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: 12/22/2022

Date Received by DCCECE: 12/27/2022

Facility Name: United Methodist Children's Home Little Rock Campus

Facility Number: 115

Facility Type: Residential

Incident Type: Licensing

Report Description: On Thursday night on the boy's floor, [redacted] was provoking a female staff, [redacted]. [redacted] Walked up into her personal space many times, and she stepped back. [redacted] pushed [redacted]l back and then she left the floor. The [redacted]. Referral number is [redacted]. Corrective action is move to girls' floor and CPI full class in-service on next available date.

Interim Action Narrative: [redacted] will be retrained on CPI at the next in-service, [redacted] will work on the girl's unit.

Maltreatment Narrative: **Outcome:**

Licensing Narrative: The following information was requested on 12/27/22 from the Agency. When will [redacted] begin working on the new unit, the date of the next in service (for CPI) and is video footage available. 12/27/22- Specialist Kendra Rice visited the facility. I reviewed camera footage for the incident that occurred on 12/22/2022 involving [redacted] (resident) and [redacted] staff member). The incident took place in the boys? foyer area. When the camera footage started the ratio was 2:2. Then the ratio was 2:1, a resident entered into the

bathroom to complete his hygiene. ██████ and ██ could be heard arguing back and forth. Staff was trying to get resident to go back into his room until it was time for him to complete his hygiene. Resident was sitting on what appeared to be furniture in the foyer area. Resident got up and walked toward ████████ was blocked by the other staff member and a resident. Another staff member (nurse) came to the foyer area, ratio 3:1. Staff was standing in front of resident requesting for him to go back into his room. Resident approached staff member each time she backed up. Staff member could be heard informing resident that he was in her personal space. After moving away from the resident a few times, I observed ██ push resident. Resident and staff were separated by the other two staff members and ██ walked into the nurse?s station.

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521 Visit Compliance Report

Licensee: United Methodist Children's Home Little Rock Campus

Facility Number: 115

Licensee Address: 2002 SOUTH FILLMORE
LITTLE ROCK AR 72204

Licensing Specialist: Kendra Rice

Person In Charge: Sherika Williams

Record Visit Date: 12/27/2022

Home Visit Date: 12/27/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Sub Regulation Description:

Regulation Number: 1.109.1.g

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Licensing specialist Kendra Rice visited the facility in response to a provider reported incident involving a resident being pushed by a staff on 12/22/22.

Specialist reviewed camera footage for the incident involving resident [redacted]. and staff [redacted] The incident took place in the boys' foyer area. When the camera footage started the ratio was 2:2. Then the ratio was 2:1, a resident entered into the bathroom to complete his hygiene. The resident and staff [redacted] could be heard arguing back and forth. Staff [redacted] was trying to get the resident to go back into his room until it was time for him to complete his hygiene. The resident was sitting on what appeared to be furniture in the foyer area. The resident got up and walked toward staff [redacted] The resident was blocked by the other staff member and an additional resident. Another staff member (nurse) came to the foyer area, ratio 3:1. Staff was standing in front of resident requesting for him to go back into his room. The resident approached staff [redacted] and each time she backed up. Staff [redacted] could be heard informing the resident that he was in her personal space. After moving away from the resident a few times, staff [redacted] can be seen on camera push the resident. The resident and staff [redacted] were separated by the other two staff members and [redacted] walked into the nurse's station.

The facility reports that staff [redacted] was moved off the boy's unit and onto the girl's unit. The staff will complete a full retraining of CPI.

The facility will be cited for regulation 109.1.g as staff [redacted] engaged in unprofessional conduct when she pushed the resident.