ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S150, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Letter of Reprimand

Centers for Youth and Families – Elizabeth Mitchell Centers
Melissa Dawson, CEO
6501 W. 12th Street
Little Rock, AR 72204

June 1, 2021

Dear Ms. Melissa Dawson,

On May 28, 2021, the Division of Child Care and Early Childhood Education recommended to the Child Welfare Agency Review Board that a Letter of Reprimand be issued to Centers for Youth and Families – Elizabeth Mitchell Centers based on noncompliance of the Minimum Licensing Standards. The Child Welfare Agency Review Board voted unanimously to issue this letter. The authority for the Board to grant a Letter of Reprimand is listed within the License Status Section of the Minimum Licensing Standards for Residential Facilities. It states, "The Board shall have the power to deny an application to operate a child welfare agency or to revoke or suspend a previously issued license. The Board may also issue letters of reprimand or caution to a child welfare agency." The Division of Child Care and Early Childhood Education will provide status updates to the Board regarding this matter per the Board's request.

While Centers for Youth and Families – Elizabeth Mitchell Centers has had a long history of compliance with licensing standards, Centers has recently failed to maintain substantial compliance with the Minimum Licensing Standards in the areas of Behavior Management, Ratio & Supervision and Inspections, Investigation & Corrective Action. This lack of sustained compliance has resulted in a Corrective Action Agreement (CAA) placed on the agency. If the agency does not substantially comply with the CAA, a Probationary License may be issued by the Child Welfare Agency Review Board. A Probationary License may be issued to an agency that has not maintained compliance with Minimum Licensing Standards, but that the Board believes that compliance can be restored and subsequently maintained. This license may be issued for up to one (1) year, at the discretion of the Board. (Arkansas Code Annotated § 9-28-401, Minimum Licensing Standards for Child Welfare Agencies).

The attached CAA reflects the excessive citations and lack of sustained compliance at Centers for Youth and Families – Elizabeth Mitchell Centers. Because of this, youth are not receiving the required care as intended by the Minimum Licensing Requirements.

The Child Welfare Agency Review Board does acknowledge the efforts Centers is making to meet the CAA. Retraining staff is a huge undertaking and we understand that it does take time.

Andy Altom, Chairman of Child Welfare Agency Review Board

June 1, 2021
Date

Cc: Tonya Williams – Division Director
Ashelyn Abney – Division Assistant Director

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Recommendation of Letter of Reprimand

Elizabeth Mitchell Centers (Centers for Youth and Families)

6501 W. 12th Street

Little Rock, AR 72204

May 17, 2021,

Facility Background:

Licensed Psychiatric Residential Treatment Facility and Residential Child Care Facility

PRTF Capacity: 49

Residential Capacity: 13

Date Licensed: September 07, 2006

Recommendation:

The Placement and Residential Licensing Unit recommends a Letter of Reprimand for continued failure to comply with the Minimum Licensing Requirements in the areas of Behavior Management, Ratio & Supervision and Inspections, Investigations & Corrective Action. The Board shall have the power to deny an application to operate a child welfare agency or to revoke or suspend a previously issued license to operate a child welfare agency. The Board may also issue letters of reprimand or caution to a child welfare agency. If the agency does not substantially comply with the Minimum Licensing Standards, a Probationary License may be issued by the Child Welfare Agency Review Board. A Probationary License may be issued to an agency that has not maintained compliance with minimum licensing standards, but the Board believes that compliance can be restored and subsequently maintained. The license may be issued for up to one (1) year, at the discretion of the Board. Ark. Code Ann. § 9-28-401, Minimum Licensing Requirements for Child Welfare Agencies).

Failure to Comply with Minimum Licensing Requirements

Section 905.09 – Behavior Management states, "Physical restraints shall be performed using minimal force and time necessary."

Since August of 2020, there have been four (4) restraints implemented on youth at this facility that have resulted in broken bones. Within those four incidents, one finding is being appealed and the most current injury is still pending.

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Section 907.2 – Ratio & Supervision states, "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."

There have been multiple incidents at the facility that resulted in peer to peer sexual activity. ***On [redacted]/20, a peer (1) walked up to staff crying and said she might be pregnant. She explained she ran into the boy's bathroom and had sex with another peer. *On [redacted]/20, peer (2) confessed to staff, he had sex with peer (1) in the boy's bathroom Friday, [redacted]/20. *On [redacted]/20, a peer disclosed that three male peers sexually assaulted him in the bathroom. The time-period is unknown. *On 1[redacted]/20, a peer disclosed to staff that another peer pulled her hand to make her touch her vagina area while they were in the bedroom together on a blanket on the floor. *On [redacted]/21, a peer reports that another peer inserted a pen into his anus**.

