



**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

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## Notice of Serious Incident

**Date of Incident: 2/2/2023**

**Date Received by DCCECE: 3/9/2023**

**Facility Name: Millcreek of Arkansas PRTF**

**Facility Number: 233**

**Facility Type:**

**Incident Type: Licensing**

**Report Description: My daughter [REDACTED] was at Millcreek for treatment for 6 weeks. She was treated poorly by staff. They would yell at her. They were constantly yelling and cussing at the other children there. She wasn't being given her medication properly.**

**Interim Action Narrative: The facility reports that they will complete their "Nurture Heart" training with the staff listed on the complaint, supervisory training for the unit coordinator and will conduct ongoing monitoring of the unit. Nurture Heart certificates of completion for**

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**Maltreatment Narrative:**

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**Licensing Narrative: 3/10/23- Reporter was contacted via telephone by licensing supervisor Chelsea Vardell. Information was gathered regarding the complaint and the case was assigned to Specialist Clayton DeBoer. 3/13/23- Program Coordinator Chelsea Vardell and Specialist Clayton DeBoer visited the facility to collect more information regarding this complaint. Licensing received a complaint on 3/9/23 regarding an accusation that several staff members had yelled and cussed at residents on the Zebra Hall. Additionally, when a**

resident reported the concerns, the resident was retaliated against by the staff. The complaint also listed concerns about a resident who did not receive her medication as prescribed (a [REDACTED] that is supposed to be taken one hour prior to eating and not taken with any other medications). The complaint stated that the residents were not being allowed to do things such as have recreation, phone calls with family, or go to school if any of the residents were having "acting out" behaviors. Licensing spoke to Chris Butler who provided the last names of the staff listed in the complaint. The facility was already aware of the allegations and had performed in service training for several of the staff listed on the complaint regarding cleanliness, recreational activities, supervision, and not cancelling activities due to other residents' behaviors. Licensing spoke to the DON and a unit nurse who stated that the [REDACTED] should be given at 6am from the night nurse, breakfast is at 7am, then all remaining morning medications should be given at 8am. However, the MARs documentation for resident [REDACTED] showed that her [REDACTED] and [REDACTED] were being given at 8am by the morning nurse. Licensing discussed ensuring that all medications required to be given at 6am before breakfast are documented as 6am on the MARs and given to residents accordingly. The facility reports that they spoke to their pharmacy consultant who reported that there is not contraindications between [REDACTED] and [REDACTED] being administered at the same time. Licensing interviewed the following residents [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. It was noted that staff do occasionally yell and use profanity on the unit. The facility reports that they will complete their "Nurture Heart" training with the staff listed on the complaint, supervisory training for the unit coordinator and will conduct ongoing monitoring of the unit. Nurture Heart certificates of completion for Zebra Hall staff involved in this complaint sent from facility 4/11/23. On 3/13/23 facility cited 905.4c and 908.8. Phone call and email sent to facility 3/21/23 asking for MAR indicating [REDACTED] [REDACTED] is given at 0600. [REDACTED] is no longer at facility. MAR requested for other clients on similar medication and that is is being distributed at 0600.



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## 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:** 3/13/2023

**Home Visit Date:** 3/13/2023

**Purpose of Visit:** Complaint Visit

### Regulations Out of Compliance:

**Regulation Number:** 9. 908. 8

**Regulation Description:** The administering of all medications, including over-the-counter, shall be logged at the time the medication is given, by the person administering the medication.

**Findings Description:** It was undetermined at what time the resident was being given her thyroid medications as the DON stated it should be 6am and documented on the MARs, but the MARs showed it given at 8am.

**Action Due Date:**

**Action Due Description:**

**Comply Date:**

**Sub Regulation Description:**

**Regulation Number:** 9. 905. 4 .c

**Regulation Description:** The following actions shall not be used, including as discipline:

**Findings Description:** Staff were using cuss words in communicating with residents.

**Action Due Date:**

**Action Due Description:**

**Comply Date:**

**Sub Regulation Description:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

Licensing received a complaint on 3/9/23 regarding an accusation that several staff members had yelled and cussed at residents on the Zebra Hall. Additionally, when a resident reported the concerns, the resident was retaliated against by the staff. The complaint also listed concerns about a resident who did not receive her medication as prescribed (a thyroid medication that is supposed to be taken one hour prior to eating and not taken with any other medications). The complaint stated that the residents were not being allowed to do things such as have recreation, phone calls with family, or go to school if any of the residents were having "acting out" behaviors.

Licensing spoke to Chris Butler who provided the last names of the staff listed in the complaint. The facility was already aware of the allegations and had performed in service training for several of the staff listed on the complaint regarding cleanliness, recreational activities, supervision, and not cancelling activities due to other residents' behaviors.

Licensing spoke to the DON and a unit nurse who stated that the thyroid medication should be given at 6am from the night nurse, breakfast is at 7am, then all remaining morning medications should be given at 8am. However, the MARs documentation for resident [REDACTED] showed that her thyroid medication and [REDACTED] were being given at 8am by the morning nurse. Licensing discussed ensuring that all medications required to be given at 6am before breakfast are documented as 6am on the MARs and given to residents accordingly. The facility reports that they spoke to their pharmacy consultant who reported that there is not contraindications between [REDACTED] and [REDACTED] being administered at the same time.

Licensing interviewed the following residents [REDACTED] and [REDACTED]. It was noted that staff do occasionally yell and use profanity on the unit. The facility reports that they will complete their "Nurture Heart" training with the staff listed on the complaint, supervisory training for the unit coordinator and will conduct ongoing monitoring of the unit.

**Provider Comments:**

CCL Staff Signature :

Date: 3/13/2023



Provider Signature :

Date: 3/13/2023

