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: 025410

Date of Incident: 11/9/2024

Date Received: 11/12/2024

Facility Name: Piney Ridge Treatment Center

Facility Number: 203

Incident Type: Licensing

Report Description: A report was received that client [redacted] was given the wrong medication and sent to Vantage Point acute hospital on 11/9/2024. [redacted] reports that they did not receive a phone call about the incident, but instead received an email. Due to the situation, [redacted] felt that it would have warranted a phone call rather than an email.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 11/12/2024-Program Manager emailed the facility to confirm if the facility has a resident by this name that was admitted into acute care on 11/9/2024. The facility reports that they do have a resident by this name, but he was never taken for acute care since he has been admitted to the program. A phone call with Angie Smith revealed that the resident was given the wrong medication by nursing staff on 11/9/2024 after the nurse was having a BHA help during medication pass. The BHA was bringing the children to the nursing station for the nurse to distribute the medication and when the resident came to the window, the nursing staff failed to ask for a DOB before providing the medication to the resident. The facility reports they immediately recognized their mistake and called the DON who spoke to the physician. The physician gave orders to hold the resident's

prescribed nightly medications and monitor him for any adverse reactions to the medications he was given. The resident was monitored and never had any adverse reactions therefore it was determined that further outside medical treatment was not necessary. Angie Smith will be sending the name of the medications, the nursing notes, and the retraining that was done with the staff to licensing for documentation. 11/14/2024-Licensing requested further documentation to show that the staff has been retrained and the list of the medications that the resident is currently prescribed. Program manager spoke to the [redacted] who reported that the resident was not in acute care or in Vantage point, but when she calls she gets transferred to the Vantage Point phone line. [redacted] reports that she has had concerns with the facility and that [redacted] was seen in the emergency room yesterday 11/13/2024 after he has been complaining of rectal bleeding for the last few weeks. The [redacted] reports the child has [redacted] and is under a specialist care in Jonesboro, AR. [redacted] sent several screenshots of conversations she has had with Piney Ridge staff regarding the care of [redacted]. Also, [redacted] states that the ER paperwork states that the child was kicked in the stomach a few weeks ago, but [redacted] reports that she was never made aware of that incident. 11/18/2024 - Licensing specialist received and uploaded proof of training for medication distribution. Reviewed and uploaded to ELS. 12/3/2024-Licensing emailed the facility to check on the status of the resident and determine if there was an incident in which the resident was kicked in the stomach by a peer between his admission and the day he was sent to the emergency room. The DON reports that they reviewed the client's chart and there is no mention, nor does she remember any incident in which the resident was kicked in the stomach by a peer since his admission. 1/8/2025 - The case was founded by Licensing. 2/18/2025, case reviewed and founded by licensing. 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

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Piney Ridge Treatment Center

Facility Number: 203

Licensee Address: 2805 E ZION RD
FAYETTEVILLE AR 72703

Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 1/8/2025

Home Visit Date: 1/8/2025

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

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 facility failed to provide the adequate level of supervision to a resident to ensure their safety and well-being when the nursing staff failed to ensure the correct medications were being provided to the resident on 11/9/2024

Action Due Date: 2024-11-15

Action Due Description: The staff involved in the incident were retrained on medication distribution and retraining documentation was provided to licensing.

Comply Date:

Action Due Description: The staff involved in the incident were retrained on medication distribution and retraining documentation was provided to licensing.

Narrative:

Licensing received a complaint regarding a resident who was given the wrong medication and sent to Vantage Point acute hospital on 11/9/2024. Licensing has investigated this complaint and determined it to be**founded.**

The facility nursing staff provided the wrong medication to the resident on 11/9/2024. The medications included were Trazodone 50mg, Geodon 40mg, and Depakote 250mg.

The resident was monitored for adverse reactions and orders were received from the physician to without prescribed nightly medications. The facility reports that the resident had no adverse reactions, and no outside medical care was necessary.

The staff involved in the incident were retrained on medication distribution and retraining documentation was provided to licensing.

The facility reports that the resident did not go to acute care or receive any emergency care as a result of this incident.

The facility failed to provide the adequate level of supervision to a resident to ensure their safety and well-being when the nursing staff failed to ensure the correct medications were being provided to the resident on 11/9/2024. This is a violation of standard**907.2**"Childcare staff shall be responsible for providing the level of supervision, care, and treatment that is 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."

***** Pursuant to A.C.A. § 9-24-406(e)(3-4): If you believe that the Department's notice of noncompliance is in error, you may ask for reconsideration. The request for reconsideration must be in writing and delivered to the Department by certified mail within twenty (20) business days of receipt of the notice of noncompliance. The request must specify the parts of the notice that are alleged to be in error, explain why you believe those parts are in error, and include documentation to support the allegation of error. Once received the Department shall issue a decision on your request within twenty (20) days after receipt of the request.

Provider Comments:

CCL Staff Signature : Chelsea Vardell Date: 1/8/2025

Provider Signature : Date: 1/8/2025