Section 110.17 – Inspections, Investigations & Corrective Action states, "The agency shall notify the Licensing Unit by the next business day of serious injuries requiring emergency medical treatment, agency vehicle accidents, arrests, elopements, suicide attempts, or deaths, and medical documentation of the incident and notification."

The agency has failed to report incidents that involved injury among youth at this facility. Prior to the most recent restraint with injury, the agency was placed on increased monitoring. The Licensing Unit met with the Administrators of this agency to discuss the concerns of restraints with injuries, elopements, sexual activity amongst peers and an increase in self-harm attempts. However, only a few days later, a report was received for another restraint with injury (broken bone). The Licensing Unit went back to the facility and implemented a Formal Corrective Action Agreement between the agency and the Licensing Unit. However, a Formal Corrective Action Agreement does not feel sufficient. Therefore, the Licensing Unit would like to make a formal recommendation of a Letter of Reprimand for Centers for Youth and Families – Elizabeth Mitchell Centers.

Compliance History:

8/10/2020 Buildings and Grounds:

- No regulations out of compliance or needing technical assistance.
- Licensing specialist made an unannounced visit to the EMAC facility. Nurse was on duty and all staff/client numbers were in ratio.

[redacted]/2020 Complaint: (Founded)

- **907.2** – Founded lack of supervision, which allowed clients to engage in sexual activity in the bathroom.

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[redacted]/2020 Complaint: (Founded)

- **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, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks. (**Child received an injury from staff trying to put the child in a physical restraint, and both parties fell to the floor**.)

[redacted]/2020 Complaint: (Unfounded)

- **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, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks. (**Alleged Staff was touching child inappropriately on her breast and bottom.**)

[redacted]/2020 Complaint: (Founded)

- **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, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks. (**On [redacted]/20, two clients disclosed to staff, they engaged in sexual activity on [redacted]/20. This information was not known by staff until [redacted]/20. During shift change and bathroom breaks for school, a male and female client both ran into one bathroom with staff in the immediate vicinity. EMAC investigated the allegations by video review and interviews.**)

[redacted]/2020 Provider Reported Incident/Complaint:

- Peer reported that another peer was touched on her breast and vagina by staff. She also stated he took a picture of her butt. She shared that peer touched his penis and he showed her a picture of his penis and kissed her on the lips. **(Agency advised staff member was terminated)**

[redacted]/2020 Provider Reported Incident/Complaint:

- Client (IC) is [redacted]yo, who lives with mother. Out of home offender is staff (S1). It has been reported client (IC) resides at centers for youth and family in Little Rock. Client (IC) was discharged from the [redacted] on [redacted]/20. When returning to Centers, Youth and Family, client (IC) hit staff (S1) in the face, and staff (S1) put the child in physical restraint. Client's (IC) hands were behind his back, and the aggression continued; staff (S1) pushed the child against the wall. The attack continued, and both parties fell to the floor. Client (IC) was taken to Arkansas Children's Hospital for further examination. Client (IC) suffered a comminuted fracture

to the arm. There are concerns the client's (IC) injury is not consistent with the history given. No additional information reported. Client (IC) has been discharged from the hospital and back at the facility. (**ASP has made a true finding. Staff is appealing decision. Centers is now asking for approval for staff to be allowed to work on 12th street campus and continue his administrative duties as Program Coordinator. The approval to continue his duties as a Program Coordinator (no contact with any youth will be allowed and licensing will be notified of findings) was confirmed by Licensing pending appeal.**

10/24/2020 Provider Reported Incident/Complaint:

- Client was injured during Emergency Safety Intervention (ESI). Client informed nurse of left arm pain that he rated a 10/10 and about a 1cm noticeable bruise along with swelling and limited range of movement. Assessment done and doctor notified. Client transported to ACH. Client came into the hospital with a left elbow fracture and this was after he was put in a hold. It has been reported that before Client's arm was broken, he hit a staff member and he spit in their face. Client was put into a hold, he continued to fight, and that is how his elbow was fractured. [redacted]

10/29/2020 Provider Reported Incident/Complaint:

- A client activated the sprinkler system and a total of nine (9) client's eloped. Several of the clients brought back to the facilities by police.

[redacted]/2020 Provider Reported Incident/Complaint: (Specific date unknown)

- A client (IC1) disclosed on [redacted]/20 that three male clients, (IC2, IC3 & IC4) sexually assaulted him in the bathroom. The time period is unknown but is being investigated by CFYF and the State Police. **(A particular staff was not providing adequate supervision. In response, that staff will be written up and re-trained.)**

12/04/2020 Buildings and Grounds:

- No regulations marked as not correctable.
- 1 restroom on both Dorm 2 and 3 is out of order. Each dorm has 2 full bathrooms, therefore there are enough restrooms for the number of children in facility.

