Reagan Stanford

Subject: UMCH LR PRTF Complaint
Attachments: UMCH Investigative Summary.pdf; Supporting Documentation 1.pdf

From: Reagan Stanford
Sent: Thursday, July 22, 2021 5:02 PM
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Attached is Disability Rights Arkansas Investigative summary of complaints for United Methodist Children's Home Little Rock PRTF.

The supporting documentation for all incidents outlined in the report is included in an attachment that is split between this email and an email that will follow. Video still frames are included in the supporting documentation attachments and attached separately as a single document in the second email. The video files that were already provided are referenced in the report as applicable. If there is anything that is referenced and does not appear to be included or you have any other questions please let us know and we will be happy to provide anything that we have.

Thank you,

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Disability Rights Arkansas(DRA) conducted a monitoring visit at United Methodist Children's Home(UMCH) in Little Rock on 06/15/21. During that visit several residents indicated they had received chemical restraints prior to our arrival on the day of our visit. They all indicated that they were calm when they received the chemical restraints. We had previously received information that four residents that eloped on 04/28/21 all received chemical restraints upon their return to the facility.

This information led to an investigation of four chemical restraints administered on 06/15/21, one on 06/14/21, and four on 04/28/21. Our investigation concluded that only one of the nine incidents could be justified as an intervention in response to a resident being a danger to themself or others.

The investigation revealed numerous serious concerns related to the use of chemical restraints including; being used punitively and in lieu of appropriate interventions, being used simultaneously with seclusion, failing to properly document the restraints, the staff members involved, or assessments and debriefings. Our investigation was limited in scope however the findings indicate a broader, cultural issue that necessitates a comprehensive outside investigation.

DRA's investigative findings regarding UMCH's use of chemical restraints as a discipline tool and not exclusively to prevent harm are outlined below. Additional concerns, including the use of improper physical restraints, are included as well. These concerns have been shared with UMCH administration and their plans to begin corrective action that have been shared with DRA are included here.

1. Use of Chemical Restraints (CR) When Residents are Calm

a. 04/27/21 – [redacted]
   i. Incident Report indicates peers were instigating [redacted], they argued back and forth, and he then "charged at 2 of his peer (sic) and hit each peer once. Staff intervened and separated the clients. Client received a chemical due to aggressive behavior."[121]
   ii. The incident occurred at 5:45PM and the chemical restraint was not administered until 6:06PM, at which time the resident was calm and walking around the foyer.[122]

b. 04/28/21 – Chemical restraints were given to 4 residents ([redacted], [redacted], and [redacted]) who eloped upon their arrival back at the facility. All four residents are escorted back to the facility by LRPD and calmly enter and sit in the lobby.[123]
   i. Two residents follow staff out of the lobby and toward the boys' unit, receive chemical restraints, and are then held in elevator vestibules.[124]
   ii. Two residents can be seen on video calmly submitting to the injections.

[121] DHS-1910 Incident Report Form
[122] Behavioral Intervention Log
[123] Video Review of MCH LR RTC 4.28.21 waiting area #1 and MCH LR RTC 4.28.21 waiting area #2. Video still frames #1 - #5 - Residents entering building and sitting in lobby.
[124] Based on UMCH documentation, video was only provided of the lobby and front entrance.

1. Approximately 5 minutes after returning S W, a UMCH Consultant, points to a wall and one of the residents walks over to the wall and pulls down the side of his pants to receive an injection.[125]
2. Approximately 9 minutes after entering the building resident enters the lobby bathroom to receive an injection.[126]
    a. Prior to this he sits in the lobby and appears to either be refusing to get up to submit to a chemical restraint or refusing unless they agree to the injection being in either his arm or leg. Nurse N F approaches him with 2 injections in her hand and holds them in front of him.[127] She then walks away and leans against the office window with the injections in hand. Numerous staff members appear to continue to talk him into submitting to a CR.[128] He is never aggressive but appears to refuse to get up. A male staff member is brought to the lobby and the resident eventually gets up and walks to the bathroom.[129]

iii. The Behavioral Intervention Observation Logs for all 4 residents do not indicate that they were combative or aggressive at the time of the CR.[130]
1. is reported to be threatening for 2 minutes and then sitting for 45 minutes in the seclusion room following the CR.
2. is reported to be threatening for 2 minutes and then sitting for 45 minutes in the seclusion room following the CR.
3. ' observation log only logs the 2 minutes during which he received a CR and states he was threatening and walking during that time.
4. "client behavior" section is not completed however he calmly complied and followed staff out of the lobby.[131]

iv. Based on documentation received from UMCH it appears the doctor's orders for the chemical restraints were obtained before the residents were returned to the facility and therefore before any assessment of their behavior could have been made or credibly relayed to the doctor.
1. The police were called to report the elopement at 2:05PM.[132]
2. Dr. H was called at 2:26PM.[133]
3. Sometime after LRPD officers arrived on scene and were collecting information they were notified that the residents had been located and were in the custody of UALR PD. They communicated with UALR PD,

[125] Video still frames #6 and #7 – Staff pointing to wall, resident standing against wall receiving injection.
[126] Video Review of MCH LR RTC 4.28.21 waiting area #2 and DRA resident interview.
[127] Video still frame #8 - Nurse F standing in front of resident with 2 injections in her hand.
[128] Video still frame #9 – Resident sitting in waiting area while staff continue to talk to him.
[129] Video still frame #10 – Resident walking to the bathroom.
[130] Behavior Intervention Observation Logs for all 4 residents.
[131] Video Review of MCH LR RTC 4.28.21 waiting area #1 and #2.
[132] LRPD Incident Report #2021-045341, Elopement Information Report for all 4 residents.
[133] 4/28/21 Report to Quality Assurance for .

who refused to transport the residents, and ultimately had to go and retrieve the residents and return them to UMCH.[134]

4. The residents received chemical restraints at the following times:[135]
    a. [redacted] – 2:53PM
    b. [redacted] – 2:58PM
    c. [redacted] - 2:53PM
    d. [redacted] – 2:56PM
5. UMCH has been unable to confirm the exact time the residents were returned to UMCH. Subtracting the amount of time between when the residents enter the building and when the 2 residents receive CRs in the lobby[136] (5 and 9 minutes) from the time the CRs are documented as having been given our conclusion is that the residents returned at approximately 2:50pm, 24 minutes after doctor authorization was sought and given.

c. <u>06/14/21 –</u> [redacted]
    i. Resident is given two injections while sitting in the foyer area of the unit. Based on video review:[137]
        1. The resident is sitting in a chair at a table and slings a deck of UNO cards across the table and into the air where they scatter across the foyer.[138] Seconds later she pushes the remaining cards off the table in a single action. The only other resident present is laying down on a bench with her head covered and appears to be asleep.
        2. The resident then continues to sit calmly in her chair for about 12 minutes when nurses begin walking towards her with injections. She takes off her jacket so they can access her shoulders as they are approaching.[139]
        3. She is given one injection in each arm by two different nurses.[140]
        4. After the injections she walks out of the view of the camera briefly and then returns to the table and sits down again.
    ii. According to UMCH "pt was physically and verbally aggressive with staff and started to throw cards around the unit and pick scabs on arms."[141]
        1. There is no audio on the videos we have but she does not appear to acknowledge or be acknowledged by staff in the minutes leading up to the chemical restraint.
        2. No physical aggression is shown. She never raises up, lifts her arms, gestures toward anyone, or gets out of her chair.

[134] LRPD Incident Report #2021-045341.
[135] Based on the Behavioral Intervention Observation Logs for each resident.
[136] Video Review of MCH LR RTC 4.28.21 waiting area #1 and of MCH LR RTC 4.28.21 Waiting area #2.
[137] Video – MCH LR RTC 6-14-21 [redacted] – Unit 2 Foyer 360 Cam, MCH LR RTC 6-14-21 [redacted] – Unit 2 Foyer
[138] Video still frame #11 - Resident sitting at table slings a deck of cards into the air, they scatter across foyer.
[139] Video still frame #13 and #14 – Resident compliantly removing her jacket as nurses approach with injections
[140] Video still frame #15 and #16 - Resident is given one injection in each arm by two different nurses
[141] Seclusion and Restraint Form

3. "Started to throw cards around the unit" misrepresents the reality that she threw something (the deck of cards) only once and then pushed the remaining cards off the table in a single action.
4. It is possible she attempts to pick scabs during the video at some point; however, for large portions of the video her sleeves are down. If any self-harm activity occurred staff did not make any attempts to remedy the situation prior to resorting to a chemical restraint. Other than one staff member speaking to her briefly when she was collecting cards near her chair no staff member attempted to talk to, comfort, or intervene when the resident can be seen looking down at her arms.[142]

d. <u>06/15/21 –</u> [redacted]
   i. Resident received a chemical restraint. She did show some aggression and self-injurious behavior in the minutes leading up to the restraint however when not provoked by staff or threatened with chemical restraints she sat or stood calmly.
      1. Resident became upset in the classroom. She was standing in the corner yelling at staff to leave her alone before exiting the classroom followed by staff member N[redacted] K[redacted].[143] We did not receive video of the classroom.
      2. We received 2 videos of the hallway that begin shortly before the resident exits the classroom and walks to the end of the hallway to stand in the corner by the double doors. Approximately 3 minutes later she can be seen lifting her head off the wall she is leaning against with her back and then hitting it against the wall. A staff member walks over and places their hand behind her head and she walks away from them. She begins walking to the other end of the hallway, appears to scream something at the 3 staff members in the hallway with her (K[redacted], S[redacted] W[redacted], and J[redacted] D[redacted]). She kicks the double doors twice and then stands against the wall with her head down.[144]
      3. She becomes upset and screams something at staff K[redacted] and then appears to pick at her arms. Staff K[redacted] approaches her and W[redacted] and D[redacted] walk down to where they are. The staff member attempts to grab the resident's hands and the resident slaps the staff member's hands away.[145]
      4. Staff members K[redacted] and D[redacted] restrain the resident. Each staff member is on either side of her and she is bent over forward at the waist.[146] Approximately 3 minutes into the restraint W[redacted] swaps

[142] Video still frame #12 - Resident sitting looking down at her arms, 3 staff members picking up cards
[143] Observation of DRA staff member present
[144] MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1
[145] MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-2
[146] Video still frame #17 - Staff members NK and J[redacted] D[redacted] restrain the resident. Each staff member is on either side of her and she is bent over forward at the waist.

places with K [147] who calls for nursing from the radio[148] and then makes an unsuccessful call from her cell phone and then W ' cell phone.[149]

5. Approximately one minute later she is released from the restraint and walks to the other end of the hallway where she stands with her face to the double doors. Approximately 2 minutes later K B appears and speaks to resident for approximately 10 seconds. Resident walks away and back to the other end of the hall followed by D . K and W briefly speak with K and then they walk to the other end of the hallway where the resident is.[150]
6. Approximately 2.5 minutes later the resident walks and sits down in the hall. The 3 staff members follow and stand across from her in the hallway. 1.5 minutes later she begins to pick at her arm and staff approach her and hold her arms for a few seconds and then release them.[151]
7. 1.5 minutes later a nurse enters the hallway with injections in her hand. She walks up to the resident and appears to speak to W before waving the injections in the air and leaving the unit.[152] **The resident begins picking at her arms again after seeing the nurse and staff grab her arms.** W and D squat down and then sit down on either side of her and hold her arms. Staff member K retrieves gloves. As K is assisting D to put on a glove the resident attempts to bite her arm. It appears staff member K was instructed to find a radio as she begins knocking on doors and then speaks to someone who opens one of the doors. A staff member responds approximately 2.5 minutes later.
8. The resident sits calmly with her head down and staff on either side of her holding her arms for several minutes before the nurse returns with injections in hand.[153] **She becomes upset when she sees the nurse with the injections** and begins yelling and attempting to get away from staff.[154] She is eventually brought to her feet and is restrained by D and W while the nurse administers the injections.[155]

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[147] MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1, Video still frame #18 - S W swaps places with staff member NK in the restraint.

