DHS Placement and Residential Licensing Unit
Office of the Secretary
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

Case Number: 018781

Date of Incident: 1/18/2024

Date Received by PRLU: 1/28/2024

Facility Name: Piney Ridge Treatment Center

Facility Number: 203

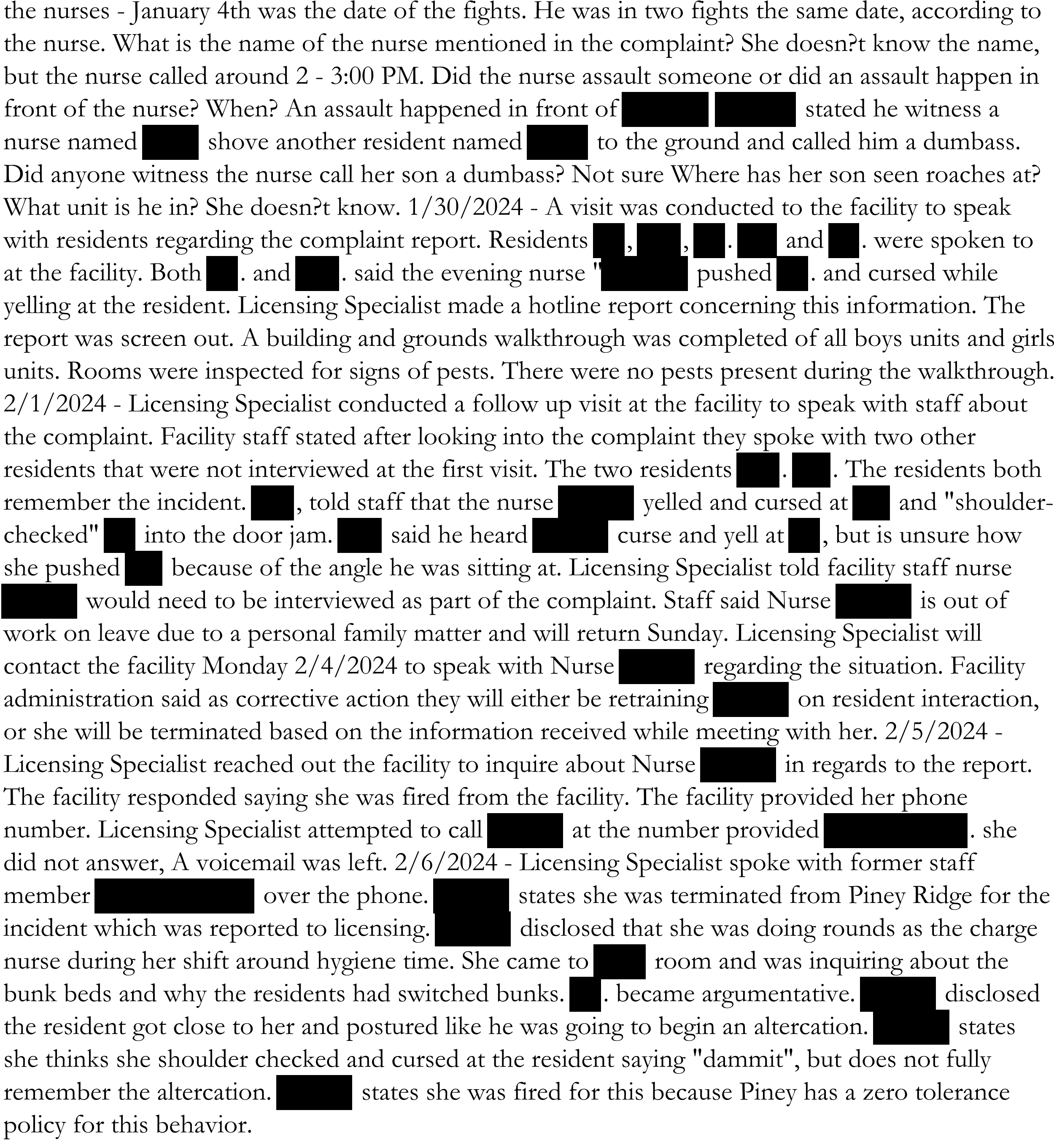
Incident Type: Licensing

Report Description: My son is currently a patient and I as well as my son who is 12, is and has had issues with peers stealing from him, kids fighting kids, my son said that a nurse I have her information as well as the kid this nurse physically assaulted in front of my son information and she called him a dumbass. My son has reported unsafe environment that there is roaches and the staff has yelled at him a lot, I have heard grown adults screaming at kids while we was talking on set days, I need help please ??

