



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: 12/20/2022

Date Received by DCCECE: 12/20/2022

Facility Name: Dacus RTC

Facility Number: 108

Facility Type: Residential

Incident Type: Licensing

Report Description: Client: [REDACTED] D.O.B [REDACTED] Insurance: Arkasas Total Care Guardian: [REDACTED] - [REDACTED] County DHS- Caseworker Christina Hughs Staff Members: [REDACTED], [REDACTED] Date of Incident: 12/20/2022 Client ([REDACTED]) was slamming doors and making racial slurs. Client ([REDACTED]) attempted to hit staff and then proceeded to his bedroom. A peer ran out of his bedroom into the Client's ([REDACTED]) bedroom and attacked the Client ([REDACTED]) by punching the Client ([REDACTED]) with closed fist until staff ([REDACTED] and [REDACTED]) was able to separate them. [REDACTED] was directed back to his room while staff was trying to calm the peer down. At this time, Peer 2 ran in Client ([REDACTED]) room and attacked Client ([REDACTED]) with closed fist until staff were able to separate them. Minutes later, Client ([REDACTED]) was laying on the hallway floor where Peer 1 and Peer 2 attacked Client ([REDACTED]) again by kicking and punching with closed fist. Staff separated the clients and took [REDACTED] straight to the nurse for examination. Client ([REDACTED]) right side nasal bridge edematous, red and slight bruising present. An x-ray was ordered. Client was negative for any fractures.

Interim Action Narrative: Resident were separated by staff. Injured resident was assessed by the nurse. Resident's right side nasal bridge edematous, red and slight bruising present. X-ray ordered, negative for any fractures. Residents were separated from each other.

Maltreatment Narrative:

Outcome:

Licensing Narrative: Licensing Specialist will inquire about precautions and camera footage. Licensing Specialist informed that the resident was separated from his peers. Licensing Specialist reviewed camera footage on 12/20/2022. 1/12/2023, Licensing Specialist reviewed camera footage on 1/12/2023 and interviewed staff members and residents. Licensing Specialist viewed camera footage for the 12/20/2022 incident on the big boy hall. Licensing Specialist observed resident walking with the nurse back onto the big boy hall. Resident was walking up and down the hall. Staff were walking up and down the hall also. Licensing Specialist observed a peer rushing into the resident's bedroom. Staff was observed running into the resident's bedroom. Licensing Specialist was unable to observe what took place in the resident's bedroom due to no cameras are in the residents' bedroom. While staff were processing with the client that rushed into the resident's bedroom, another peer ran into the resident's room. A staff member went into the resident's bedroom and removed peer. Other residents were observed trying to enter the bedroom but were stopped by staff. There were two staff members present during the first altercation and another staff member was observed during the second altercation. During the last altercation, staff (all three) were observed separating the residents. Licensing Specialist and Corporate Compliance Director (Shannon Rouse) discussed the response of the staff members to each altercation. Staff responded quickly and separated the residents immediately. Licensing Specialist did not observe any licensing concerns viewing the camera footage of the incident. 1/5/2023, Licensing Specialist spoke with Ms. Banks regarding witness statements and nursing notes of the incident. Licensing Specialist received resident's x-ray results, nurse and staff statements. 1/9/2023, Licensing Specialist will review statements. 1/12/2023, Licensing Specialist interviewed staff members and residents. 1/11/2023- Licensing received additional footage of this incident and determined that it was not presented to the licensing specialist at the time of the visit on 12/21/2022. 1/23/2023- Licensing spoke to Shannon Rouse, who originally shared the video footage with the assigned Specialist on 12/21/2022, to discuss the additional footage received on 1/11/2023. Shannon reported that this issue has been under review at their agency, and she believes that she was provided the time frame for the footage of the first half of this reported incident, so she showed that to the Licensing Specialist. It was later determined that a second half of this incident occurred several minutes after the first one, but Shannon was unaware as she does not work directly at the Dacus facility site. The Program Coordinator requested that Shannon send the time frame of the video that the Licensing Specialist was shown and the time frame of the camera footage of when the second half of the incident occurred.



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521 Visit Compliance Report

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Kendra Rice

Person In Charge: Waynette Banks

Record Visit Date: 12/21/2022

Home Visit Date: 12/21/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

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

Census: 15

Licensing Specialist viewed camera footage for the 12/20/2022 incident on the big boy hall.

Licensing Specialist observed resident walking with the nurse back onto the big boy hall. Resident was walking up and down the hall. Staff were walking up and down the hall also. Licensing Specialist observed a peer rushing into the resident's bedroom. Staff was observed running into the resident's bedroom. Licensing Specialist was unable to observe what took place in the resident's bedroom due to no cameras are in the residents' bedroom.