[148] DRA staff member present in a room adjoining the hallway that witnessed and heard parts of the incident

[149] MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1

[150] *Id.*

[151] *Id.*

[152] Video still frame # 19 – Nurse enters with injections in her hand.

[153] Video still frame #20 - Resident sits calmly with her head down and staff on either of side of her holding her arms.

[154] Video still frame #21 and #22 - Resident becomes upset when she sees the nurse with the injections

[155] 2100-1, Video still frame #23 – Resident is restrained by J D and S W while the nurse administers the injections.

9. D[redacted] and W[redacted] continue to restrain her for approximately 2.5 minutes. She alternates between appearing listless and jerking back and forth in an apparent attempt to release herself from staff.[156]
10. **Her entire body then goes completely limp and she is laid on the floor.[157] [158] She is laid face down on the floor with both arms stretched out straight to the side for at least 12 minutes without moving at all.[159]** During this time 4 staff members are milling around in the hallway,[160] residents transition to another room on the hallway and see her laying there, and K[redacted] B[redacted] and a resident come out of a room near where she is laying and step over her.[161] She then rolls slightly so that she is flat on the ground and appears to be lifting herself up off of the ground when the video stops.[162]

ii. The UMCH Report to Quality Assurance states "Client came into the hallway and started to bang her head on the door and walls. Staff placed their hand between head and wall and she began to curse at them and hit them. Client continued to try and self-harm. She eventually sat on the floor and continued to pick at arm. She stood up and continued to self-harm and became aggressive causing two restraints. Client then began to bite her arm until skin was coming up.
    1. "Bang(ing) her head on the door and walls" is an exaggerated description of the resident lifting her head off the wall she was leaning against with her back and then hitting it against the wall.
    2. She was restrained by K[redacted] and D[redacted] and then W[redacted] and D[redacted] before she sat down in the hallway, this is not reflected in the report.
    3. After sitting on the floor she only became aggressive when she realized the nurse had returned to give her a chemical restraint. At that point she began yelling that she did not want it[163] and attempting to get out of staff's grip. "She stood up and continued to self-harm and became aggressive" does not accurately reflect what occurred.

iii. Additional concerns:
    1. Multiple restraints occurred that were not observed by a nurse.

[156] Video Review Hallway 6-15-21 MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1.
[157] Video MCH LR RTC Hallway 6-15-21 Hallway 2100-2 – Video showing opposite view of hallway (Hallway 2100-1) does not show the resident going limp and being laid on the floor, it skips from the standing restraint to her laying on the ground.
[158] Video still frame #24 – Resident's entire body goes completely limp and she is laid on the floor.
[159] Video still frame #25 - Resident is laid face down on the floor with both arms stretched out straight to the side.
[160] Video still frame #26 - Resident laying on floor, no staff observing resident.
[161] Video still frame #27 - K[redacted] B[redacted] and a resident come out of a room near where she is laying and step over her.
[162] Video Review MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1.
[163] DRA staff member present in a room adjoining the hallway that witnessed and heard parts of the incident

2. UMCH documentation indicates Dr. H authorized a chemical restraint at 5:10pm[164] and it was administered at 5:15pm.[165] If that is correct the chemical restraint had not been authorized yet when the nurse responded with the injections the first time.
3. The ESI staff debriefing was conducted by L B with staff members L T, T D, C W, and V M (RN). None of these staff members are believed to have been involved in the physical or chemical restraint.
    a. Video review identified S W, J D, and N K as the staff members involved in physical restraints.
    b. The "staff in attendance" listed on the Behavioral Intervention Log were "SW, NK, LB, and JD."
        i. The log only lists the 15 minutes prior to the chemical restraint being given.
    c. L T, T D, and C W were not scheduled to work 2nd shift (when the restraints occurred) on 06/15/21.[166]
    d. B A is believed to be the RN who administered the chemical restraint.[167]
4. The Behavioral Intervention Log only logs the 15 minutes prior to the Chemical restraint and one minute after receiving it.

e. <u>06/15/21 –</u>
    i. Resident received a chemical restraint after sitting calmly in the foyer for more than 10 minutes and appearing calm for the entire 22 minutes prior to the restraint we were able to review.[168] The CR appears to have been given as a punitive response to the resident possibly kicking open the exit door.
    ii. The UMCH Report to Quality Assurance completed by staff member E H states "client became very aggressive due to wanting to get a [sic] early noon snack. He charged at the exit door full full [sic] force kicking it open and attempted to jump in staff face. He then got chemical and got back on task."
        1. Video of the hallway shows the resident leaning against the wall, going in and out of his room, and opening the exit door.
        2. 4 residents enter the bedroom hallway with a male staff member and appear to get clothing to go shower. The staff member leaves and then the residents are let off the hallway one by one. The resident gets his clothes, goes to the doors and then returns to his room with his clothes,

[164] Report to Quality Assurance
[165] Behavioral Intervention Observation Log
[166] Daily Staff Report 06/15/21 2nd
[167] Report to Quality Assurance and exclusion of V M based on previous identification.
[168] MCH LR RTC 6-15-21 – Unit 1 Foyer, MCH LR RTC 6-15-21 – Residence Hall 1 West 1, MCH LR RTC 6-15-21 – Residence Hall West 2.

appearing to have been denied the ability to leave the hallway and shower.

3. The resident then appears to kick the exit door and gesture at someone in the foyer.[169] He then stands near or opens the door for several seconds before walking down the hallway. One minute later the male staff member re-enters the unit and appears to walk to the exit door and call someone on the radio. He then leaves the unit, leaving the resident alone with the unsecure exit door and returns with S W .[170]
4. A couple of minutes later the resident calmly walks out to the foyer with staff where he proceeds to sit calmly.[171]
5. Approximately 10 minutes later a nurse appears with two injections in hand and she and a staff member direct him to the bathroom where he receives a chemical restraint.[172]
6. After the injection he returns to his seat.[173]
7. DRA staff interviewed resident at approximately 3:00PM, later the same day. He was slurring his words and lethargic during the interview. He then put his head down on the table and started snoring. Staff had to come wake him up and retrieve him. He asked to go to bed and was seen later sleeping on the circular seating in the foyer.

iii. Additional concerns:

1. Residents are seen left alone on the resident hallway before and after the exit door is breached.
2. The Post-Intervention Client debriefing is documented as having been conducted by E H , a staff member involved in the chemical restraint. The time is not indicated.
3. The Post-Intervention Staff debriefing is documented as occurring on 06/18/21, 3 days after the incident.[174]

f. <u>06/15/21 –</u>

i. Resident is placed in the seclusion room, administered a chemical restraint, and then left in the seclusion room for approximately one hour. Video we received and reviewed shows at least 45 minutes leading up to resident being placed in the seclusion room.[175] In the videos leading up to resident being placed in the

[169] MCH LR RTC 6-15-21 – Residence Hall 1 West 1, this video is from the camera above the exit door and therefore does not show the exit door. The video from the other end of the hallway, that shows the bottom of the exit door skips more than one minute that includes the resident kicking door.
[170] MCH LR RTC 6-15-21 – Residence Hall West 1, MCH LR RTC 6-15-21 – Residence Hall West 2
[171] Video still frame #28 and #29 – Resident walks to foyer calmly with staff where he proceeds to sit calmly.
[172] Video still frame #30 - Nurse and a staff member direct him to the bathroom and he receives a chemical restraint.
[173] MCH LR RTC 6-15-21 – Unit 1 Foyer
[174] Post-Intervention Debriefing 06/15/21
[175] We reviewed approximately 4 hours and 25 minutes. of video leading up to, including, and following RESIDENT receiving a chemical restraint. He is present during the recording in approximately 45 minutes leading up to the seclusion room.

seclusion room he is sitting on the floor reading a book in the elevator vestibule, wandering the hallway unattended, and being corralled by 6 staff at the end of the boy's hallway. He does not appear to be displaying any aggression.

1. The 6 video files[176] we received are not time stamped or sequentially labeled. Prior to being taken to the seclusion room and receiving a chemical restraint he can be seen:
    a. Walking around in the hallway unattended after walking out of the dayroom.[177]
    b. Sitting/standing in the elevator vestibule reading a book while staff talk at him for approximately 22 minutes.[178]
    c. Being sequestered at the end of the hallway by the gym by 6 staff members (S[redacted] W[redacted] – Consultant, J[redacted] D[redacted] – Recreational Therapist, T[redacted] H[redacted] – BI, N[redacted] F[redacted]-RN, V[redacted] M[redacted]-RN, A[redacted] J[redacted]-Office Manager) for approximately 18 minutes.[179] He does not appear to show any aggression or self-harming behaviors during this time.
    d. Walking the hallway followed by J[redacted] D[redacted] after all other staff that spent 18 minutes trying to keep him at the end of the hallway responded to the boy's unit.
2. It is unclear why the resident was corralled in the back hallway by 6 staff members or later taken to the seclusion room.
3. Once put in the seclusion room the resident kicks the door several times and then calms down and is calm for approximately one minute. Staff then open the seclusion room door and enter. He sits down in the corner.[180] Two staff members grab him by each arm and pull him up and put him face first against the wall. A nurse and the rec therapist enter the seclusion room and one administers two injections to him.[181] He is then left in the seclusion room and the door is closed and secured.
4. 11 minutes after receiving the CR the resident took his sweatshirt off, tied it into several knots, placed it around his neck for 2 seconds, and then took it off and put it back on the proper way. Three staff members then enter the seclusion room and wrestle his sweatshirt off of him and take it out.
5. The video we were provided ended 16 minutes after he received the injections; he was still in the seclusion room when the video ended.

[176] MCH LR RTC 6.15.21[redacted]1-Unit 1 Foyer,[redacted] Dayroom 1102,[redacted] Elevator Vestibule,[redacted] Unit 1 Entrance,[redacted] Hallway 1100. Second Disc[redacted]2 has Seclusion Room 1-1, Unit 1 Foyer, Unit 1 Entrance, Hallway 1100-1, Hallway 1100-2.
[177] MCH LR RTC 6-15-21[redacted] Dayroom 1102, MCH LR RTC 6-15-21[redacted] – Hallway 1100-1, Video still frame #31 – Resident walking around in the hallway unattended after walking out of the dayroom
[178] MCH LR RTC 6-15-21[redacted] Elevator Vestibule, Video still frames #32, #33, #34 and #35 – Resident in elevator vestibule.
[179] Video still frame #36 and #37– Resident sequestered at the end of the hallway by the gym by 6 staff members
[180] Video still frame #40 – Resident sitting in corner of seclusion room
[181] Video still frame #41 - Resident held face first against the wall while two injections are administered.

6. You can see staff member T H laughing at him through the window in the door and appearing to laugh in the foyer[182]. He laughs so hard that he is bent over, jumping up and down, and pointing at the seclusion door continuing to laugh at different times.[183]
7. The entire time this event is taking place there are other residents on the unit observing how staff conduct themselves.

ii. UMCH documentation of this incident is inconsistent, incomplete, and misleading or false.