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 1/29/2024 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist contacted the reported to obtain additional information regarding the report. The following inquiries were made while speaking to the reporter: What is the residents first and last name? - [redacted] What is the residents DOB? ? [redacted] What is his guardianship (does she have custody or was he placed by DCFS) ? [redacted] - parent When was he admitted ? December 21, 2023 Is he still there? yes What was stolen ? 2-3 pairs of shoes, toiletries, beanie, North-pole jacket, Have you been told he has been in fights? Who told you? Yes ,



the nurses - January 4th was the date of the fights. He was in two fights the same date, according to the nurse. What is the name of the nurse mentioned in the complaint? She doesn?t know the name, but the nurse called around 2 - 3:00 PM. Did the nurse assault someone or did an assault happen in front of the nurse? When? An assault happened in front of stated he witness a nurse named shove another resident named to the ground and called him a dumbass. Did anyone witness the nurse call her son a dumbass? Not sure Where has her son seen roaches at? What unit is he in? She doesn?t know. 1/30/2024 - A visit was conducted to the facility to speak with residents regarding the complaint report. Residents , , . and . were spoken to at the facility. Both . and . said the evening nurse " pushed . and cursed while yelling at the resident. Licensing Specialist made a hotline report concerning this information. The report was screen out. A building and grounds walkthrough was completed of all boys units and girls units. Rooms were inspected for signs of pests. There were no pests present during the walkthrough. 2/1/2024 - Licensing Specialist conducted a follow up visit at the facility to speak with staff about the complaint. Facility staff stated after looking into the complaint they spoke with two other residents that were not interviewed at the first visit. The two residents . . The residents both remember the incident. , told staff that the nurse yelled and cursed at and "shoulder-checked" into the door jam. said he heard curse and yell at , but is unsure how she pushed because of the angle he was sitting at. Licensing Specialist told facility staff nurse would need to be interviewed as part of the complaint. Staff said Nurse is out of work on leave due to a personal family matter and will return Sunday. Licensing Specialist will contact the facility Monday 2/4/2024 to speak with Nurse regarding the situation. Facility administration said as corrective action they will either be retraining on resident interaction, or she will be terminated based on the information received while meeting with her. 2/5/2024 - Licensing Specialist reached out the facility to inquire about Nurse in regards to the report. The facility responded saying she was fired from the facility. The facility provided her phone number. Licensing Specialist attempted to call at the number provided . she did not answer, A voicemail was left. 2/6/2024 - Licensing Specialist spoke with former staff member over the phone. states she was terminated from Piney Ridge for the incident which was reported to licensing. disclosed that she was doing rounds as the charge nurse during her shift around hygiene time. She came to room and was inquiring about the bunk beds and why the residents had switched bunks. . became argumentative. disclosed the resident got close to her and postured like he was going to begin an altercation. states she thinks she shoulder checked and cursed at the resident saying "dammit", but does not fully remember the altercation. states she was fired for this because Piney has a zero tolerance policy for this behavior.

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521 Visit Compliance Report

Licensee: Piney Ridge Treatment Center

Facility Number: 203

Licensee Address: 2805 E ZION RD
FAYETTEVILLE AR 72703

Licensing Specialist: Jarred Parnell

Person In Charge:

Record Visit Date: 1/30/2024

Home Visit Date: 1/30/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

A visit was conducted at the facility in response to complaint case # - 018781.

Licensing Specialist conducted interviews with residents regarding the complaint reported to Licensing. Residents were interviewed about the presence of pests, altercations among peers, and theft among peers. A buildings and grounds walkthrough was completed of all living units, the cafeteria, and the day rooms in which the presence of pests was not identified. Of the 5 residents interviewed, 4 residents disclosed that they have personally had items stolen, or heard of others having items stolen from their personal belongings. The facility reports that they will look into the theft allegations.

