ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
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Corrective Action Agreement

Date: September 30, 2021, October 15, 2021

To: Craig Gammon

Owner Name: The United Methodist Children's Home, Inc.

Facility Name: United Methodist Children's Home Little Rock Campus

License: 115

Mr. Gammon,

This document constitutes a formal Corrective Action Agreement (CAA) agreed upon by United Methodist Children's Home Little Rock Campus and the Department of Human Services, Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. This CAA will be in effect for a period of six months from the date of signing by both parties. This agreement may be extended beyond six months should DHS determine any non-compliance with the CAA during the stated corrective action period.

The purpose of this agreement is to gain and maintain a high degree of compliance with licensing requirements. While this Corrective Action Agreement is in effect, the Agency will receive increased monitor visits. The following non-compliance areas have been cited during the past six months:

Minimum Licensing Standards (Residential): Section 907 – Ratio & Supervision

907.2 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, considering the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

- United Methodist Children's Home Little Rock Campus was cited for not providing care and treatment necessary to ensure the safety and well-being of each child multiple

times since 1/1/2021. The Licensing Specialist has discussed this concern with the facility and required staff involved to be retrained on proper handling of children de-escalation techniques. However, incidents have continued to occur in which staff are not providing care and treatment necessary to ensure the safety and well-being of children. This has been viewed on videos of restraint holds and client altercations. The following are dates in which the facility was issued a citation for R907.2.

- Incident **date [redacted]21**, cited on **2/4/2021** IC (Involved Child) stated that when he had gotten into a fight at RTC, staff members laughed at him. He also stated that he had bruises from them pushing him."
- [redacted]**/21**, Allegations that three boys would come into the IC's (Involved Child) room at night and beat on him and tear up his stuff. IC stated he told any available staff including the three IS listed, but no one believed him. The boys came into his room at least 6 different times. The boys would break his door open, punch him in the head, eyes, ears, jaw, and choked him. The boys would pin him down while they did this. The child allegedly has injuries from his face all the way down to his legs. He had lacerations and scars, a black left eye, and his forehead looked like it has been beaten with a shoe. He had bruising on his neck where the boys choked him. He has a big scar and bruising on his right shoulder down to below his armpit, from IS2(Involved Staff) grabbing him and shoving him against the doorway. He has a cut and bruising on his right and bruising to the left side of his collarbone, from IS2 putting him in a restraint against the wall. The cut is from being shoved into the doorway. He has an open cut on his shin, which is very deep and 1.5 inches in length, from being shoved into a doorway by IS3. There is a big bruise around the cut, and he has red petechiae spots on his upper back around his shoulders. (video footage viewed from the following dates caused the Agency to be cited for [redacted]/21, [redacted]/21, [redacted]/21, and [redacted]/21). Cited on 6/21/21 while waiting the [redacted] findings.
- [redacted]**/21** IC (Involved Child) and a peer started kicking the doors of the Boy's Unit Foyer area at approximately 8:15 p.m. IC and his peer kicked through 3 sets of doors allowing them to elope. IC and peer returned around 10:15 p.m.
- **8/3/21** Provider reported incident dated [redacted]/21 regarding an incident that took place on[redacted]21. Staff was off hall for a minimum of 1 hour and children were left unattended.

United Methodist Children's Home Little Rock Campus was cited for the use of physical injury or threat of bodily harm as a form of behavior management multiple times since 1/1/2021. The Licensing Specialist has discussed this concern with the facility and required all child caring staff be retrained on the agency's behavior management program. An incident report was submitted to the Placement and Residential Licensing Unit. During the investigation, video footage

revealed Regulation (**905.4 (g)** The following actions shall not be used, including as discipline: (g) Physical injury or threat of bodily harm.)

905.4 (g) The following actions shall not be used, including as discipline: (g) Physical injury or threat of bodily harm.

- [redacted]**/21** IC (Involved Child), IS1(Involved Staff), IS2(Involved Staff). IC stated that when he had gotten into a fight at RTC, staff members laughed at him. He also stated that he had bruises from them pushing him."

- [redacted]**/21** (no specific date of incident) [redacted]/21 Allegations that three boys would come into the IC's (Involved Child) room at night and beat on him and tear up his stuff. IC stated he told any available staff including the three IS listed, but no one believed him. The boys came into his room at least 6 different times. The boys would break his door open, punch him in the head, eyes, ears, jaw, and choked him. The boys would pin him down while they did this. The child allegedly has injuries from his face all the way down to his legs. He had lacerations and scars, a black left eye, and his forehead looked like it has been beaten with a shoe. He had bruising on his neck where the boys choked him. He has a big scar and bruising on his right shoulder down to below his armpit, from IS2(Involved Staff) grabbing him and shoving him against the doorway. He has a cut and bruising on his right and bruising to the left side of his collarbone, from IS2 putting him in a restraint against the wall. The cut is from being shoved into the doorway. He has an open cut on his shin, which is very deep and 1.5 inches in length, from being shoved into a doorway by IS3. There is a big bruise around the cut, and he has red petechiae spots on his upper back around his shoulders. (video footage viewed from the following dates caused the Agency to be cited for [redacted]/21, [redacted]/21, [redacted]/21, and [redacted]/21). Cited on 6/21/21 waiting for [redacted]

- [redacted]**/21** video reviewed of an incident that took place on 8/6/21 involving IS (Involved Staff)— and IC (Involved Child). While reviewing the video, IS was observed striking the IC in the face when the child grabbed IS's arm. IS did not attempt to get away but stepped forward and struck the child. Another IS2 intervened and separated the two. Corrective Action was requested by PRLU and the staff was terminated that day. Cited on 8/19/21.