1. UMCH narrative of this event states "client was given several directives to stop pacing and pushing on doors and client would not comply, client continued to be defiant and started to attempt to break the locks on the doors, client was turned over to nursing after being non-compliant and placed in seclusion and given a chemical."[184]
    a. In the moments before he is escorted to the seclusion room he appears to briefly attempt to open locked doors in the hallway as he is walking down it.
2. The Behavioral Intervention Observation Log indicates the resident was combative, cursing, and hurting himself in the minutes leading up to being placed in seclusion.
    a. Video review does not show the resident hurting himself. The resident is being noncompliant but not combative. Due to the videos being provided without audio it cannot be confirmed if he was cursing, but that is not a valid reason to initiate restraint or seclusion.
3. The UMCH Seclusion and Restraint Form completed by N F (RN) states the client was "physically aggressive with staff, kicking doors attempting to elope."
    a. Video review does not corroborate that the resident was physically aggressive, kicked doors, or attempted to elope.
        i. The only door he can be seen kicking is the inside of the seclusion room door.
        ii. He does not appear to make any attempts to elope. If an attempt was made in an area not captured on video the attempt was not taken seriously enough at the time to not subsequently leave him alone in the hallway.
        iii. The only "aggressive" action taken is when the resident pushes back against staff member H with his body weight in response to H attempting to use his body to control the movement of the resident.

[182] Video still frame #42 - Staff member T H laughing at resident through the window in seclusion room door.
[183] Video still frame #43, #44, and #45 – Staff member laughing and joking outside seclusion room.
[184] DHS-1910 Incident Report Form completed by T H

The action does not appear aggressive but rather responsive.

b. This form does not include J[redacted] D[redacted] as one of the staff members involved in the escort restraint or present in the seclusion room.
c. The Indication for Behavior Management/ESI section states client was an imminent danger to self because he "tied sweatshirt around neck in attempts to self-harm."
    i. The resident did take his sweatshirt off, tie it into several knots, place it around his neck for 2 seconds, and then take it off and put it back on the proper way. This however was ***after*** he was placed in seclusion and ***after*** he received a chemical restraint. The CR occurred at 11:20, this occurred at 11:31.

4. On the Staff Debriefing form a staff member[185] wrote only "client being non-compliant" as the summary of discussion regarding emergency safety situation leading to intervention. For alternative techniques that could have prevented the ESI the same staff member wrote "client being compliant." The staff member believed to have completed this form has been employed as a BI at UMCH since at least 2015.
    a. A staff member[186] added to the form stating the resident was "destroying property…attempting to break the doors…pushed staff." While this explanation better justifies the use of an ESI it does not comport with video review of the incident.

iii. The Behavioral Intervention Observation Log does not indicate a physical restraint took place. The resident was restrained to transport him to the seclusion room, inside the seclusion room in order to administer the CR, and later to remove his sweatshirt from him.
iv. Staff debriefing included T[redacted] H[redacted], S[redacted] W[redacted], S[redacted] M[redacted] and L[redacted] B[redacted]. Staff members involved in the incident include: T[redacted] H[redacted], S[redacted] W[redacted], J[redacted] D[redacted], A[redacted] J[redacted], and Nurses F[redacted] and M[redacted].
v. Additional Concerns
    1. Vitals were not attempted until 12:30PM, over an hour after he was placed in seclusion and received a chemical restraint. Vitals are marked as "refused."
    2. The Office Manager was involved in an ESI and physically blocked and pushed the resident.[187]
    3. While six staff members were blocking the hallway so that the resident could not enter the adjoining hallway two residents on the boy's unit were running, jumping up, and attempting to kick through the windows

[185] Staff member is believed to be T[redacted] H[redacted] based on his completion of the client debriefing section
[186] Staff member believed to be L[redacted] B[redacted] based on signature
[187] Video still frame #38 – Office manager blocking and pushing resident back

of the phone area. [188] There was one staff member with 3 residents on the unit. She never stands up or appears to make any attempts to redirect the residents. Eventually she either alerts the other staff members or they see the residents' behavior through the windows in the unit doors. All but one of the staff members abandon their effort to corral the resident and respond to the unit.

4. Staff member T H can be seen talking at the resident, using exaggerated hand gestures, and invading the personal space of the resident throughout the videos, even when the resident is clearly upset and could have benefited from personal space and the ability to calm down.[189]
5. Post Intervention Client Debriefing was conducted by T H, a staff member involved in all aspects of the incident and interventions.
    a. All questions are marked "client refused to answer."
    b. The debriefing occurred at 12:28pm,[190] at 12:17pm the client had been asleep in the seclusion room.[191]

2. Simultaneous Use of Chemical Restraint and Seclusion

a. 04/12/21 –
    i. Resident was placed in seclusion from 7:24am -8:21am. He received a chemical restraint at 7:29am.[192]
b. 04/12/21 -
    i. Resident was placed in seclusion from 7:23am-8:20am. He received a chemical restraint at 7:32am.[193]
c. 4/28/21 – 4 male residents that eloped were secluded after receiving chemical restraints.[194]
    i. and were put in seclusion rooms.
        1. was in the seclusion room from 3:05-3:50. The entire time he was in the seclusion room his behavior is listed as "sitting."
    ii. and were secluded in elevator vestibules[195]
d. 04/28/21 – 3 female residents appear to have been secluded when a chemical restraint was administered. The Seclusion and Restraint Log indicates they were placed in seclusion and received a chemical restraint minutes later. The time seclusion ended is not noted on any of the logs.[196]

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[188] Video still frame #39 - Two residents on the boys' unit running, jumping up, and attempting to kick through the windows of the phone area.
[189] Video still frames #32, 34, 37 -
[190] Post-Intervention Debriefing
[191] Behavioral Intervention Observation Log for
[192] April Boys Seclusion and Restraint Log
[193] *Id*.
[194] Behavioral Intervention Observation Logs for , , , and
[195] Behavioral Intervention Observation Logs for and
[196] 04/28/21 Seclusion and Restraint logs for 3 residents

i. [redacted] was placed in seclusion at 8:02am and received chemical restraints at 8:05am and 9:16am.
ii. [redacted] was placed in seclusion at 8:06am and received a chemical restraint at 8:11am.
iii. [redacted] was placed in seclusion at 7:59am and received a chemical restraint at 8:08am.

e. 6/15/21 – [redacted]. Detailed above.
   i. Video review showed resident receiving a chemical restraint in the seclusion room and then remaining there.
   ii. The incident report states, "client was turned over to nursing after being non-compliant and placed in seclusion and given a restraint."[197]
   iii. The Behavioral Intervention Observation Log indicates he was secluded for approximately one hour after receiving the CR.

3. Elevator Vestibules Used for Seclusion.

a. This raises concerns regarding the prevalence of seclusion and whether all events that qualify as seclusion are being documented. Additionally, the area is not intended for seclusion and therefore not free of potential hazards.
b. 4/28/21 - 2 residents were secluded in the elevator vestibule. Detailed above.
c. 5/15/21 - [redacted] and [redacted] were both held in the elevator vestibule at separate times. One resident was in the vestibule and the other resident kicked through the door and attacked that resident. After a staff member finally entered the attacked resident was removed and the attacker was left alone in the vestibule.

4. Lack of Documentation Related to Chemical and Physical Restraints

a. We requested all documentation related to the precipitating incidents and the administration of physical restraints, chemical restraints, and seclusion for all investigated incidents.
   i. The paperwork we received was inconsistent and did not include all necessary information in most cases.
      1. Documentation that a resident was medically assessed following a physical or chemical restraint and the medications and dosage used are not uniformly indicated on the paperwork for individual residents.
      2. With one exception the doctor authorization for the use of restraint or chemical restraint is not noted.
b. No Seclusion and Restraint logs exist for male residents prior to April 2021.[198]
c. The Seclusion and Restraint logs do not match the numbers UMCH claims have occurred for April and May 2021.[199] UMCH provided a chart breaking down personal and physical restraints by month, gender, and shift.
   i. April 2021[200]

[197] DHS 1910 Incident Report Form
[198] Email from C[redacted] G[redacted]
[199] RTC Total Restraint and Chemical Restraint data provided by UMCH. April and May 2021 were the only full months that we reviewed.
[200] Seclusion and Restraint Logs April 2021

1. Boys – UMCH chart states there were 15 CR and 5 PR
    a. S&R logs only show 7 entries, they appear to all be CR
2. Girls – UMCH chart states there were 20 CR and 23 PR
    a. S&R logs only show 17 entries that appear to be CR and 3 PR

ii. May 2021[201]

1. Boys– UMCH chart states there were 10 CR and 12 PR
    a. S&R log only shows 12 entries, at least 5 are CR, at least 7 included seclusion, some entries do not have enough information to identify what intervention was used.
2. Girls – UMCH chart states there was 1 CR and 2 PR
    a. S&R log only shows 1 entry for a CR and 1 for a PR

5. Improper Physical Restraints

a. 4/4/21 - [redacted]

i. A resident is restrained multiple times and given a chemical restraint. The resident is aggressive and resistant to being restrained however, during the altercation staff push him against walls, push him to the floor, fling him causing him to fall, cover his mouth with their hands, appear to put their elbows in his neck while on the ground, and hold his head down.[202]

1. The resident is sitting down on the floor; staff attempt to take something from him and he hits staff. Staff shove client into the wall, grabbing his shirt while trying to restrain him.[203] Staff get him into a standing hold, they maintain the standing hold for about 4 minutes and then go to the floor, face down.[204] The resident is still struggling with them while on the floor.
2. While on the floor staff members continually push their elbows into the resident's face and neck.[205]
3. A nurse comes to give him an injection, he is still struggling and tries to kick her. After the injection is administered staff release their hold. The resident appears angry when he gets up and goes toward the staff members. It appears one of the staff members is antagonizing him.
4. Staff push him down and fling him across the room and then get him down on the floor again. This time he is on his back. [206]

[201] Seclusion and Restraint Logs May 2021

[202] Video reviews of 04.04.21 100100 Unit 1 Entrance, 04.04.21 100100 Unit 1 Foyer 360 Cam, and 04.04.21 100100 Unit 1 Foyer.

[203] Video still frame #46 – Staff shoving resident into wall while attempting to restrain him.

[204] Video still frame #47 - Resident face down on floor with two staff members in restraint

[205] Video still frame #48 - Resident face down on floor with two staff members in restraint. Both staff members' elbows are pressing into his neck.

[206] Video still frames #49-#54 – Staff member lunging toward resident as he attempts to stand up after being released from a restraint, staff members pushing resident into a wall, resident on ground with staff member's hand on face, resident on ground with staff member hand covering his mouth, series showing staff member grab resident and shove him across the room, staff member pushing resident into cabinets.

