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: 8/3/2023

Date Received by DCCECE:8/4/2023

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Dual

Report Description: I wanted to inform you of an incident that occurred at The Centers (EMCC) on 8/03/2023. On 8/04/2023, client [redacted] reported Centers? staff member, [redacted], hit him ([redacted] in the left eye with his ([redacted] fist. [redacted] said the incident took place in his dorm on the evening of 8/03/2023. Centers? medical personnel assessed [redacted] and noted he had an approximate one-inch-wide purple bruise under his left eye. [redacted]?s pupils were reactive to light, and he did not complain of pain. This incident was reported to the Arkansas [redacted] Hotline and the reported allegation was accepted (Referral #[redacted] As a result of this incident, [redacted] was suspended pending his termination. [redacted]?s guardian was notified about this incident. [redacted] is a private placement at The Centers. As always, please do not hesitate to contact me if you need any additional information.

Interim Action Narrative: Staff member accused of punching the resident was placed on suspension pending investigation.

Maltreatment Narrative: Resident reported that a staff member punched him in the eye.

Licensing Narrative: Licensing Specialist was informed of the complaint. 8/7/2023, Licensing Specialist reviewed complaint for licensing concerns. Licensing Specialist will

inquire about camera footage and request permission to contact the facility. Licensing Specialist received permission to contact the facility. Licensing Specialist informed no camera footage of staff hitting resident as it allegedly occurred in the bathroom. Licensing Specialist will schedule day and time to review camera footage prior to incident. 8/8/2023, Licensing Specialist reviewed camera footage. Licensing Specialist informed that resident discharged from the facility late 8/3/2023. Licensing Specialist saw a picture of the resident's face and neck. Licensing Specialist observed a bruised eye and scratches on his neck. The guardian requested the for LRPD to come to the facility so that she could get a police report. Licensing Specialist requested nursing note. 8/11/2023, Licensing Specialist inquired about nursing note and clarification of staff member's status. 8/14/2023, Licensing Specialist confirmed that staff member was terminated on 8/7/2023. Licensing Specialist will inquire about witness statements from staff that were present during the reported incident. 9/1/2023, Licensing Specialist received witness statements. 9/5/2023, Licensing Specialist contacted investigator for an update, found true. 11/6/2023, Licensing Specialist requested a copy of termination letter for staff member.

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521 Visit Compliance Report

Licensee: Elizabeth Mitchell Centers

Facility Number: 157

Licensee Address: 6501 WEST 12TH STREET
LITTLE ROCK AR 72204

Licensing Specialist: Kendra Rice

Person In Charge: Eric Knowles

Record Visit Date: 8/8/2023

Home Visit Date: 8/8/2023

Purpose of Visit: Complaint 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 member engaged in behavior that could be viewed as physically harmful to children.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulation Number: 9. 905. 4 .g

Regulation Description: The following actions shall not be used, including as discipline:

Findings Description: Staff member used disciplinary actions that could cause physical injury or threat to bodily harm.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

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: Residents were left unsupervised while two (2) staff members were in the bathroom with a resident.

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 2:30 pm to 4:00 pm

Census: 43

Licensing received a complaint on 8/4/2023 for ELS Case #015380.

Licensing Specialist reviewed camera footage for reported complaint on 8/8/2023 for ELS Case #015380. The incident took place at EMCC on the North Dorm. The timeframe of the incident was 19:59 to 20:52.

Licensing Specialist observed resident standing in the hallway on the wall between the two bathrooms until a peer exited the bathroom. Resident then entered the bathroom, ratio 2:2. Licensing Specialist observed two other residents at the end of the hall, ratio 2:4. Resident walked out of the bathroom and into the day area/common area.

Ratio 2:2, there was a peer sitting in the day area/common area. Licensing Specialist observed a male staff member talking with the resident with a peer sitting at the opposite end. Licensing Specialist observed the peer walk over to the resident and swung at him several times in what appeared to be from shoulder up.

Residents were observed watching the two (2) residents in a physical altercation and staff members separating the two (2).

Once separated, the female staff member was observed escorting the peer off the dorm. The resident and male staff member was observed in the day area/common area. Licensing Specialist was unable to observe what took place due to the angle of the camera and the dark glare while resident and male staff member were in the day area/common area. Licensing Specialist observed the male staff member move to the other side of the day area/common by the wall near the bathroom.

