Disability Rights Arkansas

Arkansas Human Development Centers

Incident Overviews

2022

INTRODUCTION

The Arkansas Division of Developmental Disabilities Services (DDS) serves Arkansans with developmental disabilities and delays. The division operates five human development centers within the state that are designed to serve Arkansans with "profound intellectual and developmental disabilities." These facilities are state operated intermediate care facilities.

Per Arkansas DHS Policy 1090, DDS utilizes an incident reporting system to report "[i]ncidents that may affect the health and safety of Department of Human Services (DHS) clients, employees, volunteers, visitors and others on DHS premises or while receiving DHS services, and occurrences that interrupt or prevent the delivery of DHS services." Reports received through the incident reporting system are referred to as IRIS reports.

The Office of Long-Term Care (OLTC) investigates complaints against facilities, including the Human Development Centers. IRIS Reports are a form of self-reporting that can trigger the initiation of an investigation. The following represents a collection of the incidents described in the IRIS reports DRA received and whether those reports were ultimately substantiated by DHS.

ARKADELPHIA

114 IRIS Reports, 51 substantiated (44.7%)

IRIS Report Breakdown:

- 1 Injury/incident after improper supervision
- 24 Neglect
- 9 Physical maltreatment
- 1 Verbal maltreatment
- 3 Client injury
- 3 Staff failure to report or timely report affecting at least 17 residents

Incidents include:

- Staff left shift without notifying anyone, leaving residents unattended.
- Client ingested foreign objects due to improper supervision.
- Staff hit client, fracturing the client's nose.
- Staff failed to report maltreatment of clients by other staff.
- Staff "tossed [resident] to the ground and then began dragging him on the floor" and "grabbed [resident] by the ear/head and tossed him to the ground."

ARKADELPHIA

- Staff "hit [client] on his head with some papers… [staff] then picked up a shoe from the sofa and hit [client] on the head with the shoe."

"client struck multiple times by what appears to be a belt and water hose" while staff "attempted to muffle the sound by connecting his phone to a speaker provided by a client and turning the music extremely loud." Client yelling "stop" and "leave me alone" can be heard on video, along with "slapping/popping sounds followed by crying and screaming."

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2 OLTC surveys including citations for:

- Failed to ensure a thermostat was attached to the wall, a bathroom stall support was secured in place, and a drain in a commode stall was covered.
- Failed to ensure frozen food was properly stored and labeled.
- Failed to ensure the recommendations from occupational therapy for weighted utensils was implemented for client who required the use of weighted utensils.

BOONEVILLE

17 IRIS Reports, 9 substantiated (52.9%)

IRIS Report Breakdown:

- 1 Injury/incident after improper supervision
- 2 Reports of injury after restraint or improper restraint use
- 2 Elopements
- 1 exploitation
- 1 physical and verbal maltreatment
- 2 sexual maltreatment
- 1 improper medical treatment
- 1 injury of unknown origin
- 2 staff failure to report maltreatment (Neglect)

Incidents include:

- Nurse "administered several incorrect medications to [client], due to miscommunication identifying the client." Nurse Practitioner order client be transported to medical for observation. 1.5 hours later staff notified medical that they could not get the client up for transport. Medical responded and assessed client. He was lethargic and hypotensive, with a BP of 70/50 when 911 was call. He was transported by ambulance to the emergency room.

BOONEVILLE

- A client on 1:1 supervision was left alone in a bedroom, eloped, and was found walking down the highway before he was reported missing by staff responsible for his supervision.
- Staff member taking the property of client home.

Staff "punched and kicked [client] and drug him into the laundry room and continued to punch and kick him." Other staff present did not intervene or report the incident. According to the facility, "[t]he duration of the incident could possibly have been prevented had other staff present intervened."

- Client alleged he was physically abused in his bedroom by two staff members. The facility's investigation showed bruising and scratching on the client and video of the two identified staff members entering and closing the door of client's bedroom three times on the day in question. The staff members admitted placing the client in an "emergency personal hold while in [client's] room and [that they] failed to report and receive authorization for this hold" which resulted in client injury. The staff members received a written warning and retraining.

BOONEVILLE

- Food Service Director noticed a “large lump on [client’s] left temple.” Residential services staff asked did not know how the injury occurred. Medical assessment showed “swelling to his left temple area with bruising behind his left ear, and bruising starting under his right eye and below his right eyebrow.” The cause of the injury was never determined.