5. After the resident is released he is holding his neck and appears to be in pain. [207]

ii. Additional concerns related to the handling, investigation, and documentation of the restraint.
    1. The Seclusion and Restraint form does not adequately document the incident and includes incorrect information.
        a. The Seclusion and Restraint form lists a single restraint from 10:45AM – 10:50AM.
            i. There were 4 physical restraints and one chemical restraint over a period of 18 minutes.[208]
        b. Under Client Debriefing it states X[redacted] W[redacted] and N[redacted] T[redacted] were the "staff members who participated in the intervention."
            i. The [redacted] lists X[redacted] W[redacted] and E[redacted] L[redacted] as the staff members involved.
        c. Outcome of Intervention is listed as "client was placed in a team control position and received a chemical restraint."
            i. At the time the resident received the chemical restraint the intervention had not concluded.
    2. A Face-to-Face assessment is documented as having occurred at 11:37AM but vitals are not documented as having been taken until 6:49PM.
        a. The resident was transferred to an acute hospital after the incident, assessed there, the hotline was called, and an investigator made it to the home of his guardians at 4:35PM.
    3. Client and Staff Debriefings occurred at the same time.
    4. The incident was called into the Child Abuse Hotline by Admissions at Methodist Behavioral Hospital after noticing visible injuries and speaking with the resident.
        a. UMCH RTC did not call the hotline
        b. UMCH documentation of the incident notes no injuries.[209]
    5. Staff members involved in the restraint stated to an investigator that the resident was biting and scratching them during the incident.[210]
        a. This is not supported by the video reviewed and does not appear to be possible based on the manner in which his hands and head were held.
    6. The restraint was not continuously monitored.
    7. The other 14-15 residents on the unit were left to sit and watch the entire incident. One staff member responds to the unit but does not

[207] Video still frame #55 – Resident laying on floor holding his neck and appears to be in pain after restraint.
[208] Video Review of 04.04.21 100100 Unit 1 Foyer.
[209] *ID-Physical Markings/Injuries completed by S[redacted] D[redacted] (RN) at 11:42AM on 4/4/21. "None" is marked and filled in under "description of findings."*
[210] [redacted] Interviews of E[redacted] L[redacted] and X[redacted] W[redacted].

make any attempt to move the residents away from the altercation or dissuade them from watching.

b. 1/28/21 – [redacted]

i. In an attempt to keep a resident from entering and then from leaving a unit he is subjected to aggressive staff tactics that escalated the incident and resulted in injury. Staff members X[redacted] W[redacted] and T[redacted] H[redacted] push, pull, and grab resident by his arms and clothing throughout the incident and do not employ proper CPI techniques.[211]

1. Throughout the incident there are several times the resident tries to walk away and staff follow him.[212]
2. At one point T[redacted] H[redacted] pulls the resident's arm to keep him from walking away and the resident falls.[213] Staff X[redacted] W[redacted] attempts to keep H[redacted] from moving towards the resident by putting his hand on H[redacted] chest to block him from moving toward resident, indicating he believes H[redacted] is being too aggressive and may need to step away.[214]
3. Staff attempt to remove one resident from C Hall and place this resident on C Hall. When the door opens this resident tries to go toward the resident on C Hall. Once inside the hall door staff push the resident and he falls to the ground.
4. Staff H[redacted] pulls resident by his shorts and exposes his boxers. His shorts are pulled almost completely down.[215]
5. The resident is on C unit alone, W[redacted] opens the door again and pushes resident, the resident falls again.
6. W[redacted] pulls the resident by his legs out of camera view. One minute later H[redacted] opens the unit door and charges at the resident, pushing him down the hall.
7. Staff continue to not give the resident any space and the resident spends a lot of time on the floor.[216] The resident was pushed to the floor by staff at least 6 times and was also pulled by his legs multiple times once on the floor.
8. After one of the instances of being pushed by W[redacted] the resident puts his hands to his face and pulls them away, looking at what appears to be blood on them.[217]

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[211] Video Review 01.28.21-071109 Unit 1 foyer, 01.28.21-071109 Residence Hall 1 East 1, 01.28.21-071109 Residence Hall 1 East 2, 01.28.21-071109 Residence Hall 1 West 1, and 01.28.21-071109 Residence Hall 1 West 2.
[212] Video Review of 01.28.21-071109 Unit 1 foyer and 01.28.21-071109 Residence Hall 1 East 1.
[213] Video still frame #56 – Staff grabs resident arm and resident falls.
[214] Video still frame #57, #58 – Staff X[redacted] W[redacted] gloved hand on staff T[redacted] H[redacted] chest, pushing him back from resident.
[215] Video still frame #59 – Series showing staff pushing resident, resident falling, and resident being pulled by his shorts.
[216] Video review from 01.28.21-071109 Residence Hall 1 West 1, Video Still frames #60-65.
[217] Video still frame #67- Resident checking for blood from his nose.

9. Towards the end of the video another staff member enters the hall. This staff member is able to comfort and calm the resident once H[redacted] and W[redacted] leave the hall.

ii. When this incident was reported to PRLU it was misrepresented and appears to attribute all of the resident's injuries to a peer incident the previous day or self-infliction.[218]

1. The incident report was also not completed until more than 24 hours later.[219]

iii. The incident was not reported to the Child Abuse Hotline by UMCH. It appears to have been reported either by Methodist Behavioral Hospital after intake or by Arkansas Children's Hospital.

iv. The resident's nose was x-rayed, revealing an acute fracture involving the nasal bridge, on 01/28/21.[220] He was later taken to the ER. The x-ray and ER visit did not occur until after the altercation with staff detailed here and the peer incident from the previous evening, making it difficult to definitively attribute his injuries

v. Staff member X[redacted] W[redacted] refused to be interviewed by [redacted][221] He remained employed at UMCH for several months and was involved in at least 2 additional incidents of possible maltreatment.

c. <u>Report of Failure to Protect and Abuse and Neglect -</u> [redacted]

i. Resident reportedly received numerous injuries during his stay as a result of peer altercations and staff restraints and interventions. The resident reported residents would enter his room at night and attack him and that staff did not intervene. It was also reported that the resident was improperly restrained and received injuries from staff. The abuse was reported to the hotline by the guardian on 03/22/21 after visiting and then pulling the resident from the program on 03/20/21.

ii. Although the [redacted] it found there were credible disclosures of abuse/neglect. [redacted] observed marks and bruising on the resident and confirmed the occurrence of multiple incidents that did or could have resulted in injury.[222]

iii. The records indicate that the facility was not cooperative in this investigation and never provided the requested video [redacted] or licensing specialist despite multiple requests.[223]

1. Voicemails or messages were left for K[redacted] B[redacted], UMCH Director, by the investigator on 04/06, 04/14, and 05/05. The calls were never returned.[224]

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[218] PRLU Notice of Incident

[219] DHS 1910 Incident Report Form

[220] X-ray report attached to Incident Report form

[221] [redacted]

[222] [redacted]

[223] [redacted]

[224] [redacted]

2. On 05/05/21 Alicia Johnson, UMCH office manager, was informed [redacted] no one had returned her calls. A[redacted] stated that S[redacted] W[redacted], UMCH Consultant, had seen the video footage of the incident/s. [redacted] they are not allowed to let anyone view video footage at the facility and she would have to submit a request to the administrator that if granted would allow [redacted] to pick up footage from their resource department. Later on 05/05/21 S[redacted] W[redacted] verified [redacted] she was aware of the [redacted] involving this resident and agreed to email documentation she had.
3. On 05/06/21 S[redacted] W[redacted] [redacted] she watched some of the footage of the incidents. She was not able to [redacted] names of the staff members working at the time and said she would have to go back and look at the video to make that determination.[225] According to her video review, [redacted] staff were in the foyer and not on the hallways as they should have been, Mr. L[redacted] had the resident in an improper restraint and was very aggressive toward him, and the nurse took a picture of the resident's face that day. [redacted] Nurse N[redacted] F[redacted] on 05/06/21 who stated she was aware the resident had some bleeding/bruising around his eye and she believed he received it during a restraint. She took a picture of his eye but the injury was not otherwise documented. She also stated she felt L[redacted] was overly aggressive based on her video review.

iv. DRA received documentation for three separate incidents involving staff that resulted in injury and/or involved inappropriate restraint techniques.
1. 02/28/21 - Staff restrain him against the wall. At one point staff is lifting him off the floor and holding him against the wall. After he is released from the hold, he falls to the floor.[226] He pulls the neck of his shirt down, revealing injuries to his shoulder.[227] The nurse then brings supplies to clean it. [228]
2. 3/12/21– Resident hits a peer with a basketball and the peer goes for the resident. Staff grab the resident by the shirt or neck and try to escort him out of the gym.[229] Staff then chase him until he falls and

[225] During DRA's visit on 06/15/21 W[redacted] was on the floor and actively engaged with staff and residents throughout our entire visit. She is also one of the CPI trainers for the facility and reviews all incident footage. All indicators that she is knowledgeable of and familiar with staff and would be able to readily identify them.
[226] Video review of MCH LR RTC 02.28.21 Hallway 1100 -2, Still frame #70 - Resident being restrained up against the wall, feet not touching the ground.
[227] Video still frame #71 - Resident laying on floor after restraint.
[228] Video still frame #72 and #73 Resident showing staff his injury.
[229] Video review of MCH LR RTC 02.28.21 Exercise 2, Video still frame #74 Staff pulling on resident shirt to keep him from running.

slams into the wall and staff grab him by the arm.[230] Staff then toss him outside the gym doors and he falls to his knees.[231] Staff return to the gym and he is left walking the halls alone. He goes to the cafeteria and retrieves a chair. He returns with the chair and starts hitting the door with it. Staff come out, he throws the chair, and staff run after him.

3. 3/18/21 - Resident is reading a book. All of the sudden he stands up to close it and staff come towards him to take what he has in his hands. Staff move toward the resident attempting to grab him and suddenly another resident puts the resident in a headlock and holds him against the wall for staff.[232] Additional staff come to assist and remove the resident and put him in a standing hold. The resident is able to kick up his back feet so that he is being held only by his arms. [233] There are two staff restraining, one staff member watching the restraint, and no one with the other residents that were now locked on the dormitory hall. They release him, he lays down on the floor, appearing defeated. The two restraining staff members continue to talk to him. He begins to get agitated again and kicks a chair. He calms back down and then kicks the chair again prompting staff to circle him and begin talking.

6. Additional Concerns Reviewed with UMCH and UMCH Plans for Corrective Action

a. <u>Minimum staff ratios not being met and residents are being left unattended</u>

i. During our visit on 06/15/21 minimum staff to resident ratios were not being met.[234] Video review and interviews for unrelated incidents has indicated our observations on 06/15/21 were not an anomaly. One example of a resident sustaining injury as a direct result of inadequate staffing was on 02/15/21.

a. On 02/15/21 a resident was assaulted by multiple other residents. Staff minimum ratios were not being met at the time of the incident and staff did not appropriately intervene to protect the resident.[235]

i. There was one staff person in the dayroom with 9 residents. She was standing by the door, away from the residents who were mostly gathered by the television when one resident stands up and starts hitting another resident that is sitting in a chair.

