



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: 6/17/2023

Date Received by DCCECE: 6/19/2023

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

Facility Number: 115

Incident Type: Licensing

Report Description: On Saturday at 1pm, [REDACTED] age [REDACTED] and [REDACTED] DOB [REDACTED] DHS custody client, client has she/her pronouns but born male. Client was on the unit with staff having conversations and talking about things. [REDACTED] says oh your keychain is cute and its glittery, staff said thank you, and was looking at the keys, and [REDACTED] grabbed the keys and took off [REDACTED] ran through the unit, then the courtyard. Another client ran after [REDACTED] as well, [REDACTED] threw the keys at the other client outside of the facility and [REDACTED] jumped the fence. The other client returned with the keys 1 minute later. The local police were notified immediately, and they are still looking for the client.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: On Saturday at 1pm, client [REDACTED] client has she/her pronouns but born male. Client was on the unit with staff having conversations and talking about things. [REDACTED] says oh your keychain is cute and its glittery, staff said thank you, and was looking at the keys, and [REDACTED] grabbed the keys and took off. [REDACTED] ran through the unit, then the courtyard. Another client ran after [REDACTED] as well, [REDACTED] threw the keys at the other client outside of the facility and [REDACTED] jumped the fence. The other client returned with the

keys 1 minute later. The local police were notified immediately, and they are still looking for the client. Facility visited 6/20/23 and video reviewed of elopement. Staff/client ratio in video 1:3. [REDACTED] is seen and heard having conversation with staff [REDACTED] about her ([REDACTED]s) keys, when [REDACTED] grabs keys from staff and use key fob to exit area, another peer following behind him. The other peer had grabbed staff's radio and pushed door closed behind him when exiting area. Staff [REDACTED] immediately tried to chase clients but was unable to exit door to pursue them. Clients are seen in video exiting the hallway then into the courtyard where a key fob would have granted them access out of the courtyard. The peer with [REDACTED] is then seen using the key fob to re-enter facility and giving the keys back to staff. Staff did not fail to supervise clients until clients eloped during video reviewed. Staff did not properly secure keys/key fob while supervising clients. Staff [REDACTED] will complete in-service on importance of key/key fob control. Staff [REDACTED] in-service training emailed to licensing 6/21/23. Received email from Justin King 6/26/23 of UMCH that client [REDACTED] was located and brought to UMCH on 6/25/23. Email received 6/26/23 from UMCH as follows: Good afternoon, we don't have a written safety plan. We have a doctor's order that we are abiding by. The doctors order are Elopement Precaution, Building Restriction, Unit Restriction and 60k focus.



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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: Clayton DeBoer

Person In Charge:

Record Visit Date: 6/20/2023

Home Visit Date: 6/20/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Facility visited 6/20/23 and video reviewed of elopement. Staff/client ratio in video 1:3. [REDACTED] is seen and heard having conversation with staff [REDACTED] about her ([REDACTED]'s) keys, when [REDACTED] grabs keys from staff and uses key fob to exit area, another

peer following behind him. The other peer had grabbed staff's radio and pushed door closed behind him when exiting area. Staff [REDACTED] immediately tried to chase clients but was unable to exit door to pursue them. Clients are seen in video exiting the hallway then into the courtyard where a key fob would have granted them access out of the courtyard. The peer with [REDACTED] is then seen using the key fob to re-enter facility and giving the keys back to staff.

Staff did not fail to supervise clients until clients eloped during video reviewed. Staff did not properly secure keys/key fob while supervising clients.

Staff [REDACTED] will complete in-service on importance of key/key fob control. [REDACTED] in-service training emailed to licensing 6/21/23.

Provider Comments:

CCL Staff Signature :

Date: 8/17/2023



Provider Signature :

Date: 8/17/2023

