ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Date of Incident:8/11/2022

Date Received by DCCECE: 8/15/2022

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Facility Type: Residential

Incident Type: Licensing

Report Description: Letter to Andy Altom, or Division Of Childcare and Early Education RE: Centers For Youth Dear Mr. Altom, I recently accepted an Registered Nurse position at Centers for Youth and Families, particularly ?Destiny House? Having 32 years experience, and over 100 facilities in five states as a traveler, contractor- I am familiar with the norms of facilities such as this, and know what is normal to expect. After two traumatic shifts I resigned from orientation, leaving mid shift. I have worked in Emergency Rooms, State Forensics, and Inmate medicine and never felt so in danger as I did at this facility. Post resignation, feeling the children were also in danger- or in the very least traumatized , I felt the need to contact someone with oversight. I see, now a letter of reprimand you wrote as a licensing board member and I realized they are already under a 60 day order of correction. I must share my shift with you, so you can see what has not been achieved. These are the events of 7pm shift 8/10-11 2022. On arrival, I was not expected as there is no night nurse supervision, no schedule, no written assignments or way of knowing who is coming or where they will be. The dayshift nurse was covered in bruises from recent combat at work. Unnerved as I was told the residential kids were settled and gave few problems in the interview. The radio chimed five times in the hour I waited for various behavior emergencies in the three houses. Graffiti covered two walls and a door was broken recently, a hold and IM injection took place before my arrival. It was reported, sometimes a nurse doesn?t come, and a shift will not be covered. Although some dispute that statement. The nurse arrived late, and in my experience I was mislead about the nature the job, and level of violence in the workplace. The next shift One child was with a potential broken toe from kicking something, one child was enroute to the hospital at shift change for both hands swelling up and potentially broken after punching something, and non stop screaming and yelling, kicking doors- punching walls continued for 2 hours while med pass was attempted.

Children ran in circles, throwing tables, chairs, I was told we were not to intervene unless they are hurting themselves or others. The atmosphere was nerve wracking, and some kids were trembling and hyperventilating. Med pass was halted as children became dangerous, too many items thrown, screaming, and finally a punch to a teens jaw led to a swollen and immovable jaw with suspicion the jaw was broken. The nurse was attempting to contact the MD and send another one to a hospital. So much for orientation, the staff stated this was a normal day. Multiple teens were kicking and punching locked areas and the nurses station to get into, or get to another kid and I suspected the doors would give way soon. I left feeling a nurse or child could be killed or injured- and facilities like this with slow downward progression and tolerance of poor management lead to sentinel events. I have worked in Jails and prisons and can say the children were safer there. It was more peaceful there. Pinnacle Pointe, Rivendale, Bridgeway, Methodist certainly had moments like these- but it was not constant and therapeutic peaceful environment was maintained more often than not. There is no spite in writing this letter. This is written in the interest of the minors and public safety, as it seems your review of the licensure of this facility is pending. In addition, as I left- I offered my badge, the nurse stated, and meant it ? please tell them what you see here- maybe someone will do something? For Your Consideration. Victor V Swann RN

Interim Action Narrative:

Maltreatment Narrative: **Outcome: Founded**

Licensing Narrative: Response to complaint received 8/15/22 from nurse at EMAC written to Andy Altom. Incident reports and video reviewed for all incidents for Destiny House 8/10/22 and 8/11/22. Video showed no inappropriate holds, improper restraints from staff. 8/10/22: ███ was escorted by staff for disrupting and showing threatening behavior. Video reviewed. 6 staff, 1 nurse, 1 therapist observed. ██ was put in a restraint. Video reviewed. 5 staff held restraint. 1 observed and coached. LPN Sara Kirtley signed restraint report and was observed in video. 8/11/22: Incidents documented for ████████████ and ███. Video reviewed for incident between ███ and ██████ kicked ███ in the jaw while two staff observed standing in between clients, using bodies as barriers and blocking. ████████ were separated. ███ was transported to ACH ER for jaw injury. ███ incident report reviewed. ███ punched walls and complained of hand injury. ███ was taken to ACH ER for X-ray. Neither █████████ X-rays yielded fractures. Nurse staff rosters reviewed for Destiny House for 8/10/22 and 8/11/22. 8/10/22 LPN Sara Kirtley, RN Victoria Poirrior, RN Raquita Wilson, and one trainee present. 8/11/22 LPN Sara Kirtley and RN Victoria Poirrior

present. Destiny House visited. Census: 17. Staff/client ratio 5:17. All walls observed to be free of writing, marks, graffiti except for hall. Small curse words written. Staff indicate that this was recently done and began cleaning it as soon as it was brought to attention. Nurses present today LPN Sara Kirtley and RN Victoria Poirrier present, in addition to staff/client ratio. Staff supervisor Tonisha O?Neal present today, included with staff/client ratio. Facility cited 110.17. KW and ZB were transported for X-rays 8/11/22 and the Licensing Unit was not notified. Moving forward, Centers will notify Licensing Unit of all incidents requiring emergency medical treatment.