ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
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Corrective Action Agreement

Date: 5/18/2023

To: Ben Beasley

Owner Name: Habilitation Center, Inc.

Facility Name: Millcreek of Arkansas PRTF

License #: 233

Mr. Beasley,

This document constitutes a formal Corrective Action Agreement (CAA) agreed upon by Millcreek of Arkansas PRTF and the Department of Human Services, Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. This CAA will be in effect for a period of six months from the date of signing by both parties. This agreement may be extended beyond six months should DHS determine any non-compliance with the CAA during the stated corrective action period.

The purpose of this agreement is to gain and maintain a high degree of compliance with licensing requirements. The following non-compliance areas have been cited during the past three months:

Minimum Licensing Standards (Residential): Section 109-Unprofessional Conduct

109.1.g Unprofessional conduct in the practice of child welfare activities shall include without limitation: (g) Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

- **Millcreek of Arkansas PRTF received a citation on the following date regarding the inappropriate discipline given to a resident based on their age, development, and history.**

- **03/03/2023- Staff pushed residents several times during the outbreak of multiple resident altercations on the unit.**
  - Review of camera footage revealed that a male staff on the unit had pushed residents aggressively multiple times during several altercations that occurred between the residents. A resident can be seen being pushed into a table, another one into a corner, and a third being pushed over the back of a couch and landing on the other side.

Minimum Licensing Standards (Residential): Section 905-Behavior Management

905.3 Discipline shall be appropriate to the child's age, development, and history.

- **Millcreek of Arkansas PRTF received a citation on the following date regarding the inappropriate discipline given to a resident based on their age, development, and history.**

  - **03/13/2023- A ten-year-old resident was disciplined by standing in the corner of the dayroom in the evening for approximately two hours and twenty-five minutes.**
    - Camera review of the incident revealed that the resident was directed into the corner by the staff supervisor at approximately 7:15pm. The resident then stayed in the corner with staff siting at a table in front of the corner. The resident did come out of the corner 2-3 times for a bathroom break and to quickly complete his nighttime chore, but then would immediately return to the corner. At one point staff makes the resident turn his head around and face the corner with his nose against the wall for almost an hour.

905.4.f The following disciplinary actions shall not be used: (f) Restriction to a dark room or area.

- **Millcreek of Arkansas PRTF received a citation on the following date regarding inappropriate behavior management.**

  - **03/13/2023- Camera review of the incident revealed that the resident was directed into the corner by the staff supervisor for approximately two hours and twenty-five minutes.**
    - The resident can be seen directed to the corner at approximately 7:15pm. The resident then stayed in the corner with staff siting at a table in front of the corner. The resident did come out of the corner 2-3 times for a bathroom break and to quickly complete his nighttime chore, but

then would immediately return to the corner. At one point staff makes the resident turn his head around and face the corner with his nose against the wall for almost an hour

905.4.g The following disciplinary actions shall not be used: (g) Physical injury or threat of bodily harm.

- **Millcreek of Arkansas PRTF received a citation on the following date regarding inappropriate behavior management.**
    - **03/17/2023- Camera review of an incident revealed that a staff member had aggressively walked towards a resident in a threatening manner and bumped him with her stomach knocking him off balance as she directed him back to the corner, he had been standing in for over two hours.**
        - The resident can be seen being allowed to leave the corner he had been standing in for a significant amount of time by a male staff. The resident walks to the doorway of his bedroom hall then can be seen turning around and saying something to the female staff on the unit. The female staff can be seen pointing towards the corner and begins to walk quickly towards the resident with a broom in her hand. The resident looks towards the ground and turns sideways as the staff begins bumping into him with her stomach, knocking him off balance, and directing him back into the corner. The resident then stands back in the corner for approximately another hour before being allowed to go to bed.

<u>Minimum Licensing Standards (Residential): Section 907-Ratio and Supervision</u>

907.2 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 risk.

- **Millcreek of Arkansas PRTF received citations on the following date regarding the failure of staff to provide adequate supervision to residents.**
    - **01/03/2023- Camera review revealed that a resident was able to enter an unlocked staff office and return to her room with contraband.**
        - While in the bedroom with the contraband the resident used the contraband, scissors, to self-harm. Approximately eleven minutes after obtaining the scissors the resident was seen by staff, but then the resident returned to her room and was not discovered by her peers until

twenty-nine minutes later. The peers notified staff of the situation and they sought immediate medical attention for the resident.

- **01/17/2023- Review of an incident submitted to the licensing unit revealed that a resident had ingested Pine-sol cleaner.**
  - After the resident's peer had just completed his nightly chore he left Pine-Sol cleaner openly accessible on the table of the dayroom. No staff were supervising the cleaning chemicals left on the table, so the resident approached the table and swallowed an estimated two ounces of the chemical.
- **03/03/2023- Review of camera footage revealed that staff failed to provide adequate supervision of residents to ensure their safety and well-being during a multiple resident altercation.**
  - The staff viewed on camera during the several altercations that took place on the unit, can be seen being slow to intervene, failing to de-escalate, and they did not remove the remaining residents from the situation to avoid an escalation.
- **03/13/2023- Staff failed to ensure the safety and well-being of residents when they left a staff office door unlocked.**
  - Review of the camera footage of a separate issue, it was seen that staff were sitting at a day room table and leaving their door to their office open. Resident's can be seen entering and leaving the office multiple times without any supervision from staff.

The agency is required to complete the following:

- The Licensing Unit will present an intent training for all facility staff regarding the Minimum Licensing Standards sections 109, 110, and all of 900. All staff that is unavailable during the meeting shall be trained by management using the slideshow provided by the Licensing Unit and documentation of all staff trained shall be provided to the Licensing Unit.
- The facility shall conduct a minimum of once per week camera reviews of three separate locations on the facility to ensure that staff are appropriately supervising residents. Documentation of date, time, area viewed, and a brief description of what was reviewed shall be logged by the reviewer. The documentation of weekly checks shall be provided to the Licensing Specialist monthly for review.
- If at any time during the course of this corrective action agreement, a discovery is made of a staff failing to supervise or participating in inappropriate behavior management, the facility will report it to the Licensing Unit by the next business day. The report shall include the incident date, incident time, name of staff/residents involved, brief description of the incident, date it was discovered by facility management and any corrective measures taken to correct the issues.

- The facility shall retrain all child caring staff on their behavior management policy including topics surrounding acceptable forms of discipline by 6/30/2023 and provide sign in sheets of all staff trained to the Licensing Specialist.
- The facility management shall continue their daily leadership rounding program to ensure all doors required to be locked are secured, looking for safety concerns, and any environment of care issues. These walkthroughs shall be documented, noting any concerns, retained, and available to the licensing specialist upon request.
- The facility shall proceed with training all direct care staff on the topics of Nurtured Heart Approach, Improving the Milieu, De-escalation with Highly Aggressive Patients, and Processing with our Clients. The facility shall notify the licensing unit when all direct care staff have completed the above courses.

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication.

Please be advised that any serious non-compliance cited during this corrective action period may result in a recommendation for adverse action on the license. Any serious violation of this corrective action plan will result in recommendation for adverse action on the license.

Please do not hesitate to contact the Placement and Residential Licensing Unit if you have any questions or concerns regarding ongoing compliance with this agreement or any other licensing requirement.

The signature of the licensee constitutes full acceptance of the provisions of this agreement.

Owner/ Administrator/Agency Representative — Date: 5/18/23

Licensing Specialist — Date

Licensing Supervisor — Date: 5/18/2023