[230] Video still frame #75 Staff chase resident and he falls and slides into the wall.
[231] Video from MCH LR RTC 02.28.21 Hallway 1100-2, Video still frame #76 and #77 Staff shove resident out the gym door and resident lands on the floor.
[232] Video review of MCH LR RTC 3.18.21 Unit 1 Foyer, Video still frame #78 - Resident placing other resident in hold in attempt to assist staff.
[233] Video review of MCH LR RTC 3.18.21 Unit 1 Foyer, Video still #79 - Staff restraining resident, resident kicking up his feet behind staff.
[234] This was previously reported to PRLU with additional details.
[235] Video Review – 2021.02.15 – Dayroom 1102 – 1,

ii. Staff moves towards the kids and attempts to separate them. Once she can separate the perpetrator from the victim she leaves them both and walks to the other side of the room to retrieve the radio she has left on the table to call for help.
iii. Before she makes it to her radio a different resident jumps up and puts the victim who was just punched in a headlock and slams him to the floor. Another resident from across the room comes running over and starts hitting the resident who now has the resident on the floor.
iv. Another resident attempts to help the resident on the floor by separating them. The initial aggressor returns and stomps on the resident 4-5 times before staff and other residents pull him off.
v. At this point, the staff and several residents leave the room and go into the hall. There are 6 residents left in the room alone and a different resident starts hitting the victim in the back of the head and then stops. Staff finally come back and enter the room just before the video ends.
vi. The victim was taken to the Arkansas Children's hospital with a nosebleed. No other injuries are documented.
vii. The PRLU Notice of Incident is not detailed and lists only precautions for the residents involved and medical treatment for injuries as the corrective action taken.

ii. <u>Residents are left on locked dormitory hallways unattended.</u>
1. On 06/15/21 two residents were in their rooms on the locked dormitory hallway with no staff present on the unit.
    a. The nurse manager indicated this is not uncommon as there are residents that like to sleep all day or stay in their rooms sometimes.
2. On 06/15/21 there was also a resident in the foyer area of the girl's unit that was unattended. This resident was supposed to be on line-of-sight precautions at the time.
    a. The nurse manager escorting DRA stated the nurse was watching these residents. The nurse was in the nurse's station performing nursing functions and not operating as a staff member at that time. It was also reported but not observed that the nurse is called away from the unit for various responsibilities throughout the day and is not replaced by a staff member.
3. Video review and interviews for unrelated incidents has indicated our observations on 06/15/21 were not an anomaly.

b. Staff Scheduling
    i. DRA reviewed 3 days of schedules pertaining to an incident investigation. In addition to the employees present or not present the schedules showed that in just those 3 days 8 staff were scheduled for two consecutive 8 hour shifts.[236]
c. Medication Education
    i. No resident interviewed could name the medications they are taking or why they take them.
    ii. DRA asked K[redacted] B[redacted], facility director, and Nurse B[redacted] A[redacted] what the Medication Education policy or practice is for UMCH. Neither could articulate a practice or confirm that a policy exists.
        1. Nurse on duty on 06/15/21 stated that "most of the time kids know what they are taking" and she knows this because "they would tell her when she forgot something."
    iii. The policy that was later provided states only that "All clients of MH must be educated as to any prescribed medications they are taking."[237]
d. Elopements
    i. There has been a substantial number of elopements from the PRTF in recent months.
        1. UMCH administration has shared plans to reinforce an exterior hallway door frequently used by residents due to their ability to overpower the magnetic locks and kick it open. They have also shared plans to build a wall in the hallway that will add a second layer of physical barriers.
            a. These corrective actions do not address the staffing levels and levels of supervision that are attributing to the residents' ability to elope. They also do not address the fact that residents have repeatedly been able to circumvent the magnetic locks on the dormitory hall exit doors and elevator vestibule doors. Two examples of this include incidents on 05/15/21 and 03/14/21.
                i. On 05/15/21 a resident entered the elevator vestibule by kicking the door open and proceeded to attack another resident that was being held there alone. On 03/14/21 residents kicked through the elevator vestibule doors, dormitory hall doors, and ultimately an exit door.[238]
                    1. Resident kicked open the elevator vestibule doors from the foyer area multiple times. They would lock themselves in the vestibule and then free themselves and re-enter the foyer. During the several minutes they continued to do this

[236] DRA reviewed staff schedules for 06/14, 06/15, and 06/16/21.
[237] Medication Education Policy
[238] Video Review – 2021.03.14-Elevator Vestibule 1, 2021.03.14-Hallway 1101-1, 2021.03.14-Hallway 1100-2, 2021.03.14-Hallway 1124-1, 2021.03.14 Hallway 1124-2, 2021.03.14-Unit 1 Entrance, 2021.03.14-Unit 1 Foyer.

there was never any staff intervention or redirection.[239]

2. They then began to kick open the dormitory hall doors, also without any staff intervention. Several residents enter a dormitory hall. Staff stand in the foyer appearing confused and unsure of what is happening and how to respond.[240]
3. Two residents that remain in the foyer begin fighting and staff stands watching them. She then throws her hands in the air seemingly defeated.[241]
4. The eight residents that broke into the dormitory hall then run out and kick their way out of the unit through the elevator vestibule.[242]
5. The residents chase and then attack a resident that had been left unattended in the hallway.[243] They then exit the facility by kicking open the exit door.
6. After they exit a single staff member is seen walking down the hallway after them. She does not appear to be in any hurry. The residents had time to attack another resident and run down two additional hallways and exit before staff arrive.[244]

e. <u>Lack of Activities</u>

i. Observation, resident and guardian interviews, and video review have identified a dearth of structured activities for the residents. Almost all time outside of school hours, which do not occur during the summer months, is idle time. The facility does not have activity schedules posted and could not immediately produce a schedule, other than the school schedule, that aligned with actual activities occurring at the facility.

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[239] Video Review – 2021.03.14 – Elevator Vestibule 1, Video still frames #80, #81 – Resident preparing to run and kick through door and resident kicking through door

[240] Video still frames #82 - #84 - Residents running around unit and kicking through dormitory hall doors, staff appearing confused as residents enter dormitory hall

[241] Video still frame #85 and #86 – Residents fighting in the foyer as staff stands by watching, staff throws her hands in the air seemingly defeated.

[242] Video still frame #87 – Residents run down the hallway after kicking open the doors.

[243] Video still frame #88 and #89 – Residents attacking a resident that is on the ground in the corner of the hallway. Only his legs can be seen, Resident sitting in the corner as other residents walk around after attacking him.

[244] Video still frame #90 – Resident running toward the exit door as staff casually walks down hallway closing doors as she makes her way to the end of the hallway.

f. Cleanliness of facility
    i. The facility did not appear to be sanitized and the group room in particular had debris and spills in chairs indicating they had not been wiped down for some time.[245] This is particularly concerning during a pandemic.

g. UMCH Plan for Corrective Action
    i. DRA met with UMCH administration and their counsel and shared our overarching concerns and some specific instances of concerning actions. UMCH subsequently provided several documents related to their plans for improvement. Those documents are included in documentation attached here.[246]

[245] Photos of chairs in group room.
[246] 06/29/21 UMCH letter to DRA, UMCH Plan of Quality Assurance, UMCH Special Procedure Review Form, UMCH Nursing Transition Log, UMCH RTC Behavioral Crisis Reporting Checklist.

Supporting Documentation for Disability Rights Arkansas Report Regarding UMCH Little Rock PRTF

1. Use of Chemical Restraints (CR) When Residents are Calm

a. 04/27/21 – [redacted]
   i. DHS-1910 Incident Report Form ……1
   ii. Behavioral Intervention Log ……3

b. 04/28/21 – Elopements and Chemical Restraints.
   i. Video Still Frames……6
      1. Video still frames #1 - #5 - Residents entering building and sitting in lobby.
      2. Video still frames #6 and #7 – Staff pointing to wall, resident standing against wall receiving injection
      3. Video still frame #8 - Nurse F[redacted] standing in front of resident with 2 injections in her hand
      4. Video still frame #9 – Resident sitting in waiting area while staff continue to talk to him
      5. Video still frame #10 – Resident walking to the bathroom
   ii. Behavior Intervention Observation Logs for all 4 residents ……11
   iii. LRPD Incident Report #2021-045341 ……15
   iv. Elopement Information Report for all 4 residents ……23
   v. 4/28/21 Report to Quality Assurance for [redacted] ……27
   vi. DHS-1910 Incident Report form and Post-Intervention Debriefing for [redacted] ……29
   vii. DHS-1910 Incident Report form and Post-Intervention Debriefing for [redacted] ……32
   viii. DHS-1910 Incident Report form and Post-Intervention Debriefing for [redacted] ……35
   ix. DHS-1910 Incident Report form and Post-Intervention Debriefing for [redacted] ……38

c. 06/14/21 – [redacted]
   i. Video Still Frames……41
      1. Video still frame #11 - Resident sitting at table slings a deck of cards into the air, they scatter across foyer.
      2. Video still frame #13 and #14 – Resident compliantly removing her jacket as nurses approach with injections
      3. Video still frame #15 and #16 - Resident is given one injection in each arm by two different nurses
      4. Video still frame #12 - Resident sitting looking down at her arms, 3 staff members picking up cards
   ii. Seclusion and Restraint Form ……44

d. 06/15/21 – [redacted]
   i. Video Still Frames……55
      1. Video still frame #17 - Staff members NK and J[redacted] D[redacted] restrain the resident. Each staff member is on either side of her and she is bent over forward at the waist.
      2. MCH LR RTC Girls Hallway 6-15-21 Hallway 2100-1, Video still frame #18 - S[redacted] W[redacted] swaps places with staff member NK in the restraint.
      3. Video still frame # 19 – Nurse enters with injections in her hand.
      4. Video still frame #20 - Resident sits calmly with her head down and staff on either of side of her holding her arms.
      5. Video still frame #21 and #22 - Resident becomes upset when she sees the nurse with the injections
      6. 2100-1, Video still frame #23 – Resident is restrained by J[redacted] D[redacted] and S[redacted] W[redacted] while the nurse administers the injections.

7. Video still frame #24 – Resident's entire body goes completely limp and she is laid on the floor.
8. Video still frame #25 - Resident is laid face down on the floor with both arms stretched out straight to the side
9. Video still frame #26 - Resident laying on floor, no staff observing resident
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3. Video still frame #36 and #37– Resident sequestered at the end of the hallway by the gym by 6 staff members
4. Video still frame #40 – Resident sitting in corner of seclusion room
5. Video still frame #41 - **-** Resident held face first against the wall while two injections are administered.
6. Video still frame #42 - Staff member T H laughing at resident through the window in seclusion room door.
7. Video still frame #43, #44, and #45 – Staff member laughing and joking outside seclusion room.
8. Video still frame #38 – Office manager blocking and pushing resident back
9. Video still frame #39 - Two residents on the boys' unit running, jumping up, and attempting to kick through the windows of the phone area.

