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Notice of Serious Incident

Date of Incident: 11/14/2022

Date Received by DCCECE: 11/15/2022

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Facility Type: Residential

Incident Type: Dual

Report Description: I wanted to inform you of an incident that occurred at The Centers (EMAC) on 11/14/2022. On 11/14/2022, at approximately 0950 hours, client [redacted] ([redacted], DOB: [redacted]) was in her dorm area when she wrapped what appeared to be a torn piece of clothing around her neck. Although [redacted] was on several precautions at the time, staff did not properly follow the protocols in place. It was approximately ten minutes before staff called for additional personnel and they were able to remove the piece of cloth from around [redacted]s neck. [redacted] told Centers medical staff personnel ?she has a plan and wanted to commit suicide.? Medical personnel assessed [redacted] and noted all her vitals were within normal ranges. The Centers Medical Director, Dr. Bowling, reviewed this incident and determined it should be classified as an Attempted Suicide. Dr. Bowling determined [redacted] would benefit from a higher level of care to keep her safe based on an escalating pattern of self-harm and suicidal behaviors. Dr. Bowling and The Centers medical team located an acute placement for [redacted] at Conway Behavioral Health (CBH). At Conway Behavioral Health?s request, [redacted] was transported to Arkansas Children?s Hospital (ACH) for medical clearance prior to her admission to CBH. After [redacted]?s medical evaluation at ACH, she was transferred to CBH. [redacted] guardian was notified about this incident. [redacted] is a private placement client at The Centers. After reviewing video footage of this incident, the staff member responsible for [redacted] care at the time of the event, was immediately terminated. Due to that staff?s negligence, a call to the [redacted] was made and the report was accepted ([redacted] [redacted]). Although Dr. Bowling has not classified the following incident as an Attempted Suicide, I feel it is appropriate to report due to the fact it involves the same client and similar circumstances. On 11/12/2022, at approximately 1920 hours, client [redacted], was in her dorm bedroom when she wrapped a pillowcase around

her neck. When staff finally observed [redacted] with the pillowcase tied around her neck, they intervened and removed the pillowcase from her neck. [redacted] did not report to staff that this was a suicide attempt, and she did not appear to have sustained any injuries because of this incident. On 11/14/2022, video footage of this incident was reviewed and the staff member responsible for [redacted]s care was terminated. As always, please do not hesitate to contact me if you need any additional information.

Interim Action Narrative: The facility terminated staff on 11/15/22.

[redacted]Narrative: AV: [redacted] Category: [redacted]: Injury Characteristics: Inadequate Supervision [redacted]What/When Happened?/Who did it? Does the person still have access to the child?: The AV is 1[redacted] The AO is a direct care staff, Outcome:

Licensing Narrative: On 11/14/2022 resident [redacted] was on several precautions for self-harm behaviors. The resident went into the dorm area where she wrapped what appeared to be a torn piece of clothing around her neck. The staff responsible for her supervision was reportedly on her cell phone and not supervising the resident per facility protocols. The staff was alerted that the resident was turning purple and went over to the resident and stood over her with her hands in her pockets. The staff did not call for additional assistance until approximately ten minutes after the initiated of the suicidal behavior. The incident was [redacted] by the facility and accepted for investigation (reference # [redacted]). The staff was terminated from employment at the facility. Licensing Specialist Ezell Breedlove reviewed camera footage of this incident on 11/15/22 which supported report. Licensing Supervisor Chelsea Vardell reviewed video 11/16/22 from 11/14/22 and 11/12/22 for client [redacted]. Client was unsupervised for more than 30 minutes on 11/12/22 during self-harm incident. Client [redacted] was placed on "line-of-sight" 11/12/22, which was not followed by staff on 11/14/22. Facility cited 907.2 for incidents on 11/12/22 and 11/14/22.