12/15/2020 Buildings and Grounds: (Cited)

- **R911.15.f -** Ensure items that pose a risk of self-injury are not left in children's room. (drawstrings found in sweatpants, north building last room on right)
- **R908.8** - Ensure all medication is logged at time medication is given.

- **R911.6** - Ensure all rooms are sufficiently lit. (lights in a couple of rooms that need replacing) Lights were either out or extremely dim.

12/17/2020 Psychiatric Residential Personnel Record Review: (Cited)

- **P103.5 -** Ensure state criminal background results are received. Centers did not receive results for several of their background checks due to miscommunication and the new system.
  - K. Amato
  - S. Wiley
  - V. Stumon
  - T. Kirkpatrick

- **105.5 c -** Ensure verification of qualification is documented in employee file for J. Pegues.

Reviewed 10 personnel employees:
T. Kirkpatrick
J. Pegues
J. Norful
M. Peterson
E. Harris
V. Stumon
W. Hicks
C. Whittington
K. Amato
S. Willey

[redacted]**/2021 Provider Reported Incident/Complaint: (Cited / Regulation 907.2)**

- Client asked to go to the restroom. Shortly, after about five (5) minutes, staff knocked on the door to check on client's non-response. Staff walked in and found client lying on the bathroom floor with a shirt tied around her neck. **(This incident on[redacted], was found that (IC) was on suicide precautions and line of sight supervision had been ordered. After review, the staff was found not to have followed the supervision guidelines. At this time, we are determining what type of disciplinarian action will be taken and he is suspended.)**

[redacted]**/2021 Provider Reported Incident/Complaint:**

- Client was sitting on washing machine. Staff yanked client off the washer resulting in client being injured, twisting her ankle, and hitting the back of her head. **(The staff member in question was suspended during the investigation and subsequently terminated. The one QBHP staff that was present who did not assist or intervene was written up and placed on probation. The Shift Supervisor who was called for assistance who failed to intervene/assist was demoted and placed on probation. The Arkansas Child Abuse Hotline call was accepted.**)

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[redacted]/2021 Provider Reported Incident/Complaint:

- Client (IC) reported that staff (S1) bent his hand back on Sunday morning prior to breakfast. The client advocate and I reviewed the video footage but was unable to corroborate this complaint. The advocate called it in to the hotline and it was accepted for further investigation.

[redacted]

2/10/2021 Buildings and Grounds: (Cited)

- **R911.15.f** - Ensure drawstrings are removed from personal items that can be used to inflict self-injury.
- Specialist Breedlove observed drawstring in clothing (dorm 2-private room). Corrected during visit. (Items removed)
- Ensure all buildings and furnishings shall be safe, clean, and in good repair. Specialist Breedlove

- **R911.6 (TA) -** Ensure all buildings and furnishings shall be safe, clean, and in good repair.
- Specialist Breedlove observed paint chipping in dorms.
- We also followed up on 4 self-reports and viewed video

2/24/2021 Buildings and Grounds: (Cited)

- **R911.15.f** - Ensure items that pose a risk of self-injury are not left in children's room.
  - Specialist Breedlove observed a drawstring in clothing in a room on the North dorm.

- **R908.8 -** Ensure medication is logged at time it's administered to clients.
  - Specialist Breedlove viewed mars log and observed client MB medication had not been administered on 2/21 and 2/22.
- **R910.1(TA) -** Ensure playground is free of safety hazards.
  - Specialist Breedlove viewed bench on playground that has loose board with nails visible and one corner of red roof on playset was leaning.

[redacted]/2021 Buildings and Grounds EMAC: (Cited)

- **R907.2** - Ensure the safety and well-being of child at the facility, surrounding circumstances during a time of hazards and risk (Line of Sight (LOS), Suicide Watch).
  - Specialist Breedlove viewed video footage of an attempt suicide, (client, LA-S) and noticed there was a period of time that elapsed while client was in the room alone and no one had checked to see what was happening or what she was doing.

  Centers - EMAC

  Ratios:

Dorm 1 - 2:8
Dorm 2 - 4:7
Dorm 3 - 2:8
Dorm 4 – Unoccupied

4/26/2021 Buildings and Grounds EMCC: (Cited)

- **R911.15.f** - Ensure personal items that can be used to inflict self-injury shall not be left in children's room.
  - Specialist Breedlove observed clothing with drawstrings in the room on South dorm.

- **R911.6 -** Ensure profanity written on wall is taken down and wall where paint is chipping is repaired. Ensure blinds leading to East, South, and North dorm in hallway are repaired. Blinds were broken with a jagged edge.

- **R908.6 -** Ensure all control substances shall always be kept under double lock.
  - Lock on drug cart unable to be secured at time of visit. Informed by nurse an order for a new drawer has been placed.

