ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 025131

Date of Incident: 10/31/2024

Date Received: 11/1/2024

Facility Name: Piney Ridge Treatment Center

Facility Number: 203

Incident Type: Dual

Report Description: On 10/31/2024 at approximately 1640 [redacted]) and [redacted]) were horse playing by slapping a staff member, BHA [redacted] reportedly made a comment along the lines of "if you hit me again I'll restrain you" and [redacted] hit the staff member with his jacket again. [redacted] placed [redacted] into a standing HWC restraint. According to the resident, while he was struggling against the restraint, the staff member shoved resident against the fence wall and down onto the ground, scraping his shoulder and the side of his ear in the process. Employee was suspended pending investigation. On 10/31/2024 at approximately 1730 the [redacted] . An [redacted] was at the facility on 11/1/24 and spoke with the resident [redacted] and staff member [redacted] that was present for part of the situation.

Interim Action Narrative: staff member suspended pending the investigation.

[redacted]

[redacted]

Licensing Narrative: Program Coordinator checked [redacted] for the [redacted]. Licensing specialist reviewed the report. Licensing specialist will acquire permission from [redacted] to reach out to the facility for video footage archiving and safety plan. Facility staffed responded stating there is no video footage because the alleged incident occurred outside. Licensing specialist received permission from investigator [redacted] Licensing specialist requested witness statements from staff [redacted] and resident [redacted]. 11/8/2024 - Licensing specialist sent a reminder email to the facility for the requested documentation 11/13/2024 - Licensing specialist staffed with program director c. vardell and sent a notification to the facility to provide the requested documentation by the end of the day. 11/14/2024 - Risk manager R. Adams contacted licensing specialist to inform the [redacted] and the facility would be doing retraining for staff [redacted]. 11/15/2024 Licensing specialist attempted to contact facility to follow up with information regarding the report, risk manager R. Adams is out of the office until Monday 11/18/2024. Licensing specialist will follow up on monday. 11/20/2024 - Licensing specialist contact the facility to inquire if they felt the restraint done by staff [redacted] was necessary and met minimum standards. The facility responded stating they believe the restraint was necessary and met minimum standards. 11/20/2024 - Retraining documentation for handle with care has been received, reviewed and uploaded to ELS. 11/22/2024 - Licensing specialist staffed case with supervisor. 12/6/2024 - A visit was conducted at the facility to review information for the complaint and discuss the incident with facility staff. Facility was cited for 109.1 G based on information obtained during the investigation concerning the conduct of the employee horse-playing with the resident prior to the incident, wiping his face with the residents shirt, and refusing to leave the area when asked by another staff who was taking over for the restraint. Licensing specialist spoke with the facility staff to address concerns with boundaries and horse playing. 12/9/2024 - 521 inspection report sent to the facility. ICA was lifted by Program Coordinator C. Vardell Signed 521 inspection report received from the facility, uploaded to ELS. 12/27/2024, this complaint has been founded by licensing. Program Coordinator reviewed and approved complaint. Case complete.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

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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: 12/6/2024

Home Visit Date: 12/6/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

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: 109.1.g- 109.1.g- Horse playing with residents, failing to leave the area after being prompted multiple times by staff restraint instructor, and using the residents shirt to wipe his face causing the resident to further escalate.

Action Due Date: 2024-12-09

Action Due Description: The facility provided re-education on 11/19/2024 for seclusion and restraint policies and the Handle with Care verbal program.

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 provided re-education on 11/19/2024 for seclusion and restraint policies and the Handle with Care verbal program.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

A visit was conducted at the facility to speak with facility staff for case number 025131.

Based on the information received during the investigation the facility is being cited for standard 109.1.G: " **Unprofessional conduct in the practice of child welfare activities shall include without limitation: (g) Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.** (Founded)

Due to conflicting reports and a lack of video evidence, licensing was unable to determine if excessive force was used during the restraint hold. 905.9**"Physical restraints shall be performed using minimal force and time necessary. Physical restraint means the application of physical force without the use of any device, for the purpose of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort them or holding a hand to safely escort a child from one area to another, is not considered a physical restraint."**(Unfounded)

The Interim Corrective Action has been lifted, and the employee may return to normal job duties.

Provider Comments:

This event described should have more content around the situation. The youth involved had a propensity to not respond to various interventions and clinical therapy, objective and goals. The youth was easily elevated and had previous incidents including what not limited to property destruction, elopement and physical aggression toward others. The facility had regular communication with the legal guardians about the youth's lack of process and ongoing unsafe behavior and overall lack of willingness to make necessary strides in his treatment. The facility had identified the youth was no longer appropriate due to unsafe behavior but understanding the guardian didn't have other options the facility decided to continue to serve the youth until the guardians and facility could ensure a plan was in place with the assistance with other 3rd party members. The multi-disciplinary team was assisting the guardians in this endeavor.

The facility has been cited for **Unprofessional conduct in the practice of child welfare activities shall include without limitation: (g) engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children. (Founded by PRLU)** The incident was review by OLTC, AFMC and Washington County DCFS investigator and at the current time, the facility has not been cited by any of those entities. Furthermore, the citation in which the facility received is very serious **"engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children"**, yet the employee has been approved to return to work from DHS.

Parts of the investigation reveals that the employee did or stated something as:

"If you don't stop, or if you do that again you will be restrained" while this is not a therapeutic response this was a youth who did not respond to staff redirects to stop the physically aggressive behavior.

It was stated that the employee did not immediately leave the restraint when directed, however it was later discovered that the employee did not want to leave the only other stronger staff alone while in an emergency safety issue which is a best practice.

The staff member wiped his face with the shirt/jacket of the youth that was on the ground but later discovered this because the youth had spit in the staff face multiple times and this was the closest item to use.

While there is always opportunity's for improvements when conducting an emergency safety intervention. We do not agree with the citation, we have to look at these events in context. This youth is stronger in size and has a history of unsafe behavior and an unwillingness to participate and or engage in treatment.

CCL Staff Signature :  Date: 12/6/2024

Provider Signature : Date: 12/6/2024