

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: 9/7/2023

Date Received by DCCECE:9/8/2023

Facility Name: Dacus RTC

Facility Number: 108

Incident Type: Licensing

Report Description: Staff members present: Elisha Brewer, Yasmine Prater Date of Incident: 9/7/2023 Client () broke the soap dispenser in the bathroom. When Staff opened the door, client () refused to leave and proceeded to hit and kick walls and doors. While transitioning downstairs, Client () attempted to go down the stairs head first. Once staff instructed him to stop, Client () complied. Once the client reached the bottom of the stairs, he broke the handicap chair lift. While in the transitional hallway, client screamed, threatened to kill staff and a peer, and kicked doors and walls. Client took his hoodie and placed it around his neck in the cafeteria. Client () was able to flex, extend each finger on right hand and dorsiflex right wrist without difficulty. Slight redness present to right hand. No other injuries noted. Client transferred to MBH via ambulance- Medic One, no distress noted, resp. even, non labored., denies SI, AVH, C/O HI. Client became aggressive when the ambulance got here but eventually calmed down after talking to Consultant and was cooperative with staff.
Interim Action Narrative: Resident was assessed by nursing and transported to MBH by Medic One.
Maltreatment Narrative:

Licensing Narrative: Licensing Specialist reviewed provider reported incident for licensing concerns. Licensing Specialist will inquire about camera footage. Licensing Specialist is scheduled to review camera footage on 9/13/2023. 9/13/2023, Licensing Specialist reviewed camera footage. Resident returned from acute care on 9/12/2023.



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Dacus RTC 211 CHURCH STREET BONO AR 72146 Kendra Rice Donaghey Plaza P.O. Box 1437 Little Rock, AR. 72203

Facility Visit Compliance Notice

Facility#: 108

Date of Visit: 9/13/2023

Visit Type(s): Self Report Visit

Time: 10:30 AM - 0:34 AM

Visit Comment:

Time of Visit: 10:30 am to 12:30 pm

Census: 14

Licensing Specialist spoke with Ms. Program Director, regarding ELS Case The provider reported incident happened on 9/7/2023 in the transitional hallway. Licensing Specialist reviewed camera footage on 9/13/2023.

Licensing Specialist observed resident and a staff member at the top of the stairs before entering the transitional hall. Resident observed sitting at the top of the stairs and laying on the stairs with his head facing toward the bottom of the stairs. Staff member was observed standing by the resident and what appeared to be communicating with the resident. Licensing Specialist observed another staff member in the area, ratio 2:1.

Resident observed turning around, standing up, and walking down the stairs. Once at the bottom of the stairs, Licensing Specialist observed what appeared resident shaking the lift chair. Resident was observed pacing in the transitional hall, tearing up and throwing therapy cards received from his therapist, standing on a bench and messing with the camera, and banging on the wall and door.

A staff member was standing in the door leading to the chair lift when resident was observed grabbing the door and swinging it back and forth. A staff member was observed moving out of the resident's way but close enough to monitor him. Resident was observed slamming the door closed. Staff members were observed trying to get resident to comply, ratio 2:!

Resident was observed sitting in the floor underneath the camera where he took his hoodie and attempted to tie it around his neck. A staff member was observed attempting to take the hoodie from the resident. Another staff member was observed attempting to assist with removing the hoodie from the resident who was holding the hoodie tight in his hands.

The hoodie was removed from around the resident's neck and once he started running around the transitional hallway staff was observed throwing their hands up for safety due to resident showing aggression. Resident was observed putting his hoodie on appropriately. Licensing Specialist observed resident being escorted into the dining room.

Resident was observed pacing the floor, standing on top of a table, and walking on a dining room table. A staff member observed what appeared talking with resident while he was on the table. Resident got off the table and began pacing the floor, ratio 2:1. Licensing Specialist observed the Program Director enter the dining room and what appeared to be communicating with the resident. Resident was observed sitting down at a table and laying his head down on the table. The therapist was observed walking into the dining room area and sitting down at the table where the resident was sitting.

Per maintenance, the chair lift has been repaired. Licensing Specialist observed the lift chair. Licensing Specialist informed resident returned from acute care on 9/12/2023.

CCL Staff Signature:

Date: 9/13/2023

Provider Signature:

WANTE

Date: 9/13/2023

Your Signature indicates that this form has been reviewed with you; it does not imply your agreement with it.

Right to Appeal: For more information on how to appeal these findings, refer to the minimum Licensing Requirements or contact your Licensing Specialist.