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        4. Video still frames #49-#54 – Staff member lunging toward resident as he attempts to stand up after being released from a restraint, staff members pushing resident into a wall, resident on ground with staff member's hand on face, resident on ground with staff member hand covering his mouth, series showing staff member grab resident and shove him across the room, staff member pushing resident into cabinets.
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        3. Video still frame #59 – Series showing staff pushing resident, resident falling, and resident being pulled by his shorts.
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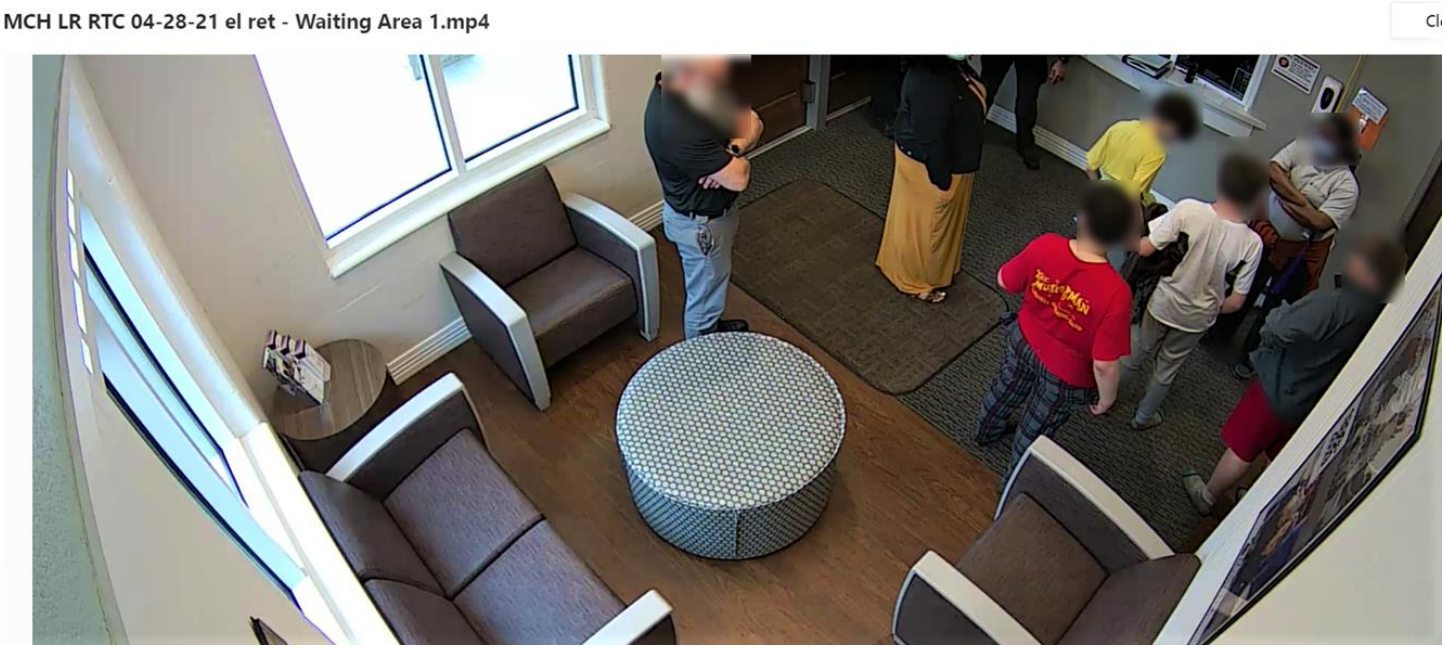
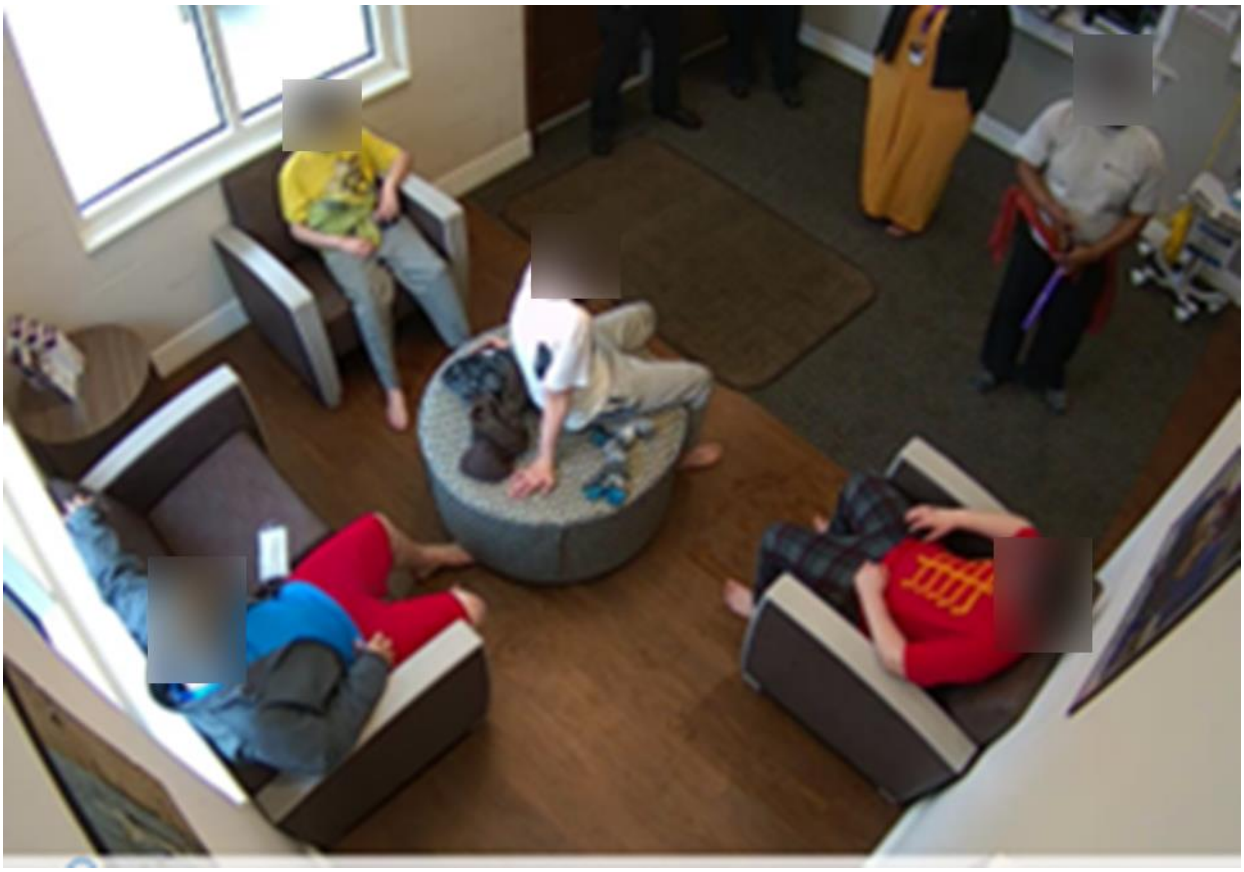
        5. Video still frame #67- Resident checking for blood from his nose.

On 04/28/21 chemical restraints were given to 4 residents that eloped upon their arrival back at the facility. All four residents are escorted back to the facility by LRPD and calmly enter and sit in the lobby.

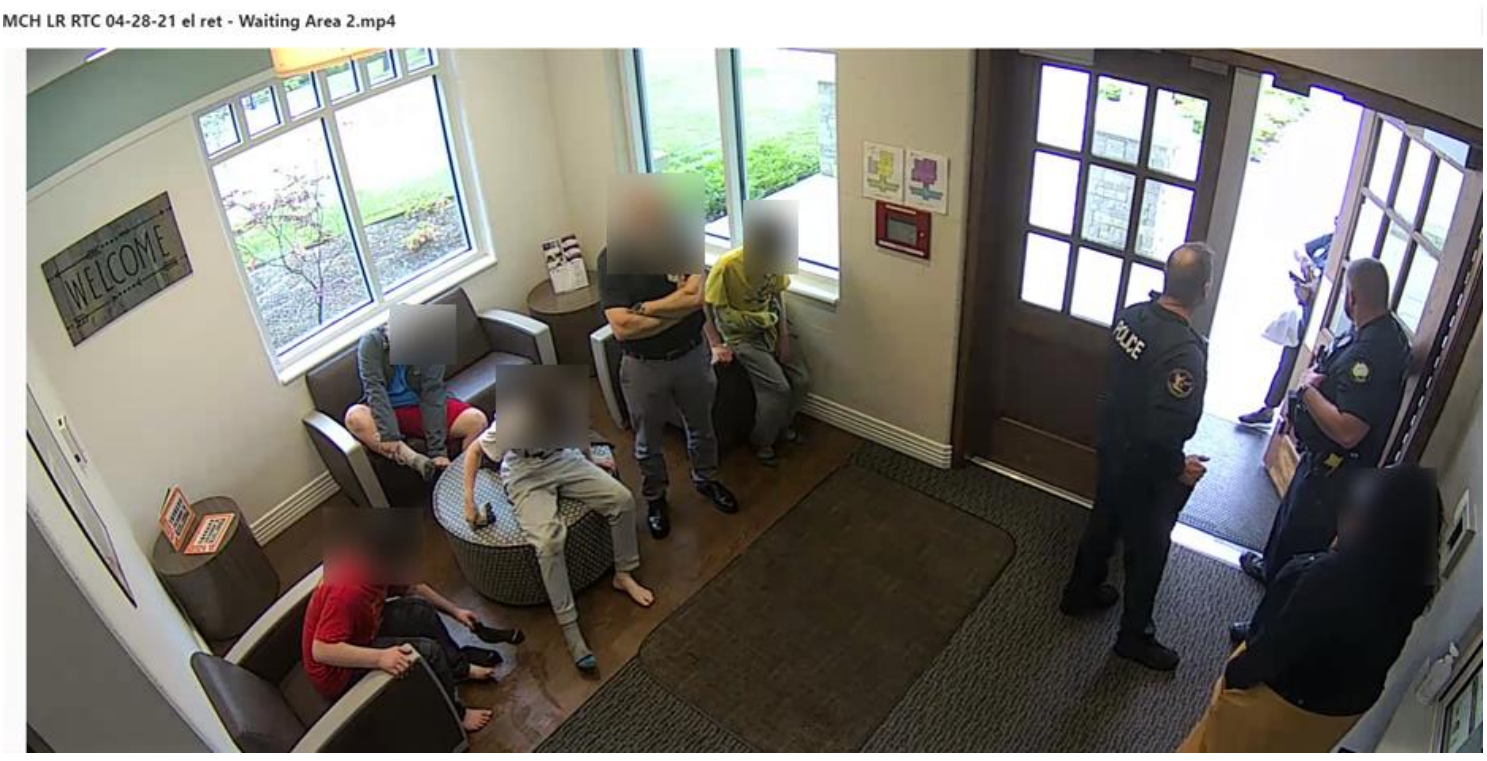
#1 – Four residents walking back into building followed by police. Staff holding door open.



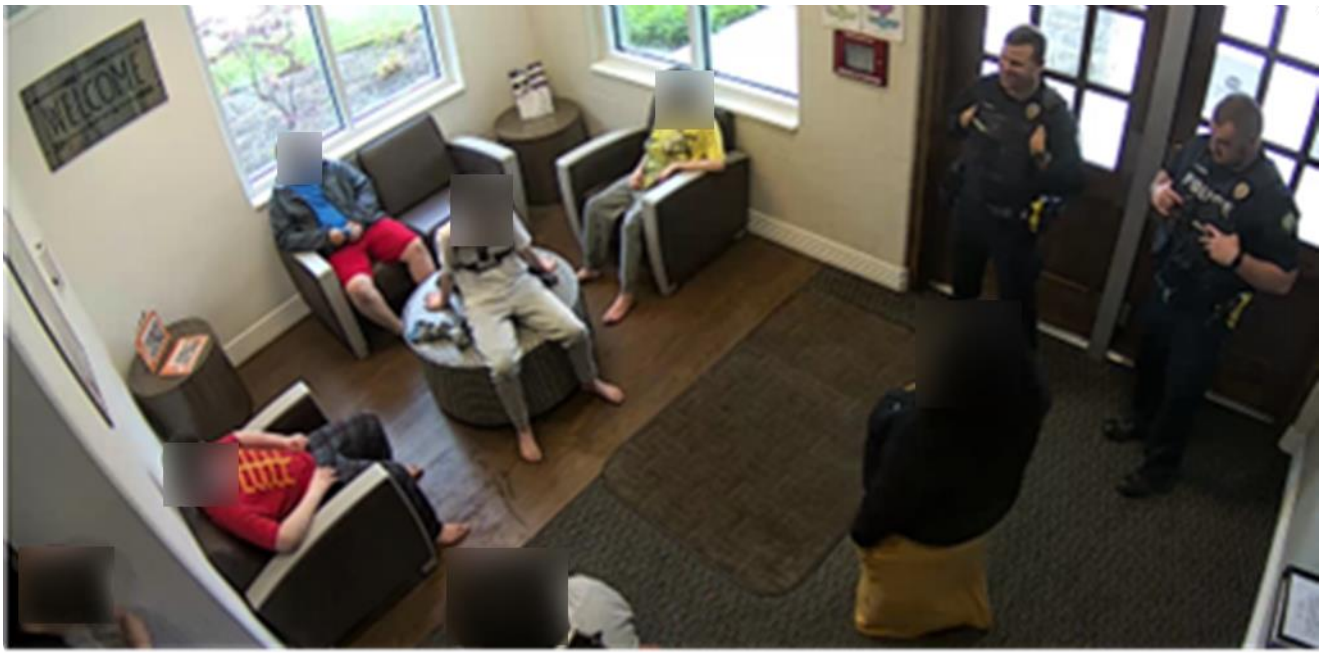
#2 – Four residents standing in lobby.



