Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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Notice of Serious Incident

Date of Incident: 12/8/2022

Date Received by DCCECE: 12/9/2022

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 12/08/2022. On 12/08/2022, at approximately 1930 hours, client [redacted], DOB: [redacted] refused to transition back to her dorm area. As staff attempted to verbally convince [redacted] to return to her dorm, she picked up a small plastic/metal cap and swallowed it. Centers medical personnel assessed [redacted] and noted the object did not obstruct her airway. [redacted] was able to drink liquid and did not have difficulties swallowing. [redacted] did not report any pain or discomfort. Dr. Perkins was contacted and advised of the situation. Out of an abundance of caution, Dr. Perkins gave an order for [redacted] to be transported to Arkansas Children?s Hospital (ACH) for further evaluation. Centers staff transported [redacted] to ACH. Once at ACH, medical personnel there conducted an x-ray of [redacted] from her nose to her rectum. The x-ray showed the foreign object traveling down her [redacted]) digestive track without obstruction. After her medical evaluation, [redacted] was transported back to EMAC. The Centers medical staff will continue to monitor [redacted]. [redacted]?s guardian was notified about this incident. [redacted] is a DCFS placement at The Centers. As always, please do not hesitate to contact me if you need any additional information.

Interim Action Narrative: Resident was evaluated by the nurse. The doctor was called and ordered for resident to be further evaluated at AR Children's Hospital. X-ray completed of resident's from her nose to rectum. X-ray showed foreign object traveling down resident's digestive t

Maltreatment Narrative: **Outcome:**

Licensing Narrative: Licensing Specialist will contact facility regarding the plastic/metal cap. Licensing Specialist informed that the incident happened in a classroom. Licensing Specialist also informed that resident grabbed a pencil sharpener from the desk and tore the battery cap off the bottom of the sharpener. It was reported that the cap was made of plastic and metal. Licensing Specialist inquired about camera footage. 12/14/2022, Licensing Specialist viewed camera footage for 12/8/2022 incident. It was reported that resident swallowed a small plastic/metal cap. Incident took place in a classroom at EMAC. Licensing Specialist observed resident and staff in the classroom. Resident was heard making a phone call while sitting in a chair. Licensing Specialist heard resident say, ?I need to talk to her.? She was unable to talk with who she was calling. Another staff member was observed taking the phone from the classroom. Licensing Specialist heard resident refusing her medication. Licensing Specialist heard staff asking resident to leave the classroom to return to her room. Resident refused to leave the classroom. Licensing Specialist observed resident walking around the classroom touching different objects. Staff could be heard repeatedly asking resident to leave the classroom. Resident grabbed the pencil sharpener from what appeared to be a shelf and emptied the sharpener. The pencil sharpener appeared to be battery operated. Licensing Specialist observed resident removing what appeared to be a small object from the pencil sharpener. Staff was heard asking resident what she and staff held her hand out for resident to give the small object. Resident refused. Resident was observed placing the object into her mouth. Licensing Specialist heard staff asking resident for the object. The nurse and other staff members were observed in the classroom trying to get the resident to comply with giving up the object. Ratio 5:1, including the nurse. Resident was observed playing with the object while staff was trying to get her to comply. Licensing Specialist heard staff explain the danger if resident swallowed the small object. Resident was observed placing the object in her mouth. Licensing Specialist heard staff telling her that she needed to be evaluated to make sure that what she swallowed did not damage anything. The nurse was heard talking with the doctor about the incident via telephone. Staff and the resident were observed leaving the classroom. Licensing Specialist and Eric Knowles, Director of Risk Management discussed the incident. Staff members responded appropriately to the resident without provoking her. Licensing Specialist observed staff members having patience while trying to process with the resident. Mr. Knowles informed Licensing Specialist that resident was placed on self-harm precautions that were removed on 12/12/2022.

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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: 12/14/2022

Home Visit Date: 12/14/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Time of Visit: 10:30 am to 11:45 am
Census: 48

Licensing Specialist viewed camera footage for 12/8/2022 incident. It was reported that resident swallowed a small plastic/metal cap. Incident took place in a classroom at EMAC. Licensing Specialist observed resident

and staff in the classroom. Resident was heard making a phone call while sitting in a chair. Licensing Specialist heard resident say, “I need to talk to her.” She was unable to talk with who she was calling. Another staff member was observed taking the phone from the classroom. Licensing Specialist heard resident refusing her medication.

Licensing Specialist heard staff asking resident to leave the classroom to return to her room. Resident refused to leave the classroom. Licensing Specialist observed resident walking around the classroom touching different objects. Staff could be heard repeatedly asking resident to leave the classroom. Resident grabbed the pencil sharpener from what appeared to be a shelf and emptied the sharpener. The pencil sharpener appeared to be battery operated.

Licensing Specialist observed resident removing what appeared to be a small object from the pencil sharpener. Staff was heard asking resident what she and staff held her hand out for resident to give the small object. Resident refused. Resident was observed placing the object into her mouth. Licensing Specialist heard staff asking resident for the object. The nurse and other staff members were observed in the classroom trying to get the resident to comply with giving up the object. Ratio 5:1, including the nurse.

Resident was observed playing with the object while staff was trying to get her to comply. Licensing Specialist heard staff explain the danger if resident swallowed the small object. Resident was observed placing the object in her mouth. Licensing Specialist heard staff telling her that she needed to be evaluated to make sure that what she swallowed did not damage anything. The nurse was heard talking with the doctor about the incident via telephone. Staff and the resident were observed leaving the classroom.

Licensing Specialist and Eric Knowles, Director of Risk Management discussed the incident. Staff members responded appropriately to the resident without provoking her. Licensing Specialist observed staff members having patience while trying to process with the resident. Mr. Knowles informed Licensing Specialist that resident was placed on self-harm precautions that were removed on 12/12/2022.