



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: 6/30/2023

Date Received by DCCECE: 6/30/2023

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

Facility Number: 115

Incident Type: Licensing

Report Description: On June 30th 2023, about 6:45 am, client [REDACTED] age [REDACTED] DOB [REDACTED] DHS custody, was on the unit in active tantrum, yelling, screaming, attacking staff. Staff removed other clients from the hallway, and during this [REDACTED] went into her bedroom and grabbed a pair of pants and wrapped them around her neck, stating I want to kill myself, staff intervened and removed the pants from the clients neck. [REDACTED] was assessed by the nurse and no markings were found. [REDACTED] later in the morning was transported by MEMS to the Behavioral Hospital in Maumelle.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: Licensing received complaint 6/30/23 that on 6/30/23 client [REDACTED] made a suicidal gesture by wrapping a pair of pants around her neck. Client was later transported to Maumelle Behavioral Hospital by MEMS. Email sent to facility 7/3/23 to inquire of video footage of this incident. Facility visited 7/5/23 in response to self-report incident of client [REDACTED] demonstrating suicidal behavior. Video reviewed of incident. Client [REDACTED] can be seen in a hall by herself, initially staff seen on the other side of a security access door observing client. [REDACTED] is seen spitting on bedroom doors and displaying escalated behavior. At

one point client [REDACTED] can be seen entering her room and getting a cloth ligature and wrapping it around her neck. Client [REDACTED] can be heard saying she wants to die. About 3 minutes go by with ligature wrapped around client's neck before staff enter the hallway and remove the ligature. No staff could be seen supervising client on the other side of the door from this camera angle. Camera footage of the other side of the security doors was reviewed for these 3 minutes. One staff is seen sitting in a chair outside of the security doors, not looking in on client [REDACTED]. Client [REDACTED] was on a hall, by herself, escalated with no staff present on the hallway for 3 minutes. Facility cited 907.2 and 907.3.



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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: 7/5/2023

Home Visit Date: 7/5/2023

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 failed to supervise an escalated client for 3 minutes while client made suicidal gesture.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulation Number: 9. 907. 3

Regulation Description: Staff/child ratio shall be at least 1:6 during waking hours and 1:8 during sleeping hours.

Findings Description: No staff were present nor supervising an escalated client for 3 minutes.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Facility visited 7/5/23 in response to self-report incident of client ■ demonstrating suicidal behavior. Video reviewed of incident. Client ■ can be seen in a hall by herself, initially staff seen on the other side of a security access door observing client ■ is seen spitting on bedroom doors and displaying escalated behavior. At one point client ■ can be seen entering her room and getting a cloth ligature and wrapping it around her neck. Client ■ can be heard saying she wants to die. About 3 minutes go by with ligature wrapped around client's neck before staff enter the hallway and remove the ligature. No staff could be seen supervising client on the other side of the door from this camera angle. Camera footage of the other side of the security doors was reviewed for these 3 minutes. One staff is seen sitting in a chair outside of the security doors, not looking in on client ■. Client ■ was on a hall, by herself, escalated with no staff present on the hallway for 3 minutes. Facility cited 907.2 and 907.3.

Provider Comments:

All staff will be retrained on the standards regarding supervision. Discuss policy and procedure regarding clients' supervision when on sick leave, hygiene, and isolation. Discussion with Consultants regarding process for hygiene in the am and pm. Discussion about possible disciplinary action. Video will be shown to the 1st shift staff members for training purposes.

CCL Staff Signature :

Date: 7/5/2023



Provider Signature :

Date: 7/5/2023





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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: CRAIG GAMMON

Record Visit Date: 7/10/2023

Home Visit Date: 7/10/2023

Purpose of Visit: Monitor Visit

Regulations Out of Compliance:

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: Several videos reviewed (5) had more than 30 minutes in between checks.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Visit conducted 7/10/23 and random video reviewed of facility from 7/5/23, 7/6/23 and 7/7/23.

7/5/23:

Hall A night supervision checks completed: 2:29AM, 2:39AM and 2:53AM

Hall B night supervision checks completed: 2:01AM, 2:29AM and 2:43AM

Hall C night supervision checks completed: 2:11AM, 2:18AM and 2:23AM

Hall D night supervision checks completed: 2:27AM, 2:56AM and 3:37AM, 41 minutes in between two checks.

7/6/23:

Cafeteria video reviewed from 12:00PM, staff/client ratio 4:16.

Cafeteria video reviewed from 5:00PM, staff/client ratio 3:15.

Hygiene time, 6:00AM reviewed of Hall B. No more than 10 clients occupy a Hall at a time. During Hygiene, one staff assist/escort 4 clients of the Hall at a time for hygiene, keeping staff/client ratio within licensing standards. One Hall engages in hygiene at a time.

7/7/23:

Hall A night supervision checks completed: 8:41PM, 9:27PM, 9:39PM and 9:45PM. 46 minutes in between two checks.

Hall B night supervision checks completed: Video started at 8:30PM until next check at 9:03PM, 9:18PM, and 9:34PM, 33 minutes in between two checks.

Hall C night supervision checks completed 8:47PM, 9:20PM, 9:30PM and 9:46PM. 33 minutes in between two checks.

