 9/10/22 [Client #1] was placed in a physical restraint and then given a chemical restraint. The documentation on the ESI [Emergency Safety Intervention] report indicates the physical and chemical restraint orders were received at the same time. Should the orders for the physical and chemical restraint been given at the same time?" She stated, "No." The Surveyor asked the DON, "What is the procedure for obtaining orders for the chemical and physical restraints?" She stated, "The doctor should have been called after the restraint was not successful and de-escalating, then asked for further orders."	N 142		

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N 147	Continued From page 6 N 147 ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(2) [Each order for restraint or seclusion must include] the date and time the order was obtained; and This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the documented times on the Physician's Order and the time on the Emergency Safety Intervention Report were the same for 1 (Client #1) of 1 sampled client who was placed in a physical restraint. The findings are: 1 Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) Justification Progress Note dated 7/29/22 documented, "...Date & [and] Time Actually Placed in Restraint: Date: 7/29/22; Time: 1225 [12:25 p.m.]; Date & Time Removed from Restraint: Date: 7/29/22; Time: 1232 [12:32 p.m.] Date & Time Restraint Order Received from MD [Medical Doctor]: 7/29/22; Time: 1226 (12:26 p.m.) ..." b. The Emergency Safety Intervention Physician's Order dated 7/29/22 documented, "...Date 07/29/22 Time: 1220 [12:20 p.m.] ..." The times documented on the Progress Note and the Physician's Order did not match. 2. On 9/14/22, at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "The time on the order for 7/29/22 is 1220 for the physical restraint,	N 147 N 147	N147 Step 1: Director or Nursing had provided education to all nursing staff regarding our policies with ESI orders. including documented times match on: A. Physician's Order B. Emergency Safety Intervention Report. Step 2: By the date of 09/20/2022 the DON, reviewed 50 ESI packet for the last 30 days to ensure clients were not affected by checking to ensure documented times match on: A Physicians Order, B. Emergency Safety Intervention Report with any negative findings corrected. Step 3: On 09/14/2022, the Director of Nursing provided written education to nursing staff. The written education provided included ensuring documented times match on: A. Physician's Order B. Emergency Safety Intervention Report Step 4: Auditing and Monitoring: the Director of Nursing/Designee will monitor to ensure documented times match on: A. Physician's Order B. Emergency Safety Intervention Report by checking all ESI documentation the next business day for 8 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 147	Continued From page 7 the ESI report documented 1226. Should both the Physician's Order and ESI times match?" She stated, "Yes."	N 147	N147 (Cont.) or until compliance is verified by OLTC.	
N 188	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff involved in an emergency safety intervention were present at the client debriefing for 1 (Client #1) of 1 sampled clients. The findings are: 1. Client #1 was admitted on 11/30/21 and had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Justification Progress	N 188	Completion Date: 10/14/2022 N188 Step1: Director of Nursing provided written education to all nursing staff, to ensure all staff all staff involvement in an emergency safety intervention are present at the client debriefing. Step 2: By the date of 09/20/2022 The Director of Nursing reviewed 50 ESI packet or the last 30 days to ensure clients were not affected by checking to ensure all staff involvement in an emergency safety intervention are present at the client debriefing with any negative findings corrected. Step 3: Director of Nursing provided written education to all nursing staff, including the policy that all staff involved in an emergency safety intervention are present at the client debriefing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 188	Continued From page 8 Note dated 8/3/22 documented, "...Type of Restraint Used: Standing 2 person..." The Staff Emergency Safety Intervention Debriefing, dated 8/3/22, documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it. LPN [Licensed Practical Nurse] #1, RN [Registered Nurse] #1, RN #2..." There were only two staff members listed as attending the Resident Emergency Safety Intervention Debriefing. RN #2 did not sign as attending the debriefing. There was no documentation of why RN #2 did not attend. b. The Emergency Safety Justification Progress Note dated 9/10/22 documented, "...Type of Restraint: Standing 2 person..." The Staff Emergency Safety Intervention Debriefing dated 9/10/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it: BHA [Behavioral Health Assistant] #1, BHA #2, RN #3, RN #4..." There were only three staff members listed as attending the Resident Emergency Safety Intervention Debriefing. BHA #2 did not sign as attending the debriefing. There was no documentation of why BHA #2 did not attend. 2. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "Should all staff involved in the ESI [Emergency Safety Intervention] be at the debriefings?" She stated, "Yes." 3. The Emergency Safety Interventions policy and procedure received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...G. Physical Restraint and Seclusion Debriefing: 1. Staff involved in the emergency safety intervention as well as an	N 188	N188 (Cont.) Step 4: Director of Nursing or Designee will monitor to ensure all staff involvement is an emergency safety intervention are present at the client debriefing, this will be verified by all signatures of involved parties being present on the debriefing sheet. ESI packets will be monitored the next business :lay for 8 weeks or until compliance is verified with OL TC. Completion Date: 10/14/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 188	Continued From page 9 appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (24) hours of the emergency safety intervention..."	N 188	N189 Step1: On 09/14/2022, the Director of Nursing provided written education to all nursing staff to ensure all staff involved in an Emergency Safety Intervention (ESI) is present at the staff debriefing. Step 2: by the date of 09/20/2022, The DON did chart reviews of ESI packet for the last 30 days to ensure clients were not affected by checking to ensure all staff involved in an Emergency Safety Invention is present at the staff debriefing with any negative findings corrected. Step 3: On 09/14/2022, the Director of Nursing provided written education to all nurses. Education was provided to all nursing staff to ensure all staff involved in an Emergency Safety Intervention is present at staff debriefing.	
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff involved in an Emergency Safety Intervention (ESI) were present at the staff debriefing for 1 (Client #1) of 1 sampled client. The findings are: 1. Client #1 was admitted on 11/30/21 and a had diagnosis Post Traumatic Stress Disorder. a. The Emergency Safety Justification Progress Note dated 8/3/22 documented, "...Type of Restraint Used: Standing 2 person..." Staff Emergency Safety Intervention Debriefing, dated 8/3/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the	N 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	C 09/14/2022