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4 OLTC surveys including citations for:

- Failed to ensure adequate staffing to manage and supervise clients.
- Failed to ensure tile was not broken and missing, floors were not discolored, toilets were clean, walls were not damaged, door facings were not damaged, fire doors were not damaged, and light cover switches were not cracked to provide a clean, safe, and sanitary environment in half of the residences.
- Failed to ensure a staff member was wearing gloves in a residence that was under quarantine due to COVID-19 to prevent spread.
- Failed to ensure physician orders and dietary recommendations were followed.

BOONEVILLE

- Failed to ensure an unvaccinated staff with a religious exception wore a NIOSHI approved N95 at all times and remained socially distanced from clients.
- Failed to exercise general policy, budget, and operating direction over the facility to ensure written policies and procedures were developed and correctly implemented.

CONWAY

79 IRIS Reports, 10 Founded (12.6%)

IRIS Report Breakdown:

- 3 injury/incident after improper supervision
- 3 injury after restraint or improper restraint use
- 6 elopement
- 5 physical maltreatment
- 2 sexual maltreatment
- 3 improper medical treatment
- 3 client injury
- 1 failure to intervene and report maltreatment

Incidents include:

- Conway police department officers located and brought a resident back to campus. The resident was on an emergency visual supervision at all times assignment and at the time they were returned to the facility the staff responsible for their supervision was not aware they were gone.
- Staff failed to ensure client was assessed following a fall in the shower, leaving a fractured hip and head injury untreated for almost 12 hours.
- Staff grabbed a resident by the arm and pushed her down in a doorway.

CONWAY

- Staff “performed a personal hold, they went to the ground and [client] landed on his left shoulder and left knee” which resulted in a “left distal clavicle fracture”
- Staff witnessed another staff “grab [resident] by the throat and throw her to the floor”

“[client] had marks and bruising on his legs that looked like it could have been from a BB gun,” along with a “trash can that appeared to have what looked like BB marks on it“ and “multiple BB’s were found in the dayroom, ...BB was found in...(resident) room, and one BB was found in back hall.”

- Ingestion of foreign objects including cleaner, pencil end, and paper clip.
- Peer-to-peer sexual assault despite “emergency one-on-one supervision [that] was assigned to [client] at the time of the allegation.”

CONWAY

5 OLTC surveys including citations for:

- Failed to ensure client who experienced a fall in the shower room and sustained a head injury and a fracture hip, was immediately assessed by nursing staff.
- Failed to ensure the physician was notified of a head injury, signs/symptoms of pain, and increased difficulty with ambulation after a fall.
- Failed to ensure medications were administered as ordered by the physician which resulted in actual harm.
- Failed to ensure electrical outlet covers were in good repair and shower drains were not missing to provide a clean and safe environment.
- Failed to ensure nasal cannula tubing for oxygen was kept in a plastic bag when not in use.
- Failed to ensure expired food items are stored, prepared, distributed, and served in a sanitary manner to prevent food borne illness.
- Failed to ensure dietary staff washed their hands before handling clean equipment

JONESBORO

38 IRIS Reports, 12 substantiated (31.5%)

IRIS Report Breakdown:

- 4 incidents or injuries following improper supervision
- 3 injury after restraint or improper restraint use
- 2 elopement
- 5 neglect
- 4 physical maltreatment
- 2 client injury
- 3 failure to report

Incidents include:

- Client found extremely soiled despite having 1-1 caregiver.
- Staff member reported the resident fell due to a seizure. Video review revealed the staff member pushed client to ground resulting in client breaking his hip and requiring surgery. Video review also showed staff acting “aggressive in nature” toward the injured resident and other residents.
- Staff witnessed improper restraint and failed to report it.
- Staff placed resident in headlock

JONESBORO

- Staff “us[ed] unapproved restraining techniques and excessive force” which included the staff “putting his forearm across the front of [resident’s] neck and using his full body weight to apply force which resulted in significant bruising to [residents] chest, neck and shoulder.”

Staff “grabbed [client] by the neck, picked her up and slammed her.”