#3 – Four residents sitting calmly in the waiting area. Program Consultants speaking to them.



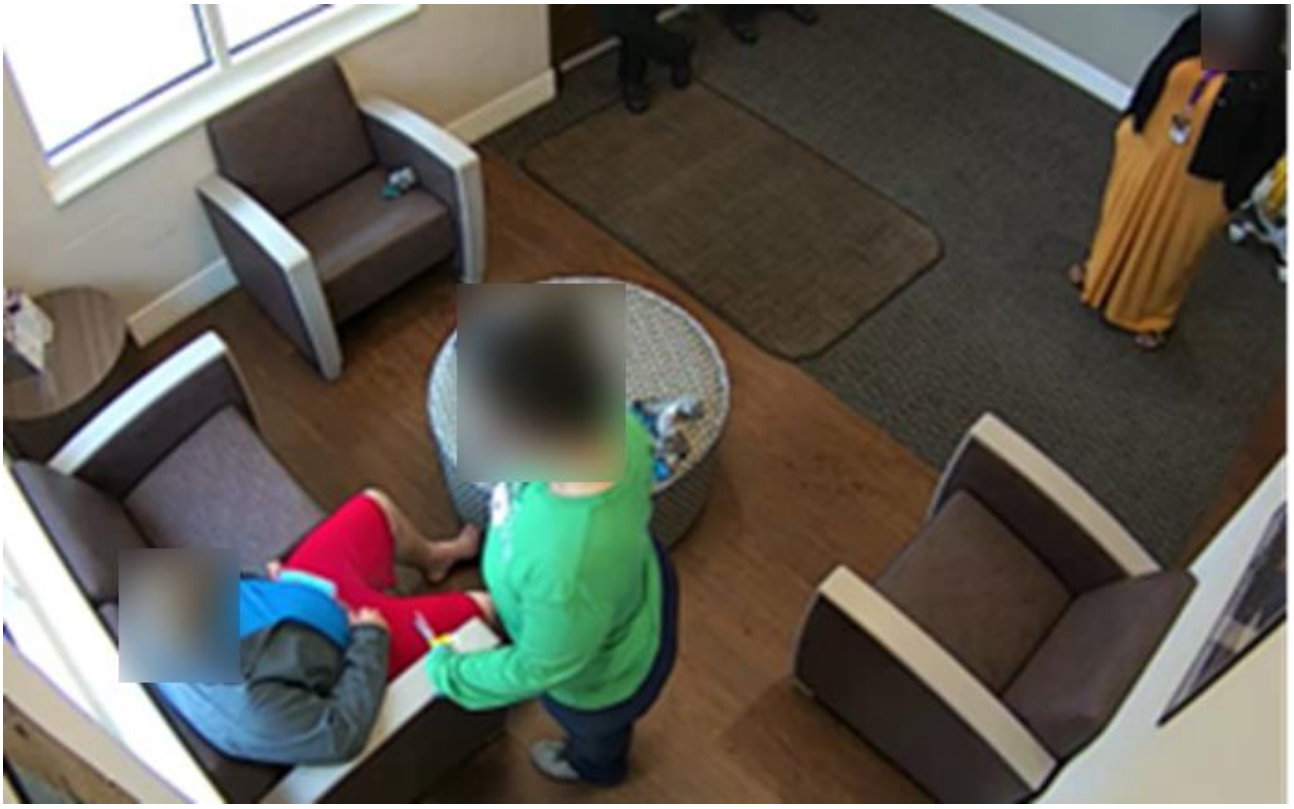
#4 – Four residents sitting in waiting area and removing socks. Staff and police attention diverted to individual bringing in food.



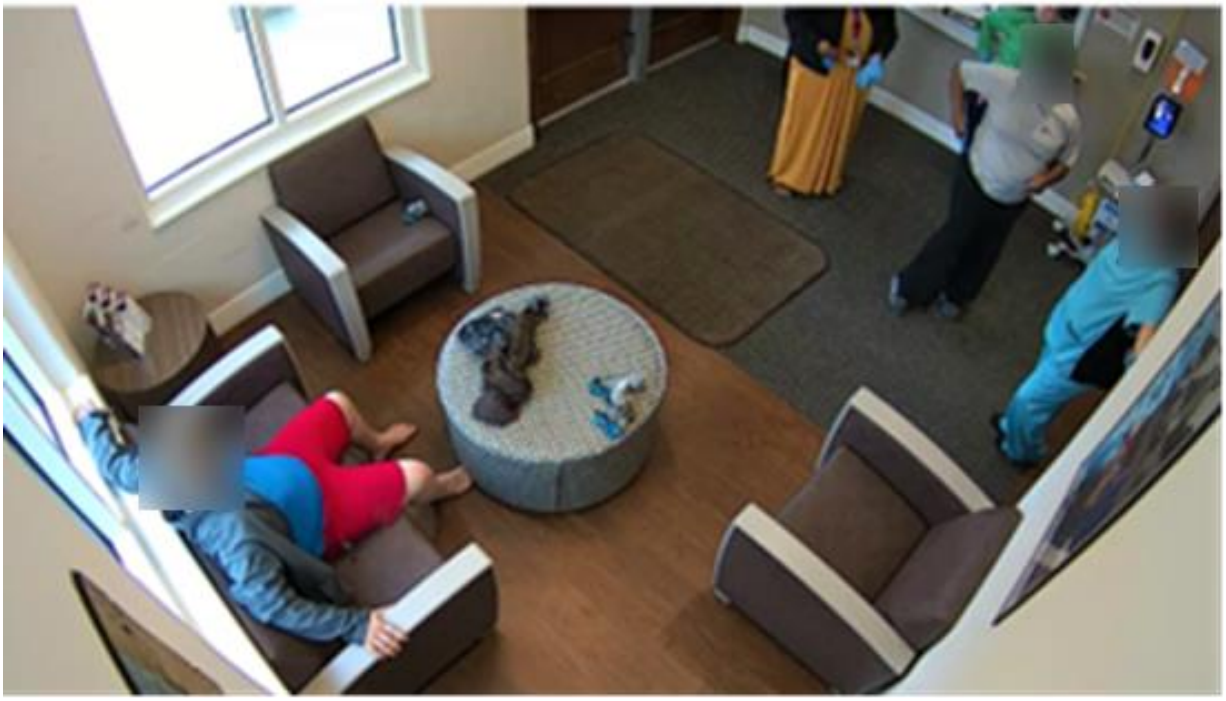
#5 – Four residents sitting in lobby. Staff speaking to them. Two LRPD officers standing by doors laughing.

#6 – Staff Williams, a UMCH Consultant, points to a wall and one of the residents walks over to the wall and pulls down the side of his pants to receive an injection.

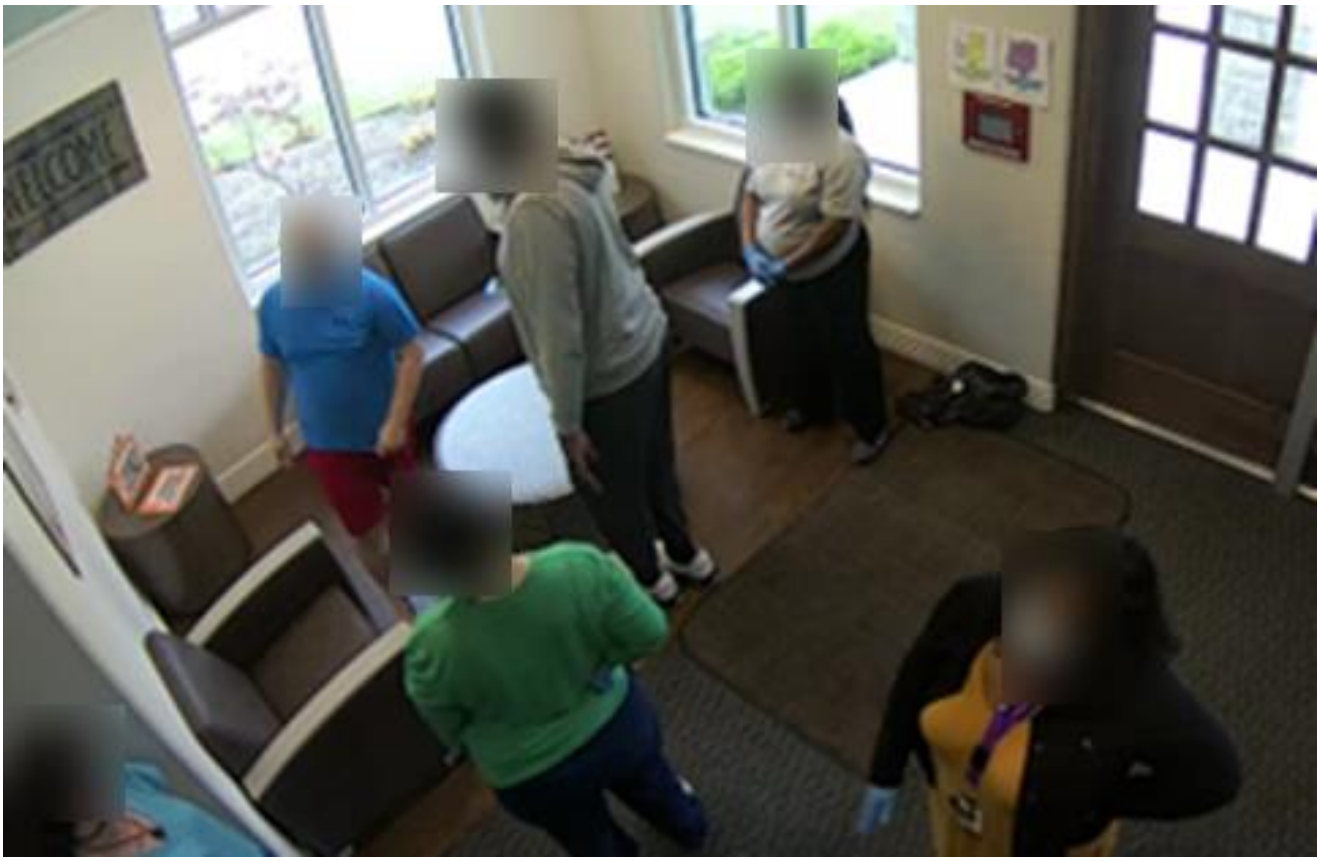
#7 – Resident calmly follows orders and submits to injection.



#8 - Nurse Frey approaches resident with two injections in her hand and holds them in front of him.



#9 – Resident siting in waiting area while staff continue to talk to him.

