



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

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### Notice of Serious Incident

Date of Incident: 9/16/2023

Date Received by DCCECE: Little Creek Behavioral Health

Facility Name: Little Creek Behavioral Health

Facility Number: 255

Incident Type: Dual

Report Description: On Saturday 16th, around 630am, [REDACTED] ( [REDACTED]-caseworker) reported that staff member [REDACTED] asked her an inappropriate question regarding her body and then proceeded to touch her on the butt when the resident returned from the bathroom. [REDACTED] has been placed on administrative leave and called into the [REDACTED] hotline, reference number [REDACTED] and assigned to a CACD investigator.

Interim Action Narrative: Staff [REDACTED] placed on administrative leave pending investigation.

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Maltreatment Narrative: Ref# [REDACTED]

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Licensing Narrative: Licensing received complaint 9/18/23 that on 9/16/23 [REDACTED] reported that staff member [REDACTED] asked her an inappropriate question regarding her body and then proceeded to touch her on the butt when the resident returned from the bathroom. [REDACTED] has been placed on administrative leave and called into the [REDACTED] hotline, reference number [REDACTED] and assigned to a CACD investigator. Email sent 9/18/23 to CACD Investigator Tollece Sutter asking permission to visit facility. No return correspondence received as of 9/18/23. Email sent to facility 9/18/23 to inquire about video of alleged incident. Return correspondence from Jlynn Perkins of Little Creek

indicated that there is video of alleged incident. Facility visited 9/19/23 in response to complaint that staff [REDACTED] had made inappropriate advances towards client [REDACTED] FBI and Central Registry checks observed for staff [REDACTED] in file. Video reviewed of the morning of 9/15/23 between around 6-6:15AM. Staff [REDACTED] can be seen walking to client [REDACTED] room 4 times but does not enter room. Staff [REDACTED] told facility staff Jlynn Perkins he was doing this for med pass. Staff [REDACTED] and [REDACTED] are seen walking from [REDACTED] room to the front door of the living area, then walking back. At one point client [REDACTED] is seen entering the restroom area. [REDACTED] was not on any increased precaution. Staff [REDACTED] stands in the doorway (not the door to the bathroom) but door to the bathroom area. Staff is not seen looking into bathroom area. Staff [REDACTED] remains in the doorway to the bathroom area until [REDACTED] is seen exiting bathroom area and going back to her room. Audio was functioning for video, but nothing was nor appeared as if it should be making noise. No conversation seems to take place nor is heard. Staff [REDACTED] is not seen touching client [REDACTED] inappropriately. No evidence from video observed shows something definitively was inappropriate. However, both client [REDACTED] and staff [REDACTED] observed movements were not indicative of normal interactions and/or behavior. Licensing is not prepared to make a finding as of 9/19/23. 12/7/23-Received notification that maltreatment was unfounded. 521 issued to facility indicating that licensing complaint was unfounded. Staff [REDACTED] was immediately suspended after incident and terminated on 11/20/23.



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## 521 Visit Compliance Report

**Licensee:** Little Creek Behavioral Health

**Facility Number:** 255

**Licensee Address:** 161 SKUNK HOLLOW  
CONWAY AR 72032

**Licensing Specialist:** Clayton DeBoer

**Person In Charge:** Jlynn Price

**Record Visit Date:** 9/19/2023

**Home Visit Date:** 9/19/2023

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

Facility visited 9/19/23 in response to complaint that staff [REDACTED] had made inappropriate advances towards client [REDACTED] FBI and Central Registry checks observed for staff [REDACTED] in file. Video reviewed of the morning of 9/16/23 between around

6-6:15AM. Staff [REDACTED] can be seen walking to client [REDACTED] room 4 times but does not enter room. Staff [REDACTED] told facility staff Jlynn Perkins he was doing this for med pass. Staff [REDACTED] and [REDACTED] are seen walking from [REDACTED] room to the front door of the living area, then walking back. At one point client [REDACTED] is seen entering the restroom area. [REDACTED] was not on any increased precaution. Staff [REDACTED] stands in the doorway (not the door to the bathroom) but door to the bathroom area. Staff is not seen looking into bathroom area. Staff [REDACTED] remains in the doorway to the bathroom area until [REDACTED] is seen exiting bathroom area and going back to her room. Audio was functioning for video, but nothing was nor appeared as if it should be making noise. No conversation seems to take place nor is heard. Staff [REDACTED] is not seen touching client [REDACTED] inappropriately. No evidence from video observed shows something definitively was inappropriate. However, both client [REDACTED] and staff [REDACTED] observed movements were not indicative of normal interactions and/or behavior. Staff [REDACTED] has been placed on administrative leave starting immediately after this was reported and will remain on administrative leave pending results of investigation.

Licensing is not prepared to make a finding as of 9/19/23.

**Provider Comments:**

CCL Staff Signature :

Date: 9/19/2023



Provider Signature :

Date: 9/19/2023

