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:10/9/2022

Date Received by DCCECE: 10/27/2022

Facility Name: Little Creek Behavioral Health

Facility Number: 255

Facility Type: Residential

Incident Type: Licensing

Report Description: Licensing received a complaint from an outside source that information reported in an elopement at the facility on 10/9/22 was not accurate and licensing concerns may have occurred. The report contains information that the two residents who eloped were potentially missing off the unit for approximately three hours before a call was made to the police and staff were unaware of the elopement.

Interim Action Narrative:

Maltreatment Narrative: **Outcome:**

Licensing Narrative: Program Coordinator reviewed the information and visited the facility on 10/28/22 (see inspection # 055335). The DON and CEO reported that the residents eloped at 730am based on nightly visual observations they produced documenting the staff [redacted] was viewing them in their rooms until 7:30am. Both residents who eloped were interviewed and report that they eloped around 5am as they looked at the clock in the dayroom. The residents state that staff was off the unit leaving them alone, so they went to the restroom, got dressed, and used a staff key card to elope off the back entrance to the

unit. One resident reported that he found the keycard after staff dropped it during a restraint hold performed on another resident earlier that same day. However, the DON and CEO report that the key card was from a previous staff who left the agency approximately 2-3 weeks ago. The nurse who reported the resident elopement to police and the staff who reviewed the camera footage of the elopement, prior to its deletion, spoke to the Program Coordinator via phone on 10/28/22 after leaving the facility visit. The nurse reports staff was unaware when the residents eloped, and it was reported to her they were missing around 730am-745am when they began to look for the residents prior to calling police. Staff who reviewed the camera footage reported that the resident did elope from the unit around 530am and the staff responsible for their supervision, [redacted], was off the unit and not conducting his mandatory visual bed checks. The staff, [redacted] quit work at the facility after this incident. Facility will be cited for 907.2 and 907.6 see inspection 055371 for determination notice.

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521 Visit Compliance Report

Licensee: Little Creek Behavioral Health

Facility Number: 255

Licensee Address: 161 SKUNK HOLLOW
CONWAY AR 72032

Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 10/28/2022

Home Visit Date: 10/28/2022

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Visit Conducted from 12:45pm-2:30pm

Census: 56

Program Coordinator spoke to the DON and CEO that the Licensing Unit received a complaint against the facility on 10/27/22 that an incident reported to licensing on 10/10/22 was missing information involving potential serious licensing concerns. The information provided by the agency stated that two residents eloped from the facility by kicking open a door and climbing a fence around 535am on 10/9/22. However, the information provided to licensing showed that the facility did not contact the police department to report the elopement until 8:28am in which the staff states that she is unaware of when the residents eloped, and the staff will have to review camera footage to determine how long they have been gone.

The DON and CEO of the facility report that their documents show that the residents were not noted as missing until 7:30am at which time the staff began to look for the residents and contact supervisors prior to reporting the elopement to the police department at 8:30am.

Program Coordinator viewed the bed check logs for both residents that show staff ([redacted] viewed the residents in their beds through the night until 7:30am. Notes on the log shows that staff "[redacted] came onto the unit during a shift change around 7:20am and reported that they could not locate the two residents. Video footage is unavailable as it automatically deletes after 72 hours. The staff who viewed the footage to determine when and how the residents eloped is not currently at work today. All other involved staff in this incident are also not present at the facility today. The facility reports that the staff who reviewed the camera footage to determine the time of the elopement will contact the Program Coordinator via phone to discuss his findings.

The facility reports that they did determine that the residents eloped from the facility using a former staff key badge who quit 2-3 weeks ago. The badge has been obtained by the facility and a new process has been put in place to expedite the badges being disabled after an employee resigns or is terminated.

Program Coordinator spoke to both residents about the elopement and discussed the events.

Resident [redacted] reports that he and a peer came out of their bedrooms between 4:30am-5:00am when they noticed that staff was not on the unit. The resident reports that the staff was at the nurse station, so the two residents went back to their room, grabbed clothes, went to the restroom and got dressed then used a staff badge to exit the back door and elope. The resident states that he is the one who found the staff badge after it dropped on the floor during a restraint of another resident earlier the same day.

Resident [redacted] reports that he and a peer eloped from the facility at approximately 5:00am after noticing that staff was not on the unit. The resident reports he did not know where staff was so he and the peer eloped using a badge they had found.

The Program Coordinator discussed with the facility the reports of the residents about staff not being on the unit and how they obtained the badge. The facility states that the staff who was responsible for the supervision of the residents ([redacted] no longer works at the facility as he resigned his position. The HR Director is currently

out of the office but will confirm the day the staff quit upon her return with licensing. The facility reports that they will conduct a retraining of staff to ensure appropriate supervision is occurring during the night shifts and staff remain on their assigned units.

Licensing is not prepared to leave a finding at this time.

Provider Comments:

CCL Staff Signature : Date: 10/28/2022

Provider Signature : Date: 10/28/2022

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521 Visit Compliance Report

Licensee: Little Creek Behavioral Health

Facility Number: 255

Licensee Address: 161 SKUNK HOLLOW
CONWAY AR 72032

Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 10/31/2022

Home Visit Date: 10/31/2022

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 9. 907. 2

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.

Findings Description: Staff failed to provide supervision to the residents who eloped off the unit on 10/9/22.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulation Number: 9. 907. 6

Regulation Description: Supervision during sleeping hours shall include a visual check on each child at least every thirty (30) minutes.

Findings Description: The staff did not complete visual checks on the residents during sleeping hours and falsified documents stating that he was checking on them every 15 minutes.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

No site visit conducted on this day.

Licensing received a complaint on 10/27/22 that an incident involving the elopement of two residents on 10/9/22 was not fully reported to the licensing unit, as it involved issues that were violations against the Minimum Licensing Standards. An in-person visit was conducted by the Program Coordinator on 10/28/22 in which bed check logs were viewed, information was provided by the DON and CEO, and interviews were conducted with both the residents involved. After the visit ended, the nurse who notified police of the elopement and the staff who reviewed the camera footage of the elopement called the Program Coordinator. The discussion confirmed that the resident's did elope around 5:30am using a staff key card they obtained. It is unknown where the key card came from because the residents reported they obtained it earlier that day when staff dropped it during a restraint hold, but the management state that the key card was from a staff who quit 2-3 weeks ago. The staff ([redacted] responsible for their supervision was seen on camera off the unit and falsifying his visual bed check log for the residents. The facility reports that staff [redacted] resigned his position at the facility prior to the visit on 10/28/22.

Licensing complaint is founded. The staff failed to provide adequate supervision to the residents on the unit when he left the unit unattended. The staff also falsified documents and was not completing visual checks on the resident every 30 minutes during sleeping hours as required by the Minimum Licensing Standards. The facility is being cited for 907.2 and 907.6.

The facility reports that they have instituted a new process to expedite the deactivation of staff key cards when they quit or are terminated from employment. Additionally, the facility will retrain night shift staff on the importance of staying on the unit and conducting visual observations of the residents.

Provider Comments:

CCL Staff Signature : Date: 10/31/2022

Provider Signature : Date: 10/31/2022