905.4 (h) The following actions shall not be used, including as discipline: h. Humiliating or degrading action.

- **8/05/21**-Complaint-Founded- When investigating an incident involving the elopement of multiple kids on [redacted]/21, pictures and video were reviewed. Video footage revealed chemical restraint given in public are not in private. (One child was injected and forced to pull his pants down in the hallway in front of others. PRLU considered this to be humiliating or degrading action).

- [redacted]**/21** Founded Incident involving IC and another child getting into a verbal altercation: IS told IC that

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 purposes of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort, or holding a hand to safely escort a child from one area to another, is not considered a physical restraint.

- United Methodist Children's Home Little Rock Campus was cited for staff failing to use the minimal force and time necessary during restraints performed on residents. Staff involved in restraints were retrained on the agency's restraint hold procedure, CPI (Crisis Prevention Intervention) or terminate. The following are dates in which the facility was issued a citation for R905.9 since 1/1/2021:

  - **6/21/21** To serve the program with the citations from March. Cited for 905.9 – Physical restraints shall be performed using minimal force and time necessary. 907.2 (See above definition) and 905.4.g – The following actions shall not be used, including as discipline. (Video footage from five incident reports involving IC including two reports form [redacted]**/21,** [redacted]**/21,** [redacted]**/21, and** [redacted]**/21**).

905.11 Chemical restraints shall e sued only if ordered by a Physician. A chemical restraint is an emergency behavioral intervention that uses pharmaceuticals by topical application, or administration, injection, or other means to modify a child's behavior. (Per this regulation, a chemical restraint should only be used if an emergency behavioral intervention is needed.

Licensing recommends re-training staff on written policy governing the use of behavioral control measures with children completed by 10/15/21).

- United Methodist Children's Home Little Rock Campus was cited nursing staff administering chemical restraints to children that did require emergency behavioral intervention on video footage or photos.
    - **8/05/21**-Compaint-Founded- A complaint was received regarding a chemical restraint used on [redacted]/21. After reviewing the still shots and video, it was noted that the child was seated and calm with the chemical restraint was used:
    - **8/05/21**- Complaint-Founded- When investigating an incident involving the elopement of multiple kids on [redacted]/21, pictures and video were reviewed. Video footage revealed that chemical restraints were used on multiple children that appeared to be complaint and not agitated upon return to the facility.

The agency is required to complete the following:

- **The agency shall ensure that all staff having direct contact with children receive re-training on the agency's behavior de-escalation and restraint hold techniques (CPI, Crisis Prevention Intervention). Documentation of all applicable staff receiving the retraining will be provided to the Licensing Specialist by 11/1/2021.**
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    - All existing direct care staff at the RTC have been retrained on the appropriate use of restraint/seclusion, not in terms of practicing techniques, but with regard to which techniques are approved, when to use restraint/seclusion or not use it and the emphasis on avoiding restraint whenever possible. This was conducted by the administrator and or the program consultants. The nurses will be required to complete an in-service review of how and for what reasons restraint/seclusion are to be used as well as reason that are not allowed to justify its use. This training was also be provided to all new direct care 3 staff and nurses, respectively as part of their on-the-job training. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. 9-12-21

- **All staff with the agency shall receive intent training on sections R905 and R907 of the Minimum Licensing Standards. All staff who cannot be present during the training will be provided with an electronic link to review the recorded training. Documentation that all staff have been trained shall be provided to the Licensing Specialist within 30 days of the intent training presented by the Licensing Specialist.**

- **The agency shall consistently follow their policies and procedures to ensure all restraint holds performed by staff are debriefed by the staff who participated in the restraint hold. The agency shall provide this written protocol to the Licensing Specialist by 10/20/2021.**

    - The Agency has ensured that the appropriate staff were trained, and that training was documented by 9-1-21. Additionally, all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This became effective as of 9-12-21 but has already been put in place.

- **All restraint holds shall be reviewed including witness statements and/or applicable video footage for compliance with the Minimum Licensing Standards by the agency. If it is found that any restraint hold is performed inappropriately or with excessive force, the agency shall notify the Licensing Unit by the next business day.**

    - The Agency has documented with training rosters initially and then included in documentation of completed OJT training going forward. Nurses specifically, will review the pertinent policy and acknowledge the need to never administer chemical restraints to a client who is calm and not posing an immediate safety risk. Additional procedures have been to document less restrictive attempts to de-escalate a client prior to restraint of any kind. The above training also includes the necessity of releasing a client from a hold or a seclusion immediately if they appear calm and no longer pose a safety risk. This training and review was by 9-12-21.

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication.

Please be advised that any serious non-compliance cited during this corrective action period may result in a recommendation for adverse action on the license. Any serious violation of this corrective action plan will result in recommendation for adverse action on the license.

Please do not hesitate to contact the Placement and Residential Licensing Unit if you have any questions or concerns regarding ongoing compliance with this agreement or any other licensing requirement.

The signature of the licensee constitutes full acceptance of the provisions of this agreement.

Owner/ Administrator/Agency Representative

10-15-21

Date

Licensing Specialist

10/15/2021
Date

Sharra Singleton-Litzsey
Licensing Supervisor

10/15/2021
Date