Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Date of Incident: 10/15/2023

Date Received by DCCECE: 10/19/2023

Facility Name: Little Creek Behavioral Health

Facility Number: 255

Incident Type: Dual

Report Description: On 10.18.23 at 1730, A DHS investigator conducted a wellness check on pt [redacted]e, DOB: [redacted], [redacted] custody [redacted]-caseworker. [redacted] had a medication error on 10.15.23 when she took another resident's medication. [redacted] was monitored throughout the night, and all vitals were within normal limits. No injury was noted. Pt given [redacted]

Interim Action Narrative:

Maltreatment Narrative: [redacted]. It was reported that on Sunday 10/15/2023 at about 8pm, resident was given the wrong medications. The medications given to her were [redacted]. These medications are not currently or have they ever been prescribed to the resident. The out of state guardian was allegedly notified on 10/16/2023 and the guardian requested that the resident be seen by a physician outside of the facility for follow up. The facility reportedly denied this request. The report stated the resident had felt ?high? after taking the medications and the facility reported they monitored her vitals which remained within normal limits.

Licensing Narrative: Licensing received report 10/19/23 that a [redacted] report had been made as follows: On 10.18.23 at 1730, A DHS investigator conducted a wellness check on pt [redacted], DOB: [redacted] custody [redacted]-caseworker. [redacted] had a medication error on 10.15.23 when she took another resident's medication. [redacted] was monitored throughout the night, and all vitals were within normal limits. No injury was noted. Pt given [redacted] Licensing obtained permission 10/19/23 via email from DCFS Investigator DeShunte' Pointer for licensing to contact the facility. 10/19/23-Little Creed DON Nedra-Allen Jones provided additional information 10/19/23 that the LPN who administered the incorrect medication was [redacted] and that roughly 20 minutes after administration it was discovered that client had taken the wrong medication. In response to wrong medication being administered, Psychiatric NP called and DON notified. Orders given for monitoring. Nursing notes, collateral contact correspondence between facility and guardian and MAR for client [redacted] provided to licensing via email.

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521 Visit Compliance Report

Licensee: Little Creek Behavioral Health

Facility Number: 255

Licensee Address: 161 SKUNK HOLLOW
CONWAY AR 72032

Licensing Specialist: Clayton DeBoer

Person In Charge: Jlynn Price

Record Visit Date: 11/30/2023

Home Visit Date: 11/30/2023

Purpose of Visit: Revisit Complaint

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Number: 900.907.2

Regulation Description: Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

Finding Description: The nurse did not provide the level of supervision necessary to ensure the safety of a resident during a medication pass when she failed to follow the agency's two patient identifier requirement. This led to a resident receiving the wrong medications.

Action Due Date:

Action Due Description: The nurse was retrained on the medication pass procedures and received disciplinary coaching.

Comply Date:

Action Due Description: The nurse was retrained on the medication pass procedures and received disciplinary coaching.

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing complaint Case#016911 is unfounded.

Amended to include T/A provided- 907.2-Staff shall provide the level of care and supervision to ensure the safety and well-being of the residents. The facility took action byretraining the nurse on the medication pass procedure and providing her disciplinary coaching due to her failure to use the two-patient identifier required by the agency.

Provider Comments:

CCL Staff Signature : Date: 1/24/2024

Provider Signature : Date: 1/24/2024