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: 4/1/2023

Date Received by DCCECE: 4/3/2023

Facility Name: Millcreek of Arkansas PRTF

Facility Number: 233

Facility Type: Residential

Incident Type: Licensing

Report Description: [redacted] Custody, DOB: [redacted] was sent to Dallas County Medical Center following a physical confrontation. He reported pain in his nose during the on-site nursing assessment. He was sent for outpatient x-ray. X-ray report indicates "[redacted] CT imaging would best define if needed clinically." Tylenol was provided for pain. He was released to return to the facility.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: Client [redacted] was sent to Dallas County Medical Center following a physical confrontation. He reported pain in his nose during the on-site nursing assessment. He was sent for outpatient x-ray. X-ray report indicates "[redacted]. CT imaging would best define if needed clinically." Tylenol was provided for pain. He was released to return to the facility. Email sent to facility 4/4/23 to inquire of video footage of

this incident. Received email from facility 4/4/23 that there was camera footage of this incident. Per phone call 4/5/23 with Chris Butler, Risk Mgmt. Millcreek, Chris Butler reviewed this video and stated that [redacted] was punched in the nose by a peer. When this happened staff [redacted] was outside of the unit and staff [redacted] was inside of the unit but did nothing to intervene. Chris Butler stated that both staff [redacted] and [redacted]r were terminated due to this incident. Facility visited 4/6/23 and video reviewed of this incident. Staff [redacted] is seen sitting down. A client in a red shirt is seen punching client [redacted] in the face. The aggressor is seen throwing a second punch towards [redacted] The aggressor returns to a hallway area and client [redacted] leaves camera view as to go outside. Client [redacted] reported to facility that he was taken to the nurse's office by staff [redacted] (other staff at Magnolia Hall) subsequent this incident. According to video, it seems that staff [redacted] directly witnessed this incident. At no time during this incident did staff [redacted]s leave his seat to intervene nor assist client [redacted] Facility cited 907.2.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Millcreek of Arkansas PRTF

Facility Number: 233

Licensee Address: 1828 INDUSTRIAL DRIVE
FORDYCE AR 71742

Licensing Specialist: Clayton DeBoer

Person In Charge: Chris Butler

Record Visit Date: 4/6/2023

Home Visit Date: 4/6/2023

Purpose of Visit: Self Report 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 [redacted] did nothing to intervene nor assist client [redacted] in this incident.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Client [redacted] was sent to Dallas County Medical Center following a physical confrontation. He reported pain in his nose during the on-site nursing assessment. He was sent for outpatient x-ray. X-ray report indicates "There appears to be some [redacted]. CT imaging would best define if needed clinically." Tylenol was provided for pain. He was released to return to the facility.

Per phone call 4/5/23 with Chris Butler, Risk Mgmt. Millcreek, Chris Butler reviewed this video and stated that [redacted] was punched in the nose by a peer. When this happened staff [redacted] was outside of the unit and staff [redacted] was inside of the unit but did nothing to intervene. Chris Butler stated that both staff [redacted] and [redacted] were terminated due to this incident.

Facility visited 4/6/23 and video reviewed of this incident. Staff [redacted] is seen sitting down. A client in a red shirt is seen punching client [redacted] in the face. The aggressor is seen throwing a second punch towards [redacted] The aggressor returns to a hallway area and client [redacted] leaves camera view as to go outside. Client [redacted] reported to facility that he was taken to the nurse's office by staff Easter (other staff at Magnolia Hall) subsequent this incident. According to video, it seems that staff [redacted] directly witnessed this incident. At no time during this incident did staff [redacted] leave his seat to intervene nor assist client [redacted].

Facility cited 907.2.

Provider Comments:

Both employees involved in this incident completed all facility training and development and met the competency requirements to perform Millcreek's expected job functions and responsibilities. Each staff member failed to respond according to facility expectations, policies, and procedures. Their failure to respond accordingly was a violation of company policy and subjected them to disciplinary action that resulted in termination of employment. Concerning this incident, there is no failure noted in any facility system, procedure, process, or practice. This incident further proves the facility practices are sufficient and effective to respond when an employee acts of their own accord and is against facility policy.

CCL Staff Signature :

Date: 4/6/2023

Provider Signature :

Date: 4/6/2023