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N 189	Continued From page 10 events that led to it. LPN [Licensed Practical Nurse] #1, RN [Registered Nurse] #1, RN #2..." There were three staff members listed as attending the Staff Emergency Safety Intervention Debriefing. RN #2 did not sign as attending the debriefing. There was no documentation of why RN #2 did not attend. b. The Emergency Safety Justification Progress Note dated 9/10/22 documented, "...Type of Restraint: Standing 2 person..." A Staff Emergency Safety Intervention Debriefing dated 9/10/22 documented, "...List staff/resident involved in the emergency safety intervention(s) and/or the events that led to it: BHA [Behavioral Health Assistant] #1, BHA #2, RN #3, RN #4..." There were only three staff members listed as attending the Staff Emergency Safety Intervention Debriefing. BHA #2 did not sign as attending the debriefing. There was no documentation of why BHA #2 did not attend. 2. On 9/14/22 at 11:37 a.m., the Surveyor asked the Director of Nursing (DON), "Should all staff involved in the ESI be at the debriefings?" She stated, "Yes." 3. The Emergency Safety Interventions policy and procedure received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...G. Physical Restraint and Seclusion Debriefing: 1. Staff involved in the emergency safety intervention as well as an appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (24) hours of the emergency safety intervention..."	N 189	N189 (Cont.) Step 4: Director of Nursing/Designee will monitor to ensure all staff involved in an ESI is present at the staff debriefing by checking all ESIs the next business day. ESI packets will be monitored for 8 weeks or until compliance is verified with OL TC. Completion Date: 10/14/2022	

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N 207 N 207	Continued From page 11 FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to report a serious occurrence to the appropriate agencies for 1 (Client #1) of 1 sampled client who received a head injury during a physical restraint. The findings are: 1 Client #1 was admitted on 11/30/21 and had a diagnosis of Post Traumatic Stress Disorder. a. The Emergency Safety Intervention (ESI) report dated 8/30/22 documented, "...Date & [and]	N 207 N 207	N207 Step 1: 09/15/2022 Director of PI/Risk Management and Director of Nursing reviewed facility reporting CFR(s): 483.374(b) and the facility emergency safety intervention policy to ensure reporting of a serious occurrence to the appropriate agencies. Step 2: Identification of all others with the potential to be affected: By the date of)9/23/2022, the Director of Nursing/ Designee identified 50 ESIs in the past 30 days by record review to ensure they were not affected by checking to ensure reporting of a serious occurrence to the appropriate agencies with any negative findings corrected. Step 3: 09/15/2022 Director of PI/Risk Management and Director of Nursing reviewed facility reporting CFR(s): 1!83.374(b) and the facility emergency safety intervention policy to ensure reporting of a serious occurrence to the appropriate agencies.	

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N 207	Continued From page 12 Time Actually Placed in Restraint; Date: 8/30/22; Time: 1425 [2:25 p.m.]; Date & Time Removed from Restraint: 8/30/22; Time: 1430 [2:30 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] 8/30/22; Time: 1420 [2:20 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give detailed justification for restraint: R [Resident] kicking, slapping and biting staff refusing to follow direction, could not calm down... Face To Face Assessment With RN [Registered Nurse] one Hour From Initiation of ESI Event... 5. Describe any complications resulting from intervention: Hematoma to back of her head. 6. List any revisions for the resident's plan of care, treatment, or services: Sent to ER [Emergency Room] [Hospital]... Description of injuries: R had silver dollar size hematoma on R [right] lower occipital lobe @ [at] base; Description of Treatment: APRN [Advanced Practice Registered Nurse] notified, resident sent to [Hospital] for CT [computed tomography] scan of head..." b. The Nursing Progress Note dated 08/30/22 at 3:15 p.m. documented, "Resident [Client #1] was refusing outside. She refused all redirects. Nurse came out to talk to her. She became aggressive trying to bite, slap, and kick staff members. She was then placed in a restraint at 1425 and released from restraint at 1430. Resident received a hematoma to the right side of the back of head. Resident given ice pack. Nurse assessed and per APRN orders, sent to [Hospital] for screening..." c. The Nursing Progress Note dated 08/30/22 at 7:15 p.m. documented, "Resident returned from [Hospital] at 1915 [7:15 p.m.] accompanied by [facility] staff members. Diagnosis: "Injury of	N 207	N207 (Cont.) Step 4: Auditing and Monitoring: The Director of Nursing/Designee will monitor to ensure reporting of a serious occurrence to the appropriate agencies by checking and documenting the next business day of a serious occurrence for 8 weeks or until compliance is verified by OL TC. Completion Date: 10/14/2022	

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N 207	Continued From page 13 head, initial encounter. Concussion without loss of consciousness, initial encounter..." d. The [Hospital] After Visit Summary dated 8/30/22 received from the Director of Risk Management on 9/12/22 at 10:52 a.m. documented, "...Reason for Visit: head injury, fall, blurred vision; Diagnoses: Injury of head, initial encounter; Concussion without loss of consciousness, initial encounter..." e. There was no documentation of a Serious Occurrence Report sent to the appropriate State agencies. f. On 9/13/22 at 3:07 p.m., the Surveyor asked the Director of Nursing (DON), "Was the incident with [Client #1] reported to the [Agency]?" She stated, "No." g. On 9/13/22 at 3:15 p.m., the Surveyor asked the Director of Risk Management, "Did you notify all the State agencies?" She stated, "We notified licensing, we did not notify [Agency]." 2. The facility Policy on Emergency Safety Interventions received from the Chief Executive Officers Administrative Assistant on 9/14/22 at 9:19 a.m. documented, "...F. Serious Injury: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else...G. Physical Restraint and Seclusion Debriefing: ...2. Serious Injury Occurrence: ...All serious injuries will be reported to the [Agency] and [Agency] by the end of the business day..."	N 207		

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

December 28, 2022

Justin Hoover, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Mr. Hoover:

On September 14, 2022, a Complaint survey was conducted at your facility by the Office of Long Term Care to determine compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program(s). This survey found your facility was not in substantial compliance with participation requirements. Please refer to our letter, dated September 22, 2022.

