Division of Childcare & 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

Case Number: 018293

Date of Incident: 12/27/2023

Date Received by DCCECE: 12/29/2023

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Dual

Report Description: On December 28, 2023, client [redacted], reported to the nurse?s office and a bruise to the left side of her face above her eye was observed. When client was asked about the bruise, she stated that she hit her head on the underside of the desk in the dorm room while she was ?acting out?. During the video review of the incident on December 27, 2023, at approximately 6:20 am, staff members were observed grabbing the client?s clothing and grabbing her by the arm. The staff supervisor ([redacted]) responded and placed the client in multiple holds that were not CPI-approved. This incident lasted for approximately 35 minutes. After the client was able to calm down, she was observed on camera footage holding and rubbing the left side of her face and pointed to an area around her left eye. The staff supervisor was observed on video looking at the area and acknowledged it. The staff supervisor was terminated and the other staff in the room at the time of the incident have been suspended. [redacted] is in the guardianship of DCFS, which was notified of the situation. A [redacted] call was placed and accepted.

Interim Action Narrative: Resident was assessed by the nurse. Staff Supervisor was terminated and other staff were suspended.

Maltreatment Narrative: AV is [redacted]. PRFC is [redacted]. Out of Home AO is approx. 45yo Shift Supervisor at The Centers [redacted]. AV was in common area of her dorm at approximately 6:20am on 12/27/2023. AV became dysregulated and started attempting to run into peers' rooms. Staff members [redacted] and [redacted] were

present and intervened. Shift Supervisor/AO [redacted] responded and placed AV in multiple holds which were not approved. AO pushed student into a chair, stood over her, and would not allow her to get up. AO was observed wrestling with student (all while standing), pulling on her arms, grabbing her while she was trying to get away or run into peers' rooms. This lasted for approximately 40 minutes. Nurse [redacted] was present and observed a portion of the incident while administering medications. Student was also observed banging the back of her head against the wall a few times. After AV was able to regulate, she was observed holding the left side of her face and pointing to an area on the left side of her face near her eye to AO. AO is observed looking at the area and acknowledging it. This morning (12/28/2023), AV presented to nurses station and a bruise to the left side of her face near her eye. AV stated that she had hit her head on the desk, but was unable to state when it occurred. The bruise had not been previously observed. Of note, while AV was banging her head, the area where the bruise was located did not make contact with the wall, so was not sustained while she was banging her head.

Licensing Narrative: Program Coordinator reviewed complaint for licensing concerns. Program Coordinator will inquire about camera footage and the assigned investigator. Program Coordinator informed camera footage available. Program Coordinator will contact investigator for permission to reach out to facility. Program Coordinator received permission to contact the facility. 1/3/2024, Program Coordinator reviewed camera footage. 1/5/2024, Program Coordinator requested nurse note and staff termination letter. 1/29/2024, investigator reported that case is still pending. 1/30/2024, facility provided documentation from the investigator and inquired if staff members could return to work. 1/31/2024, Program Coordinator reached out to facility and inquired about plan of action for staff members to return. Program Coordinator checked CHRIS case unfounded. 2/1/2024, Program Coordinator informed facility that documentation is needed once training has been completed. Facility provided documentation of training for 2 staff members. 2/8/2024, Program Coordinator inquired if third staff member had been trained. Facilty provided documentation.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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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: John Hogue

Record Visit Date: 1/3/2024

Home Visit Date: 1/3/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Finding Description: Staff members were observed grabbing a resident's clothing and arm.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 1:00 pm to 2:15 pm
Census: 47

Licensing received a complaint on 12/29/2023 for ELS Case #018293.

Program Coordinator met with the Risk Management Team to review camera footage for this complaint.

Program Coordinator observed the resident in the day area with a staff member, ratio 1:1. The other residents were still asleep. Resident was observed walking back and forth into a bedroom, cutting the light on and off, and walking around the day area. Due to no audio, Program Coordinator was only able to observe what was going on. It appeared that maybe the resident was making noise because other residents were observed coming to the doorway of their rooms.

Another staff member was observed entering the dorm. Overall ratio was 2:6. Resident was observed being blocked by staff when she tried to enter the bedrooms. Resident was also observed trying to go around the staff members as she continued to cut the lights on and off. Program Coordinator observed resident gesturing and attempting to swing at or kick her peers.

Resident was observed by the workstation for staff and trying to get to things in that area. Resident attempted to go around staff and reach for things near the workstation. Staff members were observed blocking the resident and if she was able to grab anything it was taken away from the resident. It appeared that staff was using verbal de-escalation in which the resident failed to comply.

Program Coordinator observed another staff member enter the dorm, ratio 3:6. The third staff member that entered the dorm was observed blocking the resident from going into the bedrooms. Resident was observed going around the staff members into a bedroom. Staff members were observed grabbing the resident and brining her back into the day area. The third staff member placed the resident in a chair and blocked her from getting out of the chair. Resident was observed gesturing to swing or kick her peers as they walked by.

Eventually staff had all residents to go to their bedrooms while they tend to the resident. The third staff member was still blocking the resident from leaving the area. The resident was observed getting out of the chair and when she was unable to leave the day area, she stood in front of the bathroom door. Resident was observed kicking and butting her head on the door. Resident eventually was able to calm down, was offered some water, and it appeared that staff was processing with her.

Program Coordinator was unable to determine when resident's face was injured. The facility reported that the third staff member was terminated. The other two staff members are currently suspended pending the outcome of the investigation.

Facility will be cited for 109.1.g, staff members were observed grabbing the resident's clothing and arm to prevent her into going into different rooms and harming her peers.

Provider Comments:

CCL Staff Signature :

Date: 1/3/2024

Provider Signature :

Date: 1/3/2024

1/5/2024

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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: 2/1/2024

Home Visit Date: 2/1/2024

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 was completed on 2/1/2024.

Licensing received a complaint on 12/27/2023 for ELS Case #018293.

This complaint has been FOUNDED by Licensing.

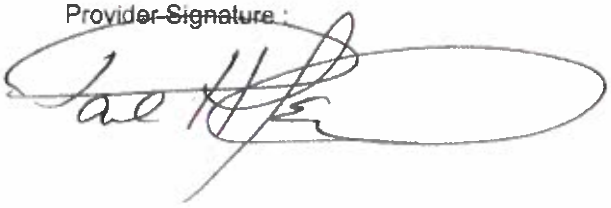
The facility was cited on 1/3/2024 for standards 109.1.g.

Provider Comments:

CCL Staff Signature :

Date: 2/1/2024

Provider Signature :



Date: 2/1/2024