While the male staff member was standing by the wall, resident was observed running toward the staff member. Licensing Specialist observed the male staff member grab the resident in a choke hold position. The male staff member had his arm around the resident's neck. The resident's neck was in the inside of the male staff's elbow. Licensing Specialist observed the male staff member release the resident and pushed him into the bathroom.

Licensing Specialist observed another male staff member enter the dorm and stand in front of the bathroom door where the resident was. The first male resident left off the dorm and returned to the dorm, ratio 2:1. The first male staff was observed walking to the end of the hallway (two (2) residents were observed looking out their bedroom door) and walk into the bathroom where the resident remained. Licensing Specialist observed the other male staff member walk into the bathroom. The door of the bathroom was cracked and then closed completely.

While the two (2) male staff members were in the bathroom where the resident was located. Licensing Specialist did not observe any other staff members in the dorm. Possibly 7 minutes later, the female staff member was observed escorting the peer back on the dorm. The female staff member was observed unlocking the other bathroom door for the peer who walked into the bathroom. Another male staff member (3rd) was observed entering the dorm and the peer was escorted off the dorm again with his mattress.

Licensing Specialist observed another female staff enter the dorm. The two (2) male staff members were still in the bathroom with the resident. Possibly 1 minute and 30 seconds after the other female staff member arrived, Licensing Specialist observed the male staff members come out of the bathroom. The first male staff walked to the end of the hallway to the bedroom of the two (2) residents. Both residents were observed walking out of their bedroom with the male staff member. The other male staff member left the dorm. One (1) resident returned to his bedroom and the other resident followed the male staff member into the bathroom where the resident remained. The door was cracked and then closed. The male staff member and second resident were in the bathroom possibly 5 minutes.

There were two (2) staff female members sitting in the day area/common area. Licensing Specialist observed the 1stmale staff member and resident exit the bathroom; resident remained. The 1stmale staff member was observed enter the other bathroom and exit back out. The 1st male staff member is observed walking back in the bathroom with the resident (ratio 1:1) the door was cracked and then closed.

A female staff member was observed on her phone with no residents in the day area/common area and the other female staff was sitting on the opposite side of the room. Due to the darkness, Licensing Specialist was unable to observe what she was doing. The peer was brought back on the dorm to the day area/common area

by the 3rdmale staff member. The 3rdmale staff member was observed walking to the bathroom where the 1stmale staff member and resident were.

The 3rdmale staff member stood in the doorway and walked back to the day area/common area. The door was observed cracked and then closed. A few minutes later, Licensing Specialist observed the 1stmale staff member walk out of the bathroom and then the resident. Once out the bathroom, resident was observed walking into his bedroom. Licensing Specialist observed resident sit on his bed, walk around his bedroom, then back to his bed, and sat down. The resident was in the bathroom for possibly 52 minutes.

Facility will be cited for R109.1.g – Staff member engaged in behavior that could be viewed as dangerous or physically harmful to children. R905.4.g – Disciplinary actions used by staff could cause physical injury or threat of bodily harm. R907.2 – Residents were left unsupervised while two male staff members were behind a closed door.

Provider Comments:

CCL Staff Signature : Date: 8/22/2023

Provider Signature : Date: 8/22/2023

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521 Visit Compliance Report

Licensee: Elizabeth Mitchell Centers

Facility Number: 157

Licensee Address: 6501 W 12TH ST
LITTLE ROCK AR 72204-1511

Licensing Specialist: Kendra Rice

Person In Charge: Paul Hofstad

Record Visit Date: 9/25/2023

Home Visit Date: 9/25/2023

Purpose of Visit: Revisit Complaint

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

No in-person licensing visit completed on 9/25/2023.

Licensing Specialist received a complaint on 8/3/2023 for ELS Case #015380.

This complaint has been **FOUNDED** by licensing.

Facility was cited for regulations 109.1.g, 905.4.g, and 907.2 for this complaint on 8/8/2023.

Provider Comments:

CCL Staff Signature : Date: 9/25/2023

Provider Signature : Date: 9/25/2023

John Hogue