A revisit was conducted on December 14, 2022, and your facility was still not in substantial compliance with the following participation requirement(s):

N100 Use of Restraint and Seclusion
N130 Protection of Residents
N140 Orders for Use of Restraint or Seclusion
N142 Orders for Use of Restraint or Seclusion
N188 Post Intervention Debriefings

Plan of Correction (PoC)
A Plan of Correction (PoC) for the cited deficiencies must be submitted within 10 calendar days of receipt of this letter to:

Theresa Forrest, LPN, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6235**
email to Theresa.Forrest@dhs.arkansas.gov.

A revisit will be authorized after an acceptable PoC is received. A completion date for each

deficiency cited must be included. Your Plan of Correction must also include the following:

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. At the revisit, the quality assurance plan is reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit; and

5. 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 and Human Services 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 or the requirement for timely submission of an acceptable plan of correction. 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.

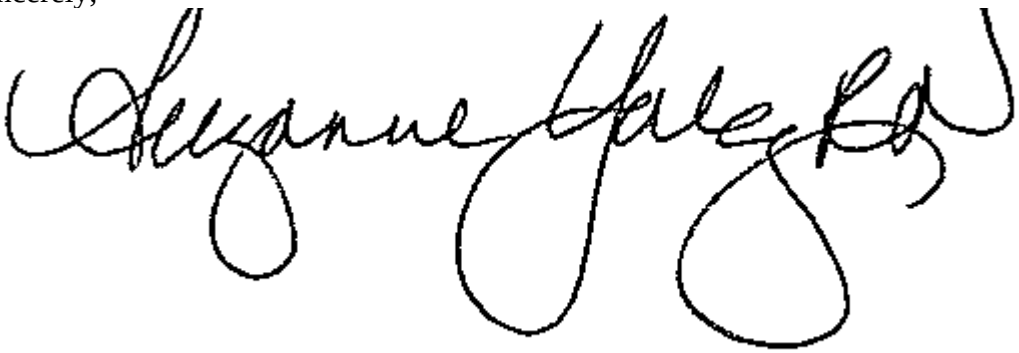
Please submit your request to:

IDR/IIDR Program Coordinator
Health Facilities Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Phone: 501-661-2201

Fax: 501-661-2165
ADH.HFS@Arkansas.gov

If you have any questions concerning this letter, please contact your reviewer.

Sincerely,



DPSQA/Office of Long Term Care
Survey & Certification Section

tf

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 000}	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	{N 000}		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to meet the Condition of Participation for the Use of Restraint and Seclusion at N100 as evidenced by the facility's failure to meet the Standard for Protection of Residents at N130 and the Standard of Orders for the Use of Restraint or Seclusion at N140 and N142. 1. The facility failed to meet the Standard for Protection of Residents at N130 as evidenced by the failure to ensure a client was released from a	N 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 100	Continued From page 1 physical restraint as soon as the emergency situation had resolved for 1 (Client #1) of 3 (Clients #1, #2 and #3) sampled clients and a chemical restraint was not administered after the emergency situation had ended for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients. 2. The facility failed to meet the Standard for Orders for the Use of Restraint or Seclusion at N142 as evidenced by the failure to ensure an order for a physical and chemical restraint was not received at the same time for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients, failure to ensure a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients and failure to ensure an order for seclusion was received for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients.	N 100		
N 130	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a client was released from a physical restraint as soon as the emergency situation had resolved for 1 (Client #1) of 3 (Clients #1, #2 and #3) sampled clients. The facility failed to ensure a chemical restraint was not administered after the emergency situation had ended for 1 (Client #2) of 3 (Clients #1, #2	N 130		

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N 130	Continued From page 2	N 130		

and #3) sampled clients. The findings are:

1. Client #1 was admitted on 7/19/22 and had diagnoses of Disruptive Mood Dysregulation Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, and Other Trauma and Stressor Related Disorder.

a. The Emergency Safety Intervention Justification Progress Note dated 11/17/22 documented, "...Date & [and] Time Actually Placed in Restraint; Date: 11/17/22; Time 1515 p.m. [3:15 pm]; Date & Time Removed from Restraint; Date 11/17/22; Time: 1517 [3:17 p.m.]; ...Type of Restraint Used; Sitting 1 person; ...While in restrain/seclusion, resident is to be monitored and assessed continuously then documented. First entry below should be upon initiation of restraint/seclusion and every 15 minutes thereafter... 1517 [3:17 p.m.] Observation/Behavior Code: (Cutting self/Attempting to cut) 5, (sitting/lying) 10; Care Code... (Physical Restraint) 2, (Processing event with resident) 6;... 1522 [3:22 p.m.] Observation/Behavior Code; (sitting/lying) 10; (Calm/Quiet/Willing to talk) 14 Care Code: 2, 6;... 1527 [3:27 p.m.] Observation/Behavior Code 10, 14 Care Code 2, 6... 1530 [3:30 p.m.] Observation/Behavior Code 14, (Exit Criterion met, no longer a danger), Care Code (Informed of Exit Criteria-No Harm) 9, (Released from containment) 10..." Documentation indicated Client #1 was calm, quiet and willing to talk for eight minutes before they were released from the physical restraint.

b. On 12/13/22 at 3:37 p.m., the Surveyor asked the Director of Nursing (DON), "It was documented that [Client #1] was in a physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	R-C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 130	Continued From page 3	N 130		

restraint for eight minutes when he was calm and quiet. Should he have been released earlier?" The DON stated, "Yes." The Surveyor asked, "When should he have been released?" The DON stated, "As soon as he was calm, at least by 1522 [3:22 p.m.]."

c. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Physical restraint or seclusion must not result in harm or injury to the resident and must be used only in the following situations: ...B. Until the emergency safety situation has ceased...When the resident has regained control, he or she will be removed from seclusion or physical restraint by the nurse..."

2. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation.

a. The Emergency Safety Intervention Justification Progress Note dated 12/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 12/3/22; Time: 1447 [2:47 p.m.]; Date & Time Removed from Restraint; Date: 12/3/22; Time: 1449 [2:47 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor]; Date: 12/3/22; Time: 1439 [2:39 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give justification for restraint: R [Resident] stripped all of his clothes off while taking a self-time out. He refused to put his clothes back on... He began tearing items up on the unit and was attempting to expose himself to everyone... Date & Time Emergency Medication Order Received from MD: Date:

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N 130	Continued From page 4	N 130		

12/3/22; Time: 1440 [2:40 p.m.]; Date & Time Nurse Actually Administered Emergency Medication; Date: 12/3/22; Time 1449 [2:49 p.m.]; Medication Administered: Thorazine/Benadryl 100 mg [milligrams]/50 mg...Resident Behavior: Please give detailed justification for Emergency Medication: Continuing to try to expose himself to everyone. He was stripping... He was tearing up items on the unit...While in restraint/seclusion, resident is to be monitored and assessed continuously then documented. First entry below should be upon initiation of restraint/seclusion and every 5 minutes thereafter... 1449 [2:49 p.m.], Observation/Behavior Code. (Calm/Quiet/Willing to talk) 14, (Exit criterion met, no longer a danger) 15; Care Code: (Obtained LIP (Licensed Physician) Authorization) 1, (Physical Restraint) 2, (Emergency Medication) 4, (Informed of Exit Criteria-No Harm) 9, (Released Containment) 10..." Documentation indicated the client was calm, quiet, and willing to talk at the time the chemical restraint was administered.

b. On 12/14/22 at 1:45 p.m., the Surveyor asked the DON was asked, "If a client is calm and quiet, should a chemical restraint be administered?" The DON stated, "No."

c. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Emergency medications are a crisis intervention used to resolve an emergency situation to contain severe, out of control behavior, exacerbation of psychosis which is likely to cause harm to the resident, other residents, or staff. Such medications are to be prescribed by the physician or approved physician extender in the lowest possible doses necessary to reduce anxiety and/or agitation

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N 130	Continued From page 5 exhibited by the resident..."	N 130		
N 140	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an order for seclusion was received for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients. The findings are: 1. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation. a. The Nursing Progress Note dated 12/03/22 at 2:30 p.m. documented, " ...Resident was given a chance to go into the timeout room because he wanted to take a self-timeout. Resident was allowed in the timeout room and stayed in there for about 30 minutes before he started becoming irritable and started to take off all of his clothes. Staff act quickly and remove the other resident outside to keep them from seeing the resident naked. Staff tried to stand in front of the time out room because the door had a mild function [malfunction] and would not lock and resident kept trying to come out to expose his naked	N 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 140	Continued From page 6 body... Staff redirected resident and told him that they would remove themselves from in front of the door if he put on his clothes and calm down...." There was no order for the seclusion found in the client's medical record. b. On 12/14/22 at 1:45 p.m., the Surveyor asked the Director of Nursing (DON), "A nursing progress note dated 12/3/22 at 1430 documented [Client #3] was in the timeout room and staff stood in front of the timeout room because the door had a malfunction and would not lock. Is standing in front of the door of the timeout room and not allowing a client to leave considered seclusion?" The DON stated, "It is a seclusion because we are still blocking it." The Surveyor asked, "Should there have been a physician's order for the seclusion?" The DON stated, "There should have been." c. The facility's Emergency Safety Intervention policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...A written order from the physician is required for the use of a physical restraint, emergency medication, or seclusion..."	N 140		
{N 142}	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.	{N 142}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	R-C 12/14/2022

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{N 142}	Continued From page 7	{N 142}		

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time for 1 (Client #2) sampled client and a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients. The findings are:

1. Client #2 was admitted on 5/3/22 and had diagnoses of Disruptive Mood Dysregulation Disorder and Borderline Intellectual Functioning.

a. The Emergency Safety Intervention Justification Progress Note dated 10/30/22 documented, "...Date & [and] Time Restraint Order Received from MD [Medical Doctor]; Date: 10/30; Time: 1940 [7:40 p.m.]... Date & Time Emergency Medication Order Received from MD; Date: 10-30-22; Time: 1940...Medication Administered: Thorazine/Benadryl 100 mg [milligrams]/50 mg..."

b. The Emergency Safety Intervention Physician's Orders dated 10/30/22 documented, "...Date: 10/30/22; Time 1940 [7:40 pm]; Restrain resident for up to 30 minutes for aggression toward staff... Date: 10/30/22; Time: 1940; Give Resident 100 mg Thorazine/50 mg Benadryl X [times] one dose now for increased behavioral dyscontrol..."

c. On 12/13/22 at 3:42 p.m., the Surveyor asked the Director of Nursing (DON), "[Client #2] has an order for a physical and chemical restraint. Documentation shows both were ordered at the same time. Should they have been ordered at the

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{N 142}	Continued From page 8	{N 142}		

same time?" The DON stated, "They should not have." The Surveyor asked, "What should have been done?" The DON stated, "The restraint, if it was given at 1940 and they decided they couldn't hold him anymore, that is when they should have called the doctor for continuing orders."

2. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation.

a. The Emergency Safety Intervention Justification Progress Note dated 12/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 12/3/22; Time: 1447 [2:47 p.m.]; Date & Time Removed from Restraint; Date: 12/3/22; Time: 1449 [2:49 p.m.]; Date & Time Restraint Order Received from MD (Medical Doctor); Date: 12/3/22; Time: 1439 [2:39 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give justification for restraint: (Resident) R stripped all of his clothes off while taking a self-time out. He refused to put his clothes back on...He began tearing items up on the unit and was attempting to expose himself to everyone...Date & Time Emergency Medication Order Received from MD: Date: 12/3/22; Time: 1440 [2:40 p.m.]; Date & Time Nurse Actually Administered Emergency Medication; Date: 12/3/22; Time 1449; Medication Administered: Thorazine/Benadryl 100 mg/50 mg...Resident Behavior: Please give detailed justification for Emergency Medication: Continuing to try to expose himself to everyone. He was stripping....He was tearing up items on the unit..." Documentation indicated the client was in a physical restraint for only 2 minutes before being administered the chemical restraint. The physical

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{N 142}	Continued From page 9	{N 142}		

restraint was not utilized long enough to determine if the client could calm before the chemical was administered. The order for the physical restraint was received one minute before the order for the chemical restraint was received.

b. On 12/14/22 at 1:45 p.m., the Surveyor asked the DON, "On 12/3/22, [Client #3] was put in a physical restraint at 1447 and a chemical restraint was administered at 1449 two minutes later. Should there have been more time between the physical restraint and the administration of the chemical?" The DON stated, "It does not look like there was time between the restraint and the chemical. It looks like they restrained him to give him the chemical. There should have been more time." The Surveyor asked, "A physician's order documented at 1439 the order was given for a physical restraint and at 1440 a chemical restraint was ordered. Was this an appropriate order?" The DON stated, "No, not enough time between interventions."

3. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...It shall be the policy of [facility] that each resident has the right to be free from physical restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation...The use of physical restraint and seclusion shall always be implemented utilizing the least restrictive measures to prevent a resident from injuring self or others in an emergency situation...The physician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based upon consultation with staff..."

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{N 188}	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff who participated in a physical restraint were present at the client debriefing for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients. The findings are: 1. Client #2 was admitted on 5/3/22 and had diagnoses Disruptive Mood Dysregulation Disorder and Borderline Intellectual Functioning. a. The Emergency Safety Intervention Justification Progress Note dated 10/30/22 documented, " ...Staff initiating Restraint: [Patient Supported Supervisor (PSS #1)]; Date (and) & Time Actually Placed in Restraint Date: 10/30/22	{N 188}		

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{N 188}	Continued From page 11 Time: 1943 [7:43 p.m.]; Date & Time Removed from Restraint Date: 10/30/22 Time: 1949 [7:49 p.m.]... Type of Restraint Used: Sitting Standing 2 person..." PSS #1's name was not listed as having attended the client debriefing on 10/30/22 at 8:30 p.m. b. On 12/13/22 at 3:42 p.m., the Surveyor asked the Director of Nursing (DON), "On the client debriefing, I did not see where [PSS #1] was present. Do you see any documentation of where he was present at the client debriefing?" The DON stated, "No, I don't see where he signed anything." c. The Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Staff involved in the emergency safety intervention as well as an appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (240 hours of the emergency safety intervention..."	{N 188}		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

January 13, 2023

Justin Hoover, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. Hoover:

On December 14, 2022, we conducted a Complaint Investigation, Follow-Up/Revisit 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 January 13, 2023.

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: **Theresa Forrest at 501-320-6235 or email to Theresa.Forrest@dhs.arkansas.gov.**

Sincerely,

David E. Miller for

Theresa Forrest, Reviewer
DPSQA/Office of Long Term Care
Survey & Certification Section

tf

APOC
01/13/2023
DM

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

PRINTED: 12/28/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 000}	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	{N 000}	Submission of this plan of correction is not an admission by the facility that all citations are true. N100 Step 1: by date of 12/20/2022, the Director of Nursing/designee identified 48 ESIs in the past 30 days by record review to ensure the clients were not affected. Records reviewed were checked to ensure emergency safety interventions were not administered after the emergency situation had resolved. Related to client #1: staff was reeducated about releasing a client from physical restraint as soon as emergency has resolved. Related to client #2: staff involved was reeducated about not administering a chemical restraint after the emergency had ended. Related to Client #3: an order for the seclusion was not obtained. The staff involved was reeducated about ensuring they obtain orders for all emergency safety interventions. The staff was also reeducated about what constitutes a seclusion including that having the door open but blocking a resident's exit still counts as a seclusion.	
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to meet the Condition of Participation for the Use of Restraint and Seclusion at N100 as evidenced by the facility's failure to meet the Standard for Protection of Residents at N130 and the Standard of Orders for the Use of Restraint or Seclusion at N140 and N142. 1. The facility failed to meet the Standard for Protection of Residents at N130 as evidenced by the failure to ensure a client was released from a	N 100	Step 2: by date of 12/20/2022 the Director of Nursing/designee identified 11 clients by record review to ensure they were not affected by checking to ensure Emergency Safety Interventions were not administered after the emergency situation had resolved.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 1/10/2023

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.

