



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

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### Notice of Serious Incident

Date of Incident: 7/2/2023

Date Received by DCCECE: 7/3/2023

Facility Name: Dacus RTC

Facility Number: 108

Incident Type: Licensing

Report Description: Client: [REDACTED] D.O.B: [REDACTED] Insurance: Empower Private Pay: Guardian-grandmother-[REDACTED] Staff present: Shantelle Moore and Sara Virgin Date of Incident: 7/2/2023 Staff(Shantelle) informed the client([REDACTED]) it was time for bed. Client([REDACTED]) refused to go to bed. Client([REDACTED]) ran behind the desk detached the HDMI Cord and wrapped it around his neck. Client ([REDACTED]) crawled under the desk. Staff unwrapped the cord from around the client's ([REDACTED]) neck. Client ([REDACTED]) grabbed a staff's clipboard, ran down the hallway and tried to use the metal part to cut his arm. The nurse noted client([REDACTED]) made a small 1-2cm abrasion to left forearm. A small amount of blood was noted. Client ([REDACTED]) denied having pain. The wound was cleaned and bandaged. Client ([REDACTED]) was placed on assault precautions, elopement precautions, suicide precautions, and line of sight to be directly supervised by staff at all times.

Interim Action Narrative: Resident was assessed by the nurse. Wound was cleaned and bandaged. He was placed on assault, elopement, and suicide precautions. Resident was also placed on line of sight.

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Maltreatment Narrative:

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Licensing Narrative: Licensing Specialist reviewed provider reported incident. Licensing Specialist will inquire about camera footage. Licensing Specialist informed camera footage is available. Licensing Specialist will schedule a day and time to review camera footage. 7/11/2023, Licensing Specialist reviewed camera footage.



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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:** 7/11/2023

**Home Visit Date:** 7/11/2023

**Purpose of Visit:** Self Report Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

Time of Visit: 11:30 am to 1:00 pm

Census: 14

Licensing Specialist spoke with Ms. Waynette Banks, Program Director, regarding ELS Case #014973.

Licensing Specialist reviewed camera footage for ELS Case #014973 for licensing concerns. Licensing Specialist observed ratio (1:2) they were sitting in a classroom. The resident was sitting at a desk and the other resident was sitting by the staff's desk. The staff appeared to be completing some paperwork,

Licensing Specialist observed the resident get up from the desk and walked to the staff's desk. It appeared that he was dropping something on the floor and was moving things on the desk. Resident then walked around the classroom. Licensing Specialist observed another staff enter the classroom and talked to the resident, ratio 2:2. The other resident left with the staff member that entered the classroom and the resident sat back down at the desk, ratio 1:1.

Another staff member entered the classroom, ratio 2:1. Resident walked to the staff desk. Licensing Specialist observed resident unplug something off the staff's desk Resident then walked around the desk and got under the desk. Staff followed the resident and Licensing Specialist observed staff bending down under the desk. It appeared that the other staff member used her phone (flashlight) to see what the resident under the desk.

Licensing Specialist observed both staff members reaching under the desk. The resident was escorted from under the desk and staff members took what appeared to be a cord from the resident. Licensing Specialist observed resident reaching for something from staff and run down the hallway. Staff was observed taking something from the resident. All doors on the hallway were locked and resident was unable to enter any rooms on the hallway.

Licensing Specialist observe resident walking up and down the hallway before sitting at the end of the hallway on the floor, ratio 2:1. Staff was observed standing at the other end of the hallway watching the resident. Resident eventually got up off the floor and walked down the hall with staff. Licensing Specialist observed resident rubbing his arm as he was walking down the hallway.

**Provider Comments:**

CCL Staff Signature :

Date: 7/11/2023



Provider Signature :

Date: 7/11/2023



