



Placement and Residential Licensing Unit

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: 024562

Date of Incident: 10/3/2024

Date Received: 10/7/2024

Facility Name: Piney Ridge Treatment Center

Facility Number: 203

Incident Type: Licensing

Report Description: In the evening of 10/3/24 [REDACTED] was running around the court outside and accidentally twisted her ankle. She reports having pain around her ankle and upon further assessment, she currently has a swollen red ankle. [REDACTED] was advised to decrease physical activity to avoid pain and further damage to her ankle. In addition, she was also given ibuprofen to help with the inflammation and pain in her ankle. A nurse followed up on 10/4/24 to assess injury again and the resident saw the APRN who ordered an x-ray. The x-ray occurred in house on 10/5/24 and the results [REDACTED] [REDACTED] No additional orders at this time.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 10/8/2024 - The provider reported incident was reviewed by the licensing specialist. Licensing requested nursing notes and hospital discharge paperwork from the facility. A follow up visit was conducted at the facility under inspection #081011 to discuss the reported incident. Facility staff will provide nursing notes for the incident.

10/9/2024 - Provider nursing notes received, reviewed, and uploaded to ELS



Division of Child Care & Early Childhood Education
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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: 10/8/2024

Home Visit Date: 10/8/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

A visit was conducted to follow up on self reported incidents: 024555, 024556, 024562.

In regards to case024555 an inspection was conducted of the out door area where the resident used the awning to scale the fence surrounding the outdoor area. Upon arrival facility staff were in the process of deconstructing the metal awning and removing the structure from the facility in order to prevent residents from climbing on the awning as a preventative precaution. Staff supervision was discussed concerning the event and the resident was seen and verbal redirects were attempted to stop the resident from climbing the awning. No physical restraint was used as a safety precaution because the resident was out of reach.

In regards to case024556 which was linked to case 024360. Nursing notes and hospital discharge information have been uploaded to ELS under case 024360.

In regards to case 024562 - The incident was discussed with facility staff and nursing notes will be provided to licensing for the report incident.

Provider Comments:

CCL Staff Signature :

Date: 10/8/2024

Provider Signature :



Date: 10/8/2024