[redacted]/2021 Provider Reported Incident/Complaint:

- EMCC Program Director notified licensing that they had an emergency safety intervention which resulted in a client injury. Client was sent to ACH and nurse notified Program Director at 12:48pm that her arm was broken. **(Hotline report was called in on (RN) that initiated the incident with client. RN later terminated as a result of the incident that occurred. Investigation pending with State Police)**

[redacted]2021 Provider Reported Incident/Complaint:

- Former client of Centers for Youth and Families, EMCC unit from [redacted]/20 to [redacted]/21, reported being sexually abused by three staff members while he was a resident. One staff was his Therapist and the other was the Program Director and an unknown staff.
  [redacted]

5/5/2021 Technical Assistance Visit: (Corrective Action Agreement)

- A visit was completed to place Elizabeth Mitchell Centers on a Corrective Action Agreement. (See additional information)
  - The following ratios were viewed
    1:1, 2:2, 2:5, 2:11, Destiny's House 2:8, 2:8

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5/5/2021 Corrective Action Plan: Based on the following regulations

- **R905.9 –** 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 or holding a hand to safely escort a child from one area to another, is not considered a physical restraint.
- **R907.2 –** 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, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.
- **110.17 –** The agency shall notify the Licensing Unit by the next business day of serious injuries requiring emergency medical treatment, agency vehicle accidents, arrests, elopements, suicide attempts, or deaths, and maintain documentation of the incident and notification.

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Corrective Action Agreement

Date: May 5, 2021

To: Melissa Dawson

Facility: Elizabeth Mitchell Centers (Centers for Youth and Families)

License #: 157

This document constitutes a formal Corrective Action Agreement ("CAA") between Elizabeth Mitchell Centers and the Department of Human Services, Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit ("DHS"). 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. The following non-compliance areas have been cited during the past six months:

Minimum Licensing Standards (Residential): Section 905-- Behavior Management, Section 907—Ratio/Supervision & Inspections, and Section 110--Investigations & Corrective Action

- 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 or holding a hand to safely escort a child from one area to another, is not considered a physical restraint.
    1. Elizabeth Mitchell Centers staff placed a resident in restraint on 5/2/21 that resulted in the resident sustaining a broken arm.
    2. Elizabeth Mitchell Centers staff placed a resident in restraint on 10/24/20 that resulted in the resident sustaining a broken arm.

3. Elizabeth Mitchell Centers staff placed a resident in a restraint on 10/23/20 that resulted in a resident sustaining a comminuted fracture.
4. Elizabeth Mitchell Centers staff placed a resident in a restraint on 10/22/20 that resulted in a resident sustaining a broken arm.

- 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, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.
    1. Elizabeth Mitchell Centers staff failed to properly supervise residents appropriately during an incident on 4/15/21.
    2. Elizabeth Mitchell Centers staff failed to keep a resident in line of site, resulting in a resident's self-harm attempt on 3/28/21.
    3. Elizabeth Mitchell Centers staff failed to supervise residents on 8/10/20 resulting in sexual activity in the bathroom.

- 110.17 The agency shall notify the Licensing Unit by the next by the next business day of serious injuries requiring emergency medical treatment, agency vehicle accidents, arrests, elopements, suicide attempts, or deaths, and maintain documentation of the incident and notification.

    1. Elizabeth Mitchell Centers failed to report a serious injury requiring medical attention after a physical restraint. Elizabeth Mitchell Centers provided the incident report to PRLU on 5/3/21, and the incident occurred on 12/24/20.
    2. Elizabeth Mitchell Centers failed to report an incident on that occurred 4/22/21 between two residents that resulted in a client having a black eye. PRLU was notified of the incident via the Child Abuse Hotline.

The agency is required to complete the following:

- The Agency will complete intent training on procedures for mandated reporting and incident report to all child caring staff and other responsible staff as outlined in Section 110 of the Minimum Licensing Standards. Intent training will be provided by the Placement and Residential Licensing Unit.
- The Agency will retrain all staff on restraints/seclusions and provide proof to the Placement and Residential Licensing Unit. (Agency will have this completed by 5/31/21).

Agency:

- Handle with Care will no longer be utilized as a form of restraints at Elizbeth Mitchell Centers. Handle with Care was discontinued as 5/3/21. CPI will be utilized while the other options are being explored.

- Admission of new residents have been placed on hold while all staff becomes proficient with using CPI (Mark Bryant and Debra Gillion are the current trainers).

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication. During this probationary time frame, frequent unannounced monitoring visits will be made to assure compliance.

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

Please do not hesitate to contact the Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit, if you have any questions or concerns regarding ongoing compliance with this agreement or any licensing requirements.

The signature of the license constitutes full acceptance of the provisions of the agreement.

Melena A Dawson 5-5-2021

Owner/ Director Date

5/5/21

Licensing Specialist – Program Coordinator Date

5/5/21

Licensing Supervisor Date

– Program Manager