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N 100	Continued From page 1 physical restraint as soon as the emergency situation had resolved for 1 (Client #1) of 3 (Clients #1, #2 and #3) sampled clients and a chemical restraint was not administered after the emergency situation had ended for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients. 2. The facility failed to meet the Standard for Orders for the Use of Restraint or Seclusion at N142 as evidenced by the failure to ensure an order for a physical and chemical restraint was not received at the same time for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients, failure to ensure a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients and failure to ensure an order for seclusion was received for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients.	N 100	(N100 continued) Step 3: On 12/15/2022 Director of Nursing met with the RN involved in the Restraint to provide counseling and additional education regarding improving documentation to ensure ESI documentation reflects an accurate depiction of the ESI event. By 01/09/2023 the director of Nursing provided written and/or verbal education to the nursing staff regarding 1) ensuring that clients are released from physical restraint as soon as emergency is resolved, 2) ensuring that clients are not administered a chemical restraint after the emergency has ended and 3) ensuring that there is an order for client seclusion. Step 4 Auditing & Monitoring: The Director of Nursing/designee will monitor to ensure Emergency Safety Interventions were not administered after the emergency situation had resolved and that ESI documentation reflects an accurate depiction of the ESI Event. Monitoring will continue for a period of eight weeks or until the Office of Long Term Care has verified compliance. Completion Date: 01/13/2023	
N 130	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a client was released from a physical restraint as soon as the emergency situation had resolved for 1 (Client #1) of 3 (Clients #1, #2 and #3) sampled clients. The facility failed to ensure a chemical restraint was not administered after the emergency situation had ended for 1 (Client #2) of 3 (Clients #1, #2	N 130	N130: Step 1: by date of 12/20/2022, the Director of Nursing/designee identified 48 ESIs in the past 30 days by record review to ensure the clients were not affected. Records reviewed were checked to ensure emergency safety interventions were not administered after the emergency situation had resolved and that the documentation accurately reflected the ESI event. Related to Client #1, staff involved were reeducated about releasing a client from physical restraint as soon as the emergency has resolved. Related to Client #2 staff involved was reeducated on proper documentation to ensure that it reflects an accurate demonstration that we are not administering a chemical restraint after the emergency has ended.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING _____ B. WING _____	R-C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 130	Continued From page 2 and #3) sampled clients. The findings are: 1. Client #1 was admitted on 7/19/22 and had diagnoses of Disruptive Mood Dysregulation Disorder, Depressive Disorder, Attention Deficit Hyperactivity Disorder, and Other Trauma and Stressor Related Disorder. a. The Emergency Safety Intervention Justification Progress Note dated 11/17/22 documented, "...Date & [and] Time Actually Placed in Restraint; Date: 11/17/22; Time 1515 p.m. [3:15 pm]; Date & Time Removed from Restraint; Date 11/17/22; Time: 1517 [3:17 p.m.]; ...Type of Restraint Used; Sitting 1 person; ...While in restrain/seclusion, resident is to be monitored and assessed continuously then documented. First entry below should be upon initiation of restraint/seclusion and every 15 minutes thereafter... 1517 [3:17 p.m.] Observation/Behavior Code: (Cutting self/Attempting to cut) 5, (sitting/lying) 10; Care Code... (Physical Restraint) 2, (Processing event with resident) 6;... 1522 [3:22 p.m.] Observation/Behavior Code; (sitting/lying) 10; (Calm/Quiet/Willing to talk) 14 Care Code: 2, 6;... 1527 [3:27 p.m.] Observation/Behavior Code 10, 14 Care Code 2, 6... 1530 [3:30 p.m.] Observation/Behavior Code 14, (Exit Criterion met, no longer a danger), Care Code (Informed of Exit Criteria-No Harm) 9, (Released from containment) 10..." Documentation indicated Client #1 was calm, quiet and willing to talk for eight minutes before they were released from the physical restraint. b. On 12/13/22 at 3:37 p.m., the Surveyor asked the Director of Nursing (DON), "It was documented that [Client #1] was in a physical	N 130	(N130 continued) Step 2: by date of 12/20/2022 the Director of Nursing/designee identified 11 clients by record review to ensure they were not affected. Client files were checked to ensure Emergency Safety Interventions were not administered after the emergency situation had resolved and that the documentation accurately reflected the ESI event. Step 3: On 12/15/2022 Director of Nursing met with the nurses involved in the emergency safety interventions to provide counseling and additional education regarding improving documentation to ensure ESI documentation reflects an accurate depiction of the ESI event. By 01/09/2023 the director of Nursing provided written and/or verbal education to the nursing staff about 1) ensuring that clients are released from physical restraint as soon as the emergency situation has resolved and 2) ensuring that documentation accurately reflects that we are not administering a chemical restraint after the emergency has ended. Step 4 Auditing & Monitoring: The Director of Nursing/designee will monitor to ensure Emergency Safety Interventions were not administered after the emergency situation had resolved and that ESI documentation reflects an accurate depiction of the ESI Event. Monitoring will continue for a period of eight weeks or until the Office of Long Term Care has verified compliance. Completion Date: 01/13/2023	

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N 130	Continued From page 3 restraint for eight minutes when he was calm and quiet. Should he have been released earlier?" The DON stated, "Yes." The Surveyor asked, "When should he have been released?" The DON stated, "As soon as he was calm, at least by 1522 [3:22 p.m.]." c. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Physical restraint or seclusion must not result in harm or injury to the resident and must be used only in the following situations: ...B. Until the emergency safety situation has ceased...When the resident has regained control, he or she will be removed from seclusion or physical restraint by the nurse..." 2. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation. a. The Emergency Safety Intervention Justification Progress Note dated 12/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 12/3/22; Time: 1447 [2:47 p.m.]; Date & Time Removed from Restraint; Date: 12/3/22; Time: 1449 [2:47 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor]; Date: 12/3/22; Time: 1439 [2:39 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give justification for restraint: R [Resident] stripped all of his clothes off while taking a self-time out. He refused to put his clothes back on... He began tearing items up on the unit and was attempting to expose himself to everyone... Date & Time Emergency Medication Order Received from MD: Date:	N 130		