Residents reported altercations do occur among peers and staff steps in to deescalate the conflicts.

It was disclosed to the Licensing Specialist an incident occurred on an unknown date in which a nurse pushed a resident and cussed at him. No further information was gathered regarding this situation, as Licensing will consult with DCFS before proceeding. Licensing is not prepared to leave a finding at this time.

Provider Comments:

CCL Staff Signature : [signature] Date: 1/30/2024

Provider Signature : Date: 1/30/2024

Administration walks through 6 days a week, usually multiple times a day and has NOT viewed any pests or had residents report such. Monthly preventative professional treatments occur. We have already started and continue room sweeps. We continue to address with residents that borrowing, trading or stealing of each others items are not allowed. Clinical will address the clinical aspects of this issue.

The allegation of the interactions between a Nurse and resident was submitted to ASP Hotline and was not accepted for investigation. Internal review of incident is presently occuring. All staff receive traing at hire, yearly and through out the year on trauma informed care.

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521 Visit Compliance Report

Licensee: Piney Ridge Treatment Center

Facility Number: 203

Licensee Address: 2805 E ZION RD
FAYETTEVILLE AR 72703

Licensing Specialist: Jarred Parnell

Person In Charge:

Record Visit Date: 2/1/2024

Home Visit Date: 2/1/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

A follow up visit was conducted at the facility on 2/1/2024 for complaint - 018781.

Licensing Specialist spoke with facility staff regarding information they had received while interviewing residents concerning the allegations made in the report. Facility administration staff stated two other residents that had witnessed the reported incident were interviewed. One of the residents disclosed he saw facility staff shove and curse at a peer. The second resident who was interviewed said he heard the facility staff person curse at the peer but did not see the staff person shove him.

The facility administration will speak with the staff member to determine the appropriate corrective action upon her return from leave on 2/4/2024.

Provider Comments:

CCL Staff Signature : Date: 2/2/2024

Provider Signature : Date: 2/2/2024

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521 Visit Compliance Report

Licensee: Piney Ridge Treatment Center

Facility Number: 203

Licensee Address: 2805 E ZION RD
FAYETTEVILLE AR 72703

Licensing Specialist: Jarred Parnell

Person In Charge: Ronissa Adams

Record Visit Date: 2/6/2024

Home Visit Date: 2/6/2024

Purpose of Visit: Revisit Complaint

Regulations Out of Compliance:

Regulation Number: 900.905.4.c

Regulation Description: The following actions shall not be used, including as discipline:

Finding Description: Interviews with residents and staff revealed that a nurse at the facility engaged in unprofessional conduct and inappropriate behavior management practices with a resident.

Action Due Date: 2024-02-06

Action Due Description: The facility terminated the nurse.

Comply Date:

Sub-Regulation Level 1 Description: Lewd or obscene language;

Action Due Description: The facility terminated the nurse.

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Finding Description: Interviews with residents and staff revealed that a nurse at the facility engaged in unprofessional conduct and inappropriate behavior management practices with a resident.

Action Due Date: 2024-02-06

Action Due Description: The facility terminated the nurse.

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

Action Due Description: The facility terminated the nurse.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

2/6/2024 -Based on information received through interviews with facility staff and facility residents, facility staff and facility residents, the licensing complaint is founded. The facility will be cited for 905.4.c and 109.1.g.

Provider Comments: Please see below

CCL Staff Signature : [signature] Date: 2/6/2024

Provider Signature : [signature] Date: 2/6/2024

Provider Comments:

The "Regulation Description" indicates the findings listed should not be used including for discipline. The findings reported are not a practice of Piney Ridge nor a de-escalation method that we use to train staff for intervention and or engagement of the residents in our care. The actions detailed in this citation are not a reflection of the facility yet the individual staff member who acted outside their training and protocols put in place by the facility. In addition, the hotline report was not accepted for investigation. Per our policy and DHS regulations we have the ability to re-train, suspend and or terminate. Piney Ridge takes these allegations and patient safety serious, it was the independent decision of the facility to terminate the employee due to them acting independently outside their scope of work and against company policy.

I don't agree with the citation due to the fact that the employee acted outside their scope of work. The facility took swift action terminating the employee within 48 hours of being made aware of the allegation and employee involved.

[signature]