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: 4/2/2023

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], Parent Custody, DOB: [redacted]) was sent to Dallas County Medical Center for assessment following a physical altercation. He reported dizziness during his on-site nursing assessment. ER report indicates no loss of consciousness, no vision changes, no neurologic deficits. Mild headache reported. DCMC provided Tylenol and ordered neuro checks every 4 hours for next 24-hours as a precautionary measure. He was released to return to Millcreek.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: Client [redacted] was sent to Dallas County Medical Center for assessment following a physical altercation. He reported dizziness during his on-site nursing assessment. ER report indicates no loss of consciousness, no vision changes, no neurologic deficits. Mild headache reported. DCMC provided Tylenol and ordered neuro checks every 4 hours for next 24-hours as a precautionary measure. He was released to return to Millcreek. Email sent to facility 4/4/23 to inquire if there is video footage of this

incident. Email received 4/4/23 stating that there was camera footage of this incident and that a report was made to the [redacted]. The report was not accepted for investigation. The [redacted] report provided by Millcreek states that "it was seen that [redacted] was taunted, punched, and kicked by peers over a period of 15 minutes" and "[redacted] and [redacted] were the employees assigned to Magnolia Hall. The camera review revealed that both employees made minimal effort to mitigate the situation". Facility cited 907.2 on 4/5/23. Facility visited 4/6/23 and video reviewed. Citation from 4/5/23 stands. Staff do not intervene as client is attacked by peers. Additionally, at the beginning of this incident, staff [redacted] is seen bear hugging client [redacted] in an aggressive manner after client [redacted] takes a drink from staff [redacted]. Client [redacted] falls to the floor. Facility cited 109.1g on 4/6/23.

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: 4/5/2023

Home Visit Date: 4/5/2023

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 responsible for supervising clients involved in this investigation made minimal effort to mitigate the situation.

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 for assessment following a physical altercation. He reported dizziness during his on-site nursing assessment. ER report indicates no loss of consciousness, no vision changes, no neurologic deficits. Mild headache reported. DCMC provided Tylenol and ordered neuro checks every 4 hours for next 24-hours as a precautionary measure. He was released to return to Millcreek.

Email sent to facility 4/4/23 to inquire if there is video footage of this incident. Email received 4/4/23 stating that there was camera footage of this incident and that a report was made to the [redacted] which was not accepted for investigation.

[redacted] report provided by Millcreek states that "it was seen tha [redacted] was taunted, punched, and kicked by peers over a period of 15 minutes" and [redacted] and [redacted] were the employees assigned to Magnolia Hall. The camera review revealed that both employees made minimal effort to mitigate the situation".

No facility visit today 4/5/23. This is to document citation for incident. Facility cited 907.2 on 4/5/23.

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 and external reporting to the [redacted]. 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 against facility policy.

CCL Staff Signature : Date: 4/5/2023

Provider Signature : Date: 4/5/2023

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: 1. 109. 1 .g

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

Findings Description: Staff [redacted] bear hugs client [redacted] causing him to fall to the floor.

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 for assessment following a physical altercation. He reported dizziness during his on-site nursing assessment. ER report indicates no loss of consciousness, no vision changes, no neurologic deficits. Mild headache reported. DCMC provided Tylenol and ordered neuro checks every 4 hours for next 24-hours as a precautionary measure. He was released to return to Millcreek.

Email sent to facility 4/4/23 to inquire if there is video footage of this incident. Email received 4/4/23 stating that there was camera footage of this incident and that a report was made to the [redacted]. The report was not accepted for investigation.

The Child Abuse Hotline report provided by Millcreek states that "it was seen that [redacted] was taunted, punched, and kicked by peers over a period of 15 minutes" and [redacted] and [redacted] were the employees assigned to Magnolia Hall. The camera review revealed that both employees made minimal effort to mitigate the situation".

Facility cited 907.2 on 4/5/23.

Facility visited 4/6/23 and video reviewed. Citation from 4/5/23 stands. Staff do not intervene as client is attacked by peers. Additionally, at the beginning of this incident, [redacted] is seen bear hugging client [redacted] in an aggressive manner after client [redacted] takes a drink from [redacted] Client [redacted] falls to the floor.

Facility cited 109.1g on 4/6/23. As to document sub-regulation g) Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

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 and external reporting to the AR Child Abuse Hotline. 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 against facility policy.

CCL Staff Signature : Date: 4/6/2023

Provider Signature : Date: 4/6/2023