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N 130	Continued From page 4 12/3/22; Time: 1440 [2:40 p.m.]; Date & Time Nurse Actually Administered Emergency Medication; Date: 12/3/22; Time 1449 [2:49 p.m.]; Medication Administered: Thorazine/Benadryl 100 mg [milligrams]/50 mg...Resident Behavior: Please give detailed justification for Emergency Medication: Continuing to try to expose himself to everyone. He was stripping... He was tearing up items on the unit...While in restraint/seclusion, resident is to be monitored and assessed continuously then documented. First entry below should be upon initiation of restraint/seclusion and every 5 minutes thereafter... 1449 [2:49 p.m.], Observation/Behavior Code. (Calm/Quiet/Willing to talk) 14, (Exit criterion met, no longer a danger) 15; Care Code: (Obtained LIP (Licensed Physician) Authorization) 1, (Physical Restraint) 2, (Emergency Medication) 4, (Informed of Exit Criteria-No Harm) 9, (Released Containment) 10..." Documentation indicated the client was calm, quiet, and willing to talk at the time the chemical restraint was administered. b. On 12/14/22 at 1:45 p.m., the Surveyor asked the DON was asked, "If a client is calm and quiet, should a chemical restraint be administered?" The DON stated, "No." c. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Emergency medications are a crisis intervention used to resolve an emergency situation to contain severe, out of control behavior, exacerbation of psychosis which is likely to cause harm to the resident, other residents, or staff. Such medications are to be prescribed by the physician or approved physician extender in the lowest possible doses necessary to reduce anxiety and/or agitation	N 130		

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N 130	Continued From page 5 exhibited by the resident..."	N 130	N140	
N 140	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an order for seclusion was received for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients. The findings are: 1. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation. a. The Nursing Progress Note dated 12/03/22 at 2:30 p.m. documented, " ...Resident was given a chance to go into the timeout room because he wanted to take a self-timeout. Resident was allowed in the timeout room and stayed in there for about 30 minutes before he started becoming irritable and started to take off all of his clothes. Staff act quickly and remove the other resident outside to keep them from seeing the resident naked. Staff tried to stand in front of the time out room because the door had a mild function [malfunction] and would not lock and resident kept trying to come out to expose his naked	N 140	Step 1: by date of 12/20/2022, the Director of Nursing/designee identified 48 ESIs in the past 30 days by record review to ensure the clients were not affected. Records reviewed were checked to ensure each emergency safety intervention had a corresponding physician's order. An order for the seclusion was not obtained. The staff involved was reeducated about ensuring they obtain orders for all emergency safety interventions. The staff was also reeducated about what constitutes a seclusion including that having the door open but blocking a resident's exit still counts as a seclusion. Step 2: by date of 12/20/2022 the Director of Nursing/designee identified 11 clients by record review to ensure they were not affected by checking to ensure Emergency Safety Interventions had a corresponding physician's order. Step 3: On 12/15/2022 Director of Nursing met with the individual nurses involved emergency safety interventions to provide counseling and additional education to ensure each emergency safety intervention receives a physician's order. By 01/09/2023 the Director of Nursing provided written and/or verbal education to the nursing staff about obtaining physician orders for emergency safety interventions. Step 4 Auditing & Monitoring: The Director of Nursing/designee will monitor to ensure each emergency safety intervention has a corresponding physician's order. Monitoring will continue for a period of eight weeks or until the Office of Long Term Care has verified compliance. Completion date: 01/13/2023	

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N 140	Continued From page 6 body... Staff redirected resident and told him that they would remove themselves from in front of the door if he put on his clothes and calm down...." There was no order for the seclusion found in the client's medical record. b. On 12/14/22 at 1:45 p.m., the Surveyor asked the Director of Nursing (DON), "A nursing progress note dated 12/3/22 at 1430 documented [Client #3] was in the timeout room and staff stood in front of the timeout room because the door had a malfunction and would not lock. Is standing in front of the door of the timeout room and not allowing a client to leave considered seclusion?" The DON stated, "It is a seclusion because we are still blocking it." The Surveyor asked, "Should there have been a physician's order for the seclusion?" The DON stated, "There should have been." c. The facility's Emergency Safety Intervention policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...A written order from the physician is required for the use of a physical restraint, emergency medication, or seclusion..."	N 140		
{N 142}	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.	{N 142}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 142}	Continued From page 7 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time for 1 (Client #2) sampled client and a physical restraint was utilized long enough to determine its effectiveness before the administration of a chemical restraint for 1 (Client #3) of 3 (Clients #1, #2 and #3) sampled clients. The findings are: 1. Client #2 was admitted on 5/3/22 and had diagnoses of Disruptive Mood Dysregulation Disorder and Borderline Intellectual Functioning. a. The Emergency Safety Intervention Justification Progress Note dated 10/30/22 documented, "...Date & [and] Time Restraint Order Received from MD [Medical Doctor]; Date: 10/30; Time: 1940 [7:40 p.m.]... Date & Time Emergency Medication Order Received from MD; Date: 10-30-22; Time: 1940...Medication Administered: Thorazine/Benadryl 100 mg [milligrams]/50 mg..." b. The Emergency Safety Intervention Physician's Orders dated 10/30/22 documented, "...Date: 10/30/22; Time 1940 [7:40 pm]; Restrain resident for up to 30 minutes for aggression toward staff... Date: 10/30/22; Time: 1940; Give Resident 100 mg Thorazine/50 mg Benadryl X [times] one dose now for increased behavioral dyscontrol..." c. On 12/13/22 at 3:42 p.m., the Surveyor asked the Director of Nursing (DON), "[Client #2] has an order for a physical and chemical restraint. Documentation shows both were ordered at the same time. Should they have been ordered at the	{N 142}	N142 Step 1: By 12/20/2022, the Director of Nursing/ designee reviewed 48 ESI packets including the packets for clients #2 and #3 to ensure an order for physical and chemical restraint are not received at the same time and the physical restraint is utilized long enough to determine its effectiveness before administration of a chemical restraint. Step 2: By 12/20/2022, the Director of Nursing/ designee identified 11 clients by record review to ensure they were not affected by checking to ensure that an order for physical and chemical restraint are not received at the same time and that physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint with any negative findings to be corrected. Step 3: On 12/29/2022 the Director of Nursing provided the nurse involved in the emergency safety intervention with individual counseling and education about ensuring that orders for physical and chemical restraints are not received at the same time and that physical restraint is utilized long enough to determine its effectiveness before a chemical restraint is administered. On 01/09/2023 The Director of Nursing provided written education to the nursing staff that orders for physical and chemical restraint are not received at the same time and physical restraint is utilized long enough to determine its effectiveness before administration of a chemical restraint. Step 4 Auditing & Monitoring: The Director of Nursing/designee will monitor to ensure orders for physical and chemical restraints are not received at the same time and that physical restraint is utilized long enough to determine its effectiveness before the administration of a chemical restraint the next business day. Monitoring will continue for a period of eight weeks or until the Office of Long Term Care has verified compliance. Completion date: 01/13/2023	

