ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 12/12/2022

Date Received by DCCECE: 12/13/2022

Facility Name: Dacus RTC

Facility Number: 108

Facility Type: Residential

Incident Type: Licensing

Report Description: Client[redacted] D.O.B:[redacted] Insurance: Empower Guardian:[redacted] Staff member 1:[redacted] Staff member 2:[redacted] Date of Incident: 12/12/2022 Client ([redacted] got out of bed and tried to get into another peer's room. Staff ([redacted]) prevented client[redacted] from leaving the client?s[redacted]) room. Client ([redacted]) started throwing clothing and laundry baskets around the room. Client[redacted]) broke laundry baskets and ripped clothing. Client ([redacted]) threw shoes at staff ([redacted]) and tried hitting staff ([redacted]) with closed fist. Client[redacted]) was placed in a CCP by staff member[redacted] and released when client ([redacted]) was calm and compliant. A few moments later, client[redacted]) tried to get past staff to get to his peers and he was placed in a TCP by staff members[redacted] and[redacted] until he appeared calmed and compliant. After being released, a few minutes later, client ([redacted]) hit staff ([redacted]) with a closed fist in the face, resulting in a laceration on his lip. Client was placed in a CCP by staff member[redacted] and escorted to the cafeteria. Police arrested client ([redacted]) at 8:50pm.

Interim Action Narrative: Resident was placed in a CCP hold twice and one TCP hold for safety reason. The police were called and resident was arrested.

Maltreatment Narrative: **Outcome:**

Licensing Narrative: Camera footage will be viewed. Licensing Specialist will inquire about the name of police department. 12.14.2022, Licensing Specialist informed Bono Police Department were called. CCP stands for Children's Control Position and consists of one staff member. TCP stands for Team Control Position and stands for two staff members. 12/14/2022- Program Coordinator visited the facility, discussed the incident with the director and head nurse, then reviewed camera footage. The Program Coordinator received the restraint justification packet, nursing notes, face to face assessment, and a copy of the police report from the police department. The Program Coordinator discussed concerns related to the staff not taking residents off the unit during the incident, nursing not staying to observe the restraint or assist, and no other staff being available to assist during the incident. The Director reported she will be retraining the nurse on proper restraint policies, staffing can be increased to ensure someone is available to respond, staff received retraining on not entering an escalated resident's bedroom, and staff will receive re-education on removing residents out of the area during an ongoing incident. 2/6/2023, Licensing Specialist received training documentation.

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521 Visit Compliance Report

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Chelsea Vardell

Person In Charge:

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:

Visit conducted from 10:45am-11:55am

Current census: 15

The Program Coordinator met with the Director to discuss an incident that occurred at the facility on 12/12/22 involving resident staff and staff The incident stated that the resident had become escalated on the unit and began to destroy property and throw items at staff. The report also stated the resident punched staff multiple times in the stomach and upper torso then punched staff in the face causing a laceration to his lip. The police were called to the scene and the resident was taken into custody.

The Program Coordinator reviewed the camera footage of the incident from 7:35pm to 8:20pm. During that time, you can see both staff involved on the unit with the resident and several of his peers. The peers are in one room while staff is in the bedroom of resident . Staff stands in the hallway to keep view of the other residents and the situation in the bedroom of resident . The video showed clothes and broken laundry buckets being thrown towards the doorway as staff moves them out of the way. Staff and resident then come back into camera view as staff is beginning a personal restraint. The resident is restrained and is later let go of the hold. The resident continues to pace and appears to be escalated. Staff try to de-escalate, but the resident punches staff who is standing a few feet away. Staff . kneels to the ground and is visibly hurt. Staff begins another personal restraint on the resident as steps out the door momentarily then returns to assist the restraint. The other residents on the unit appear escalated as well and begin to come into the hallway throwing things at the ground. The nurse on duty can be seen coming onto the unit a few times but does not stay long each time as she is on the phone with the head nurse. A resident is seen coming to staff and using his walkie talkie then places it back on s hip before returning to the other room. The resident is released from restraint again and then shortly after is placed in a one man hold by to escort him off the unit and into the cafeteria, where the resident begins to punch things and walk on tables. The resident eventually calms down talking with one on one. The camera footage did not pick up what occurred with the resident when he left the cafeteria headed to the dayroom, but the facility reports that the police responded shortly after and placed him into custody as staff was transported to the hospital to receive four stitches to his lip.

The Program Coordinator discussed concerns about why no support was available to assist or remove the residents off the unit during the incident. The Director reported that other staff were with the remaining residents and if the residents were moved, they would have been out of ratio. The Program Coordinator encouraged the Director to ensure that additional staff is available to respond in emergencies. Additionally, the Program Coordinator discussed the nurse who did not stay to assist and/or observe the restraint hold. The Director reported the nurse is new and this was the first time she had been involved with an incident, so she was on the phone with the head nurse to seek guidance.

The Director reports that she already retrained staff about staying outside of the resident's bedroom when they are escalated so they can have space and all interactions with residents will be seen on the hallway camera. The nurse on duty will be retrained on how to properly respond to a restraint hold and ensuring she can assist if needed. The Director will also discuss with staff the importance of removing residents from the scene of an escalated resident. All education will be completed by 12/23/22

The police report, the nursing note, restraint post intervention debriefing, face to face assessment, and police report were all reviewed by the Program Coordinator. The resident reportedly sustained no injuries during the incident. Concerns were discussed about a note in the police report stating, " the juvenile told me that they was trying to give him a shot in his bottom and was not showing any signs of aggression in my presence." The Director spoke to the nurses and determined no chemical restraint was requested or ordered by the doctor and the resident did not receive a chemical restraint.