Hall D night supervision checks completed 8:45PM, 9:30PM, 9:53PM and 10:05PM. 45 minutes in between two checks.

Facility cited 907.6: Supervision during sleeping hours shall include a visual check on each child at least every thirty (30) minutes.

Provider Comments:

MCH will implement a plan of correction with training, use of timers and video as well as in-person checks. Details of this plan will be submitted to the licensing specialist ASAP.

CCL Staff Signature :

Date: 7/10/2023



Provider Signature :

Date: 7/10/2023





CORRECTIVE ACTION PLAN

Arkansas Department of Human Services Residential Licensing Unit

United Methodist Children's Home

Residential Treatment Centers| Qualified Residential Treatment Programs| Supervised Independent Living

**** DISCUSSION/OBSERVATION****

Standard Reviewed: 9.907.2 and 9.907.3

Observation: Facility visited 7/5/23 in response to self-report incident of client ■ demonstrating suicidal behavior. Video reviewed of incident. Client ■ can be seen in a hall by herself, initially staff seen on the other side of a security access door observing client. ■ is seen spitting on bedroom doors and displaying escalated behavior. At one point client ■ can be seen entering her room and getting a cloth ligature and wrapping it around her neck. Client ■ can be heard saying she wants to die. About 3 minutes go by with ligature wrapped around client's neck before staff enter the hallway and remove the ligature. No staff could be seen supervising client on the other side of the door from this camera angle. Camera footage of the other side of the security doors was reviewed for these 3 minutes. One staff is seen sitting in a chair outside of the security doors, not looking in on client ■ Client ■ was on a hall, by herself, escalated with no staff present on the hallway for 3 minutes. Facility cited 907.2 and 907.3.

Corrective Action:

1. All staff will be retrained on the standards regarding supervision; ratio requirements and monitoring.
2. Retrain staff on the plan to call for help if monitoring becomes a problem at any time.
3. Retrain staff on policy and procedure regarding clients' supervision when on sick rule protocol, hygiene, and isolation.
4. Implement a plan for Consultants (or other identified individuals) to randomly monitor and document process for hygiene in the am and pm.
5. Review identified issues for possible disciplinary action. Video will be shown to the 1st shift staff members for training purposes as well.
6. All incidents will be reviewed by Consultants and Director/Administrator and documented.
7. Review communication from Lead BI to how inaccurate information was reported to the Consultant on call as evidenced by the discrepancy between the CIR and the video review; pants vs sweater, how quickly staff intervened, and the staff to client ratio.

This plan is intended to address a trend in issues regarding the monitoring and supervision of clients which has been noted in past months. The results of the plan and ongoing monitoring of issues will be documented as well.

Identify Person Responsible: Director: ■, LCSW and Consultants, ■ and ■

Completion Date:

1. __/__/__ as evidenced by Training Roster sign in sheet
2. __/__/__ as evidenced by Training Roster sign in sheet
3. __/__/__ as evidenced by Training Roster sign in sheet
4. __/__/__ : Create a form for monitoring hygiene process, via in person or video review and implement the plan no later than Monday, July 10. A copy of the form will be attached to the completed Corrective Action Plan.
5. __/__/__ as evidenced by Training Roster sign in sheet and Records of Supervision for each staff member to include a plan for improvement in monitoring to be monitored and reviewed for progress in a month.
6. __/__/__, on-going. All incidents are discussed in weekly staffings, including any changes that will be made in the resident's treatment, such as MTP problem/goal/objective additions; Addition to Target Skills, etc. As evidenced by the Treatment Team Results note in the resident's chart.
7. __/__/__ as evidenced by a Record of Supervision form.

Standard Reviewed: 9. 907. 6

Observation: Several videos reviewed (5) had more than 30 minutes in between checks.

Corrective Action:

1. Staff found to be out of compliance were addressed with disciplinary action.
2. All involved staff reviewed the requirement on timing and consistency of sleep time client checks. This was found to be a compliance issue and not one resulting from lack of training.
3. A plan was implemented beginning on the evening of July 10th to correct these issues using the following steps:
 - a. The use of timers was instituted on each residential sleeping unit. These timers are visual and light up at preset times to alert staff that checks must be initiated. The timers' audio feature can be silenced so as not to disturb clients.
 - b. Video review of overnight checks on all units at random times is now conducted a minimum of three times per week. This is scheduled and completed by the Supervisors, Director and or Administrator.
 - c. Any observations indicating lack of compliance are immediately addressed with appropriate actions.
 - d. This plan will continue for a minimum of 60 days and or until consistent compliance is observed.
4. In-person, drop-in visits to the facility during sleep hours will be increased and will be conducted by supervisors or administrative staff.

Completion Date:

1. 7/17/23 Warning reports issued to non-compliant staff and submitted to personnel file.
2. 7/10/23 Completed in person and via email with instructions on use of timers etc.

3. 7/10/23 Use of timers implemented for 3rd shift and 5th shift on this date. Verified visually by video review. Timers are visible by cameras while in use.
4. 7/10/23 plan completed during meeting of RTC management team, these visits are unscheduled but will be documented as they randomly occur.

Identify Person Responsible: Director: [REDACTED], LCSW and Consultants, [REDACTED] and [REDACTED], Administrator, [REDACTED].