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{N 142}	Continued From page 8 same time?" The DON stated, "They should not have." The Surveyor asked, "What should have been done?" The DON stated, "The restraint, if it was given at 1940 and they decided they couldn't hold him anymore, that is when they should have called the doctor for continuing orders." 2. Client #3 was admitted on 1/7/22 and had diagnoses of Major Depressive Disorder, Recurrent, Severe and Attention Deficit Hyperactivity Disorder, Combined Presentation. a. The Emergency Safety Intervention Justification Progress Note dated 12/3/22 documented, "...Date & Time Actually Placed in Restraint; Date: 12/3/22; Time: 1447 [2:47 p.m.]; Date & Time Removed from Restraint; Date: 12/3/22; Time: 1449 [2:49 p.m.]; Date & Time Restraint Order Received from MD (Medical Doctor); Date: 12/3/22; Time: 1439 [2:39 p.m.]; Type of Restraint Used: Standing 2 person; Resident Behavior: Please give justification for restraint: (Resident) R stripped all of his clothes off while taking a self-time out. He refused to put his clothes back on...He began tearing items up on the unit and was attempting to expose himself to everyone...Date & Time Emergency Medication Order Received from MD: Date: 12/3/22; Time: 1440 [2:40 p.m.]; Date & Time Nurse Actually Administered Emergency Medication; Date: 12/3/22; Time 1449; Medication Administered: Thorazine/Benadryl 100 mg/50 mg...Resident Behavior: Please give detailed justification for Emergency Medication: Continuing to try to expose himself to everyone. He was stripping....He was tearing up items on the unit..." Documentation indicated the client was in a physical restraint for only 2 minutes before being administered the chemical restraint. The physical	{N 142}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 142}	Continued From page 9 restraint was not utilized long enough to determine if the client could calm before the chemical was administered. The order for the physical restraint was received one minute before the order for the chemical restraint was received. b. On 12/14/22 at 1:45 p.m., the Surveyor asked the DON, "On 12/3/22, [Client #3] was put in a physical restraint at 1447 and a chemical restraint was administered at 1449 two minutes later. Should there have been more time between the physical restraint and the administration of the chemical?" The DON stated, "It does not look like there was time between the restraint and the chemical. It looks like they restrained him to give him the chemical. There should have been more time." The Surveyor asked, "A physician's order documented at 1439 the order was given for a physical restraint and at 1440 a chemical restraint was ordered. Was this an appropriate order?" The DON stated, "No, not enough time between interventions." 3. The facility's Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...It shall be the policy of [facility] that each resident has the right to be free from physical restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation...The use of physical restraint and seclusion shall always be implemented utilizing the least restrictive measures to prevent a resident from injuring self or others in an emergency situation...The physician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based upon consultation with staff..."	{N 142}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 188}	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff who participated in a physical restraint were present at the client debriefing for 1 (Client #2) of 3 (Clients #1, #2 and #3) sampled clients. The findings are: 1. Client #2 was admitted on 5/3/22 and had diagnoses Disruptive Mood Dysregulation Disorder and Borderline Intellectual Functioning. a. The Emergency Safety Intervention Justification Progress Note dated 10/30/22 documented, " ...Staff initiating Restraint: [Patient Supported Supervisor (PSS #1)]; Date (and) & Time Actually Placed in Restraint Date: 10/30/22	{N 188}	N188 Step 1: On 01/09/2023, Director of Nursing provided written education to all nursing staff including patient support supervisors, to ensure all staff involved in an emergency safety intervention are present at the client debriefing. Step 2: By the date of 12/20/2022, the Director of Nursing reviewed 48 ESI packets for 11 clients for the last 30 days to ensure clients were not affected by checking to ensure all staff involved in an emergency safety intervention were present at the client debriefing with any negative findings corrected. Step 3: On 01/09/2023, Director of Nursing provided written education to all nursing staff, including the policy that all staff involved in an emergency safety intervention are present at the client debriefing. Step 4: Director of Nursing/designee will monitor to ensure all staff involved in an emergency safety intervention are present at the client debriefing. This will be verified by all signatures of involved parties being present on the debriefing sheet. ESI Packets will be monitored the next business day for eight weeks or until compliance is verified by the Office of Long Term Care. Completion date: 01/13/2023	

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PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 188}	Continued From page 11 Time: 1943 [7:43 p.m.]; Date & Time Removed from Restraint Date: 10/30/22 Time: 1949 [7:49 p.m.]... Type of Restraint Used: Sitting Standing 2 person..." PSS #1's name was not listed as having attended the client debriefing on 10/30/22 at 8:30 p.m. b. On 12/13/22 at 3:42 p.m., the Surveyor asked the Director of Nursing (DON), "On the client debriefing, I did not see where [PSS #1] was present. Do you see any documentation of where he was present at the client debriefing?" The DON stated, "No, I don't see where he signed anything." c. The Emergency Safety Interventions policy received from the Risk Manager on 12/14/22 at 3:04 p.m. documented, "...Staff involved in the emergency safety intervention as well as an appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (240 hours of the emergency safety intervention..."	{N 188}		