- Client choked and became unresponsive after she was given improper food and improper supervision during meal.
- Staff “t[ied] [client] to a chair so [client] would not roam around the room by using the drawstrings of [client’s] pants.”
- Staff struck “a resident on the arm while he was attempting to take something out of the refrigerator [and] pushed the resident down and gruffly stated "get up, get out" of the kitchen.”
- Resident had seizure in shower causing her to fall and hit her head. The house was out of ratio and therefore the resident’s supervision level, which includes staff being present in the bathroom at all times and the use of a shower chair with a safety strap, was not being followed

JONESBORO

Client found unresponsive in the backyard of his living unit after having been outside more than four hours without any 15 minute checks completed.

6 OLTC surveys including citations for:

- Failed to ensure physical abuse allegations were reported and investigated.
- Failed to exercise general policy, budget, and operating direction over the facility to ensure written policies and procedures were developed and correctly implemented so clients were protected from alleged abuse and physical abuse allegations were reported and investigated.
- Failed to meet the requirements for the condition of participation for client protections as evidenced by the failure to ensure an allegation of physical abuse was reported, investigated and clients were protected.
- Failed to ensure systems to protect clients from alleged physical abuse were implemented.
- Failed to ensure clients were not subjected to alleged abuse after being allegedly hit in the head.

JONESBORO

- Failed to exercise general policy, budget, and operating direction over the facility to ensure written policies and procedures were developed and correctly implemented so clients were not subjected to alleged physical abuse by allegedly being hit in the head by a staff member.
- Failed to ensure systems to protect the clients from alleged physical abuse were implemented.
- Failed to ensure an allegation of physical abuse was reported to the Superintendent and the appropriate agencies.
- Failed to investigate an allegation of abuse.
- Failed to ensure systems to protect clients from alleged physical abuse were implemented.
- Failed to ensure the mattresses on the client's beds were kept cleaned and unstained.
- Failed to ensure sufficient direct care staff were available to consistently supervise clients.
- Failed to ensure sufficient staffing to ensure supervision of the clients to prevent the potential for aggressive and sexual abuse from other clients who were not supervised.
- Failed to ensure sufficient direct care staff were available to consistently supervise clients.

SEAHDC

81 IRIS Reports, 31 substantiated (38.2%)

IRIS Report Breakdown:

- 2 injury/incident after improper supervision
- 7 restraint/ improper restraint use
- 4 elopement – 12/12, 12/10,
- 15 neglect
- 1 physical maltreatment
- 3 verbal maltreatment
- 1 sexual maltreatment
- 4 med error/ improper medical treatment
- 13 client injuries

Incidents include:

- Clients were given duplicate medication.
- Clients' medication and tube feedings were not given while nurse took smoke break.
- Staff "was seen putting his hand around [client's] throat."
- Staff member yelling at clients while putting finger in face.
- Staff not documenting personal restraints.

Staff witnessed "throwing [client] to the ground in his room" which resulted in a "clavicular distal third shaft fracture."

SEAHDC

- Staff heard on video being verbally abusive to clients.
- Staff "compelled [resident] to verbalize and repeat his desire to perform sexual acts on [another staff member]."

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4 OLTC surveys including citations for:

- Failed to ensure clients were provided with a comfortable, safe, and sanitary environment as evidenced by, ensuring the bathroom grout was free from substance, ceiling tiles, bathroom toilet paper holders, a medicine cabinet, tubs, walls behind toilets, flooring, cabinets in kitchen, electrical outlet in a bathroom, bedroom doors and outdoor furniture were in good repair to prevent potential hazards for clients.
- Failed to ensure a staff member wore a hair covering while preparing puree food in the kitchen to prevent the potential for food contamination.
- Failed to ensure the level of supervision as documented in the IPP was consistently implemented for sampled clients who required visual supervision.

SEAHDC

- Failed to ensure the administrator and the OLTC were notified of an injury of an unknown origin.
- Failed to ensure injury of an unknown origin was investigated.
- Failed to ensure supervision was consistently maintained for sample client who required visual supervision.
- "Failed to ensure their abuse policy was consistently implemented for...sampled client who was the subject of a verbal threat by a staff member."
- "Failed to ensure an allegation of verbal abuse was immediately reported to administration for...client who was the subject of a verbal threat by a staff member."
- “Failed to ensure a restraint policy was consistently implemented for...client who was placed in a physical restraint which resulted in a fractured clavicle."
- "Failed to ensure a physical restraint did not result in injury for...client who was placed in a physical restraint which resulted in a fractured clavicle."