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: 1/30/2023

Date Received by DCCECE: 1/31/2023

Facility Name: Millcreek of Arkansas PRTF

Facility Number: 233

Facility Type: Residential

Incident Type: Licensing

Report Description: [redacted] (AR, DHS Custody, DOB: [redacted]) engaged in a verbal confrontation with peers. The peers became upset and approached him aggressively. Staff stood between the patients but a peer punched [redacted] in the face. Two other peers joined in the confrontation, displaying physical aggression towards [redacted]. Staff were able to separate and de-escalate the patients. Nurse assessment indicates bruising and swelling to left eye. Tylenol and icepack provided. Referred to DCMC for outpatient x-rays. Diagnostic report indicates a [redacted]. He received a referral to Arkansas Children's Hospital for follow-up treatment. This appointment will be scheduled by ACH.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: On 1/30/23 client [redacted] was involved in an altercation with a peer and was punched in the face. X-ray from Dallas Co Medical Center indicated a [redacted] to the [redacted]. Follow up appointment to be scheduled with ACH. Client remains at facility. Facility visited 2/3/23. Video reviewed from 1/30/23. Staff/client ratio seen in

the incident 3:7. Staff used bodies as barriers to intervene between clients in altercation. Male staff member observed grabbing clients by their shoulders to move them away from altercation. 2 female staff seen using bodies as barriers between clients in altercation. No inappropriate holds observed. Staff appeared to be attempting to provide supervision and care to each child during the incident. Safety Plan and Witness Statements of staff involved attached to investigation for this case.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Millcreek of Arkansas PRTF

Facility Number: 233

Licensee Address: 1828 INDUSTRIAL DRIVE
FORDYCE AR 71742

Licensing Specialist: Clayton DeBoer

Person In Charge: Chris Butler

Record Visit Date: 2/3/2023

Home Visit Date: 2/3/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Facility visited 2/3/23. Video reviewed from incident 1/30/23. Male staff member observed grabbing clients by their shoulders to move them away from altercation. 2 female staff seen using bodies as barriers between clients in altercation. No

inappropriate holds observed. Staff appeared to be attempting to provide supervision and care to each child during the incident. Safety plan: Client [redacted] was moved to a different cottage 1/31/23. [redacted] will remain on close observation until 2/26/23.

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Millcreek of Arkansas PRTF

Facility Number: 233

Licensee Address: 1828 INDUSTRIAL DRIVE
FORDYCE AR 71742

Licensing Specialist: Chelsea Vardell

Person In Charge: Chris Butler

Record Visit Date: 3/3/2023

Home Visit Date: 3/3/2023

Purpose of Visit: Special Visit

Regulations Out of Compliance:

Regulation Number: 1. 109. 1 .g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Findings Description: Staff aggressively pushed residents several times during the course of an incident that occurred at Pebble Creek on 1/30/23.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulation Number: 9. 907. 2

Regulation Description: 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.

Findings Description: Three staff failed to ensure the safety and well-being of a resident who was attacked on the unit by multiple residents.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

On 1/30/23 an incident involving multiple altercations between residents and the serious injury of a resident occurred in the Pebble Creek Cottage at the facility. Review of the video showed 3 staff members involved. Staff [redacted] and [redacted] can be seen slowly engaging with clients in attempts break up fights involving client [redacted] and other residents. Once a big fight breaks out, Staff [redacted]. can be seen with his hands in his pockets in the middle of the fight and pushing multiple clients. Staff [redacted] is slow to respond but does attempt keep clients separate. Staff [redacted] can be seen using her body as a shield in some instances to try and protect clients. At no time during the incident did staff attempt to call for help. After further review by licensing, it has been determined that staff failed to provide adequate supervision to ensure the safety and well-being of the residents and one staff engaged in unprofessional conduct when he aggressively pushed several residents' multiple times during the incident.

The facility will be cited for 907.2 and 109.1.g.

During the 3/3/23 visit, Millcreek's TCI (Therapeutic Crisis Intervention) instructors were present to view the video. Training for staff involved in this incident will include Protective Interventions, Proximity, and the use of codes when in a crisis situation. Discussion occurred around the programming during that time of day during transition. During the discussion, I was informed that staff are sitting outside the view of the camera at the table working on case notes because it is shift change during the video. Staff should not all be sitting at the table together; they should be engaging with the residents. If staff need to complete paperwork, they should be mixed around the common area. Or staff may take turns sitting at the table completing end of the shift paperwork. If staff realize clients are overly stimulated, they should be actively engaging using the skills learned in training.

Please ensure that all three involved staff are retrained on appropriate interventions when handling an acting out resident prior to returning to work with any resident at the facility. Documentation of the retraining shall be submitted to the Licensing Unit for review. This training should include facility protocol regarding de-escalation techniques, to include but not limited to, removing other residents out of the area of an acting out resident. Training shall be completed as soon as possible. Documentation of the retraining shall be submitted to the Licensing Unit for review.

Provider Comments:

CCL Staff Signature : Date: 3/3/2023

Provider Signature : Date: 3/3/2023