While staff were processing with the client that rushed into the resident's bedroom, another peer ran into the resident's room. A staff member went into the resident's bedroom and removed peer. Other residents were observed trying to enter the bedroom but were stopped by staff. There were two staff members present during the first altercation and another staff member was observed during the second altercation. During the last altercation, staff (all three) were observed separating the residents.

Licensing Specialist and Corporate Compliance Director (Shannon Rouse) discussed the response of the staff members to each altercation. Staff responded quickly and separated the residents immediately. Licensing Specialist did not observe any licensing concerns viewing the camera footage of the incident.



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Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Kendra Rice

Person In Charge: Waynette Banks

Record Visit Date: 1/12/2023

Home Visit Date: 1/12/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Time of Visit: 11:15 am to 2:00 pm

Census: 15

Licensing Specialist interviewed staff and residents regarding an incident that happened on 12/20/2022. Licensing Specialist interviewed two (2) staff members and five (5) residents.

Staff [REDACTED] reported that she was back and forth between the little boy hall and the big boy hall. [REDACTED] reported that she came in on the latter part of the incident. [REDACTED] stated that resident had been non-compliant with following directions beginning that morning of the incident. [REDACTED] reported that residents were upset due to resident was preventing them from going to breakfast. [REDACTED] informed Licensing Specialist that when resident was on the floor, staff was trying to get resident to comply with directions given but he just laid on the floor.

Staff [REDACTED] reported that resident was pulled out of his bedroom due to participating in self-harm behavior. [REDACTED] informed Licensing Specialist that resident had tied a sweater around his neck. When she entered the room to remove the sweater, resident put his face into his mattress (face down) and pulled up the sides of the mattress attempted to self-harm more. [REDACTED] reported that resident was upset because he had gotten jumped by his peers.

It was reported that while resident was on the floor, staff attempted to deescalate the situation. Resident used vulgar language toward staff and his peers. Other residents were standing against the wall trying to get the resident to get up so that they could go to breakfast.

Residents [REDACTED] and [REDACTED] reported to Licensing Specialist that they did not remember anything. Resident ([REDACTED]) informed Licensing Specialist that resident [REDACTED] is always getting into fights. The day of the incident [REDACTED] reported that [REDACTED] was making too much noise. [REDACTED] informed Licensing Specialist that resident was hit by two residents. He also reported that staff was present and broke up the fights by separating his peers.

Resident ([REDACTED]) informed Licensing Specialist the day before he was upset because he could not go on a pass. He reported that his peer ([REDACTED]) had disturbed his sleep by making noises, so he went into [REDACTED] room and jumped him. [REDACTED] reported that staff pulled him out of his peer's bedroom. [REDACTED] informed Licensing Specialist when [REDACTED] was pulled into the hall, he and his peers were trying to get him to get off the floor so that they could go eat breakfast. [REDACTED] reported that was when [REDACTED] got jumped again.

Licensing Specialist interviewed the AV resident [REDACTED]. He informed Licensing Specialist that he was jumped by his peers because a peer lied on him. [REDACTED] reported that his peers started punching him in the face and staff tried to stop his peers, but they couldn't. [REDACTED] stated that there were two (2) staff members and ten (10) residents.

Licensing Specialist, Ms. Banks, and staff member ([REDACTED]) discussed how the other residents could have been removed off the hallway once resident was placed on the floor. Ms. Banks informed Licensing Specialist staff is not allowed to physically move a resident off the floor when a resident refuses to comply with directions unless the resident is causing harm to self or others.

Licensing Specialist checked the MAR's for the residents below:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

All initialed and updated.



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521 Visit Compliance Report

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Kendra Rice

Person In Charge: Waynette Banks

Record Visit Date: 1/25/2023

Home Visit Date: 1/25/2023

Purpose of Visit: Monitor Visit

Regulations Out of Compliance:

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.

Sub Regulation Description:

Regulation Number: 9.907.2

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Time of Visit: 10:30 am to 10:45 am

Census: 13

Licensing Specialist reviewed camera footage on 12/20/2022 and 1/12/2023 for provider reported incident on 12/20/2022. Licensing Specialist interviewed staff members and residents on 1/12/2023.

On 12/14/2022 the Program Coordinator encouraged the facility to ensure that additional staff is available to respond in emergencies.

Facility will be cited for R907.2. Childcare staff shall be responsible for providing level of supervision, care, and treatment necessary to ensure safety and well-being of each child at the facility. Encourage staff to remove other residents from escalated incidents for safety.