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: 1/13/2023

Date Received by DCCECE: 1/17/2023

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Facility Type: Residential

Incident Type: Licensing

Report Description: I wanted to inform you of an incident that occurred at The Centers (EMAC) on 01/13/2023. On 01/13/2023, at approximately 1650 hours, client [redacted] became dysregulated, grabbed a fire extinguisher, and discharged it in the hallway, causing the fire alarm to be activated. [redacted] then threw the fire extinguisher at a female member of the nursing staff. A second client, [redacted] who is friends with [redacted], became dysregulated and attempted to join [redacted] in her outburst. In an attempt to keep them from harming themselves and others, Centers staff members placed [redacted] and [redacted] in Emergency Safety Interventions (ESI?s). The Little Rock Fire Department (LRFD) and Little Rock Police Department (LRPD) responded to the facility because of this incident. Due to the fact [redacted] and [redacted] continued to be aggressive and verbally threaten others, Dr. Perkins made the decision to seek acute placement for both clients. MEMS transported [redacted] to Arkansas Children?s Hospital (ACH), where she remained until she was transferred to Methodist Behavioral Health on 01/14/23. MEMS transported [redacted] from Centers to Rivendell Behavioral Health. [redacted] did not sustain any injuries because of this incident. [redacted]?s guardian was notified about this incident. [redacted] is a DCFS placement at The Centers. [redacted] did not sustain any injuries because of this incident. [redacted]?s guardian was notified about this incident. [redacted] is a private placement at The Centers. As always, please do not hesitate to contact me if you need any additional information. **As of this report, [redacted] is at Methodist and [redacted] is at Rivendell**

Interim Action Narrative: Dr. Perkins was contacted due to the residents aggressive behavior and verbal threats to others. A decision was made to seek acute placement for both residents.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist will follow-up with the facility to schedule a time to view camera footage. 1/19/2023, Licensing Specialist informed there were no witness statements. 1/23/2023, Licensing Specialist reviewed camera footage and inquired about nursing notes.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

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521 Visit Compliance Report

Licensee: Elizabeth Mitchell Centers

Facility Number: 157

Licensee Address: 6501 WEST 12TH STREET
LITTLE ROCK AR 72204

Licensing Specialist: Kendra Rice

Person In Charge: Eric Knowles

Record Visit Date: 1/23/2023

Home Visit Date: 1/23/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 11:15 am to 12:15 pm

Census: 43

Licensing Specialist reviewed camera footage for reported incident on 1/13/2023 involving two (2) residents.

Licensing Specialist observed resident [redacted] on the EMAC hallway walking down the hall. It appeared that maybe words were exchanged between resident and a peer. Resident walked in the other direction into a corner where the fire extinguisher was in a case on the wall. Staff (2:1) was observed trying to get the fire extinguisher from the resident. She started spraying the fire extinguisher down the hall toward her peers. Licensing Specialist observed the resident dropping the fire extinguisher to the floor, before staff was able to pick up the fire extinguisher, resident picked up the fire extinguisher and started spraying it toward staff.

Licensing Specialist observed the fire alarm going off from the flashing of the lights on the wall. Staff (4:1) were able to get the fire extinguisher away from the resident. Licensing Specialist observed resident pacing up and down the hall being aggressive toward staff and destroying property. Each attempt that resident tried to get to another fire extinguisher she was blocked by staff. Two (2) Little Rock police officers were observed walking down the hall.

Resident [redacted] was observed trying to get out the door of the EMAC's administration hall, ratio 2:1. Licensing Specialist observed staff attempting to get resident to comply. Resident was observed being aggressive with staff and destroying property. Licensing Specialist observed resident running for the door kicking the door and at staff, ratio 3:1.

Licensing Specialist was unable to observe the resident being placed in a restraint while on the administration hall due to the angle of the camera. Licensing Specialist also observed three (3) Little Rock firefighters walking toward the hallway where the fire extinguisher was sprayed. Residue from the fire extinguisher was observed on the floor.

While outside, Licensing Specialist observed resident [redacted] walking around the courtyard trying to get into the building. Staff was observed removing the residents from the area. Licensing Specialist observed resident being put into a restraint on the ground. A staff member was observed talking on the phone. Resident was observed being aggressive while in the restraint and receiving a chemical restraint.

Licensing Specialist and Mr. Knowles, Compliant Officer, discussed the incident. Mr. Knowles informed Licensing Specialist that all fire extinguisher cases will be locked. No licensing concerns were observed while viewing camera footage.

Provider Comments:

CCL Staff Signature :

Date: 6/19/2023

Provider Signature :

Date: 6/19/2023