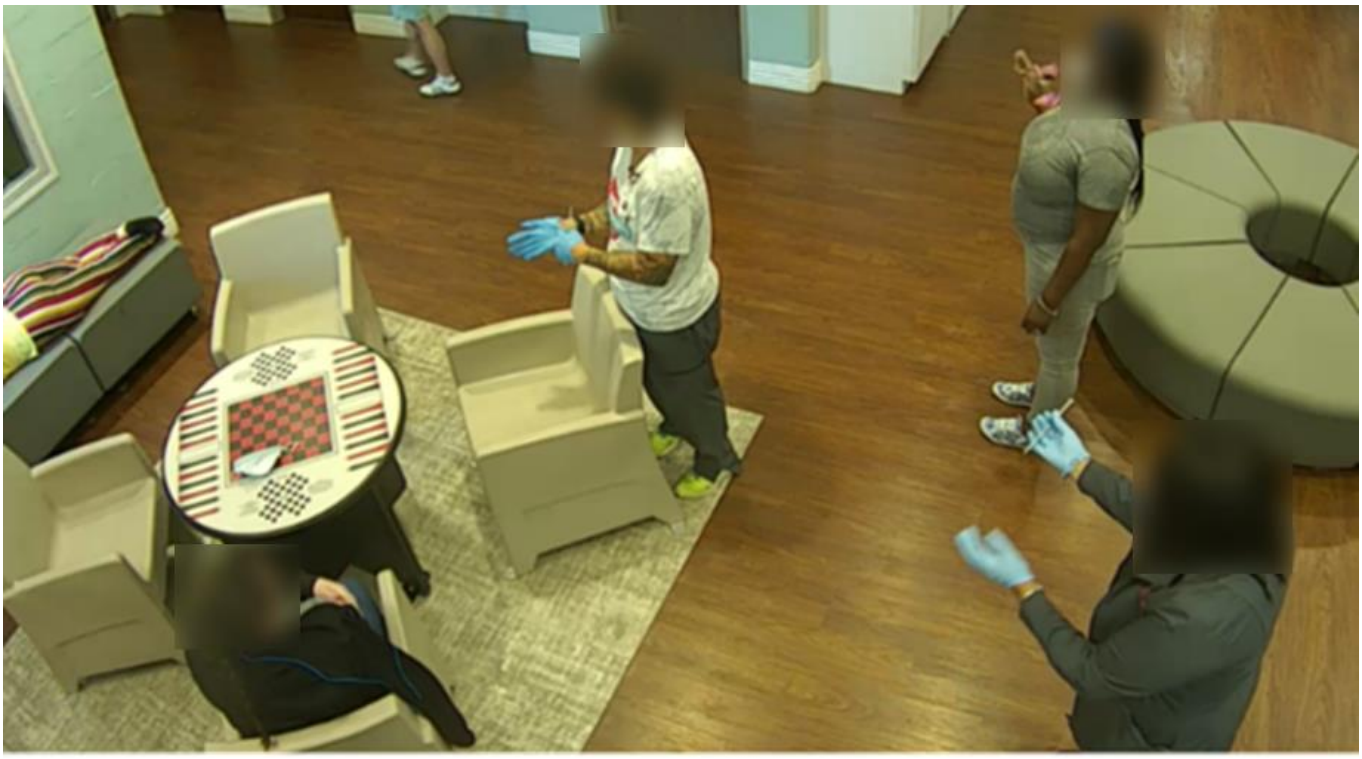


#10 – Resident walks to the bathroom to receive an injection approximately nine minutes after entering the building.

On 6/14/21 a resident is given two injections while sitting in the foyer area of the unit.

#11 – Resident sitting at table slings a deck of cards into the air, they scatter across foyer.

#12 – Resident sitting looking down at her arms, 3 staff members picking up cards.



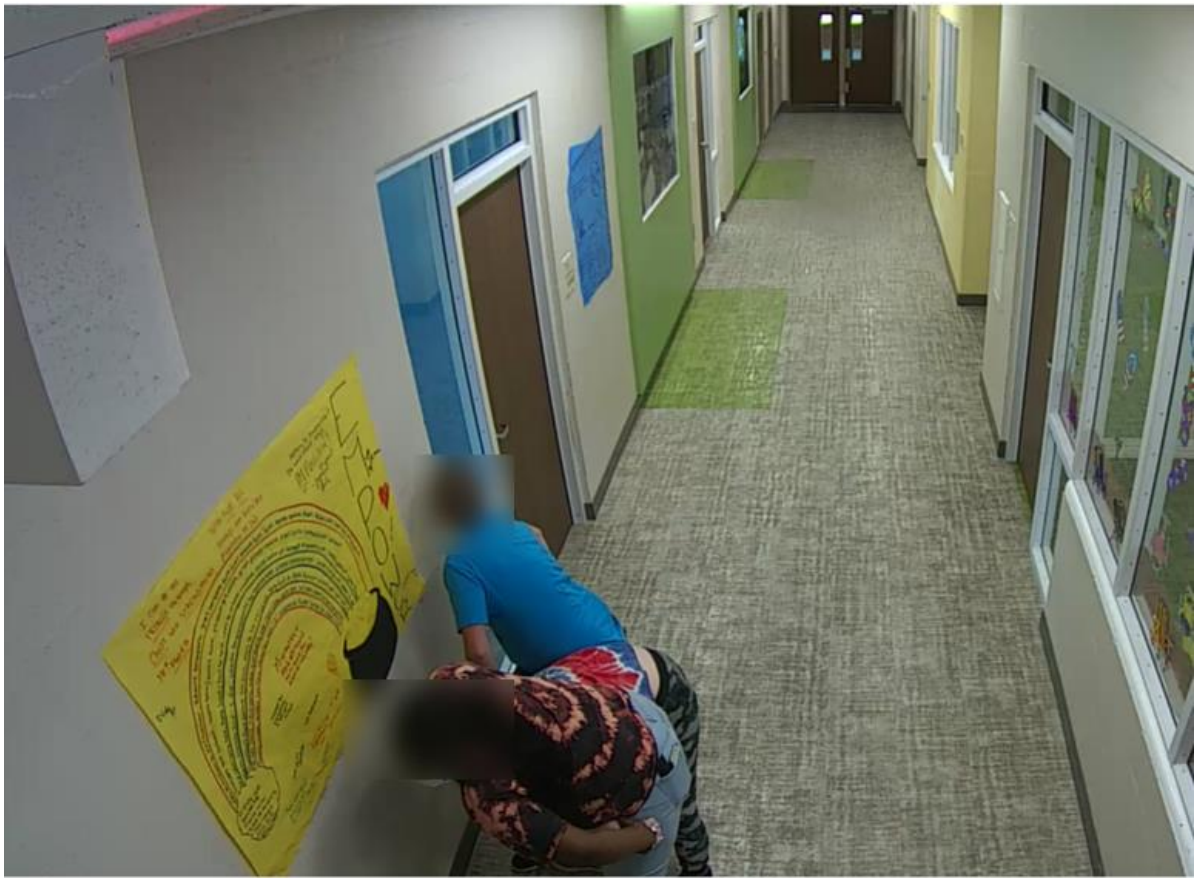
#13 - Resident compliantly removing her jacket as nurses approach with injections.

#14 - Resident compliantly removing her jacket as nurses approach with injections.

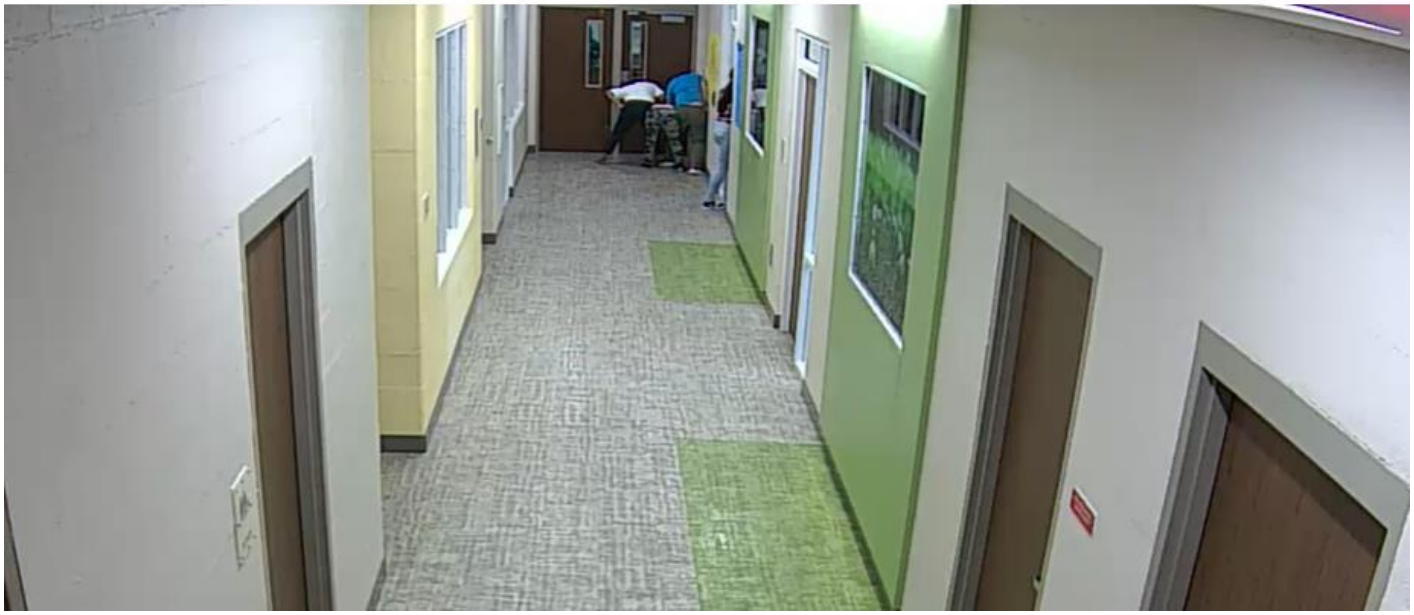
#15 and #16 - Resident is given one injection in each arm by two different nurses.

On 06/15/21 a resident received a chemical restraint.

MCH LR RTC Girls Hallway 6-15-21 - Hallway 2100-1.mp4



#17 – A male and female staff member restrain the resident. Each staff member is on either side of her and she is bent over forward at the waist.

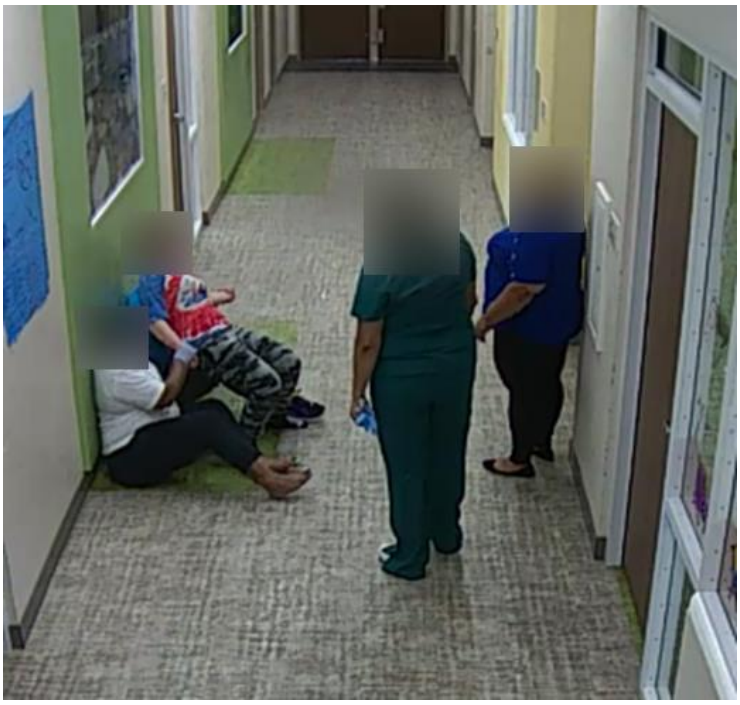


#18 – Program Consultant swaps places with the female staff member in the restraint.

The picture can't be displayed.

#19 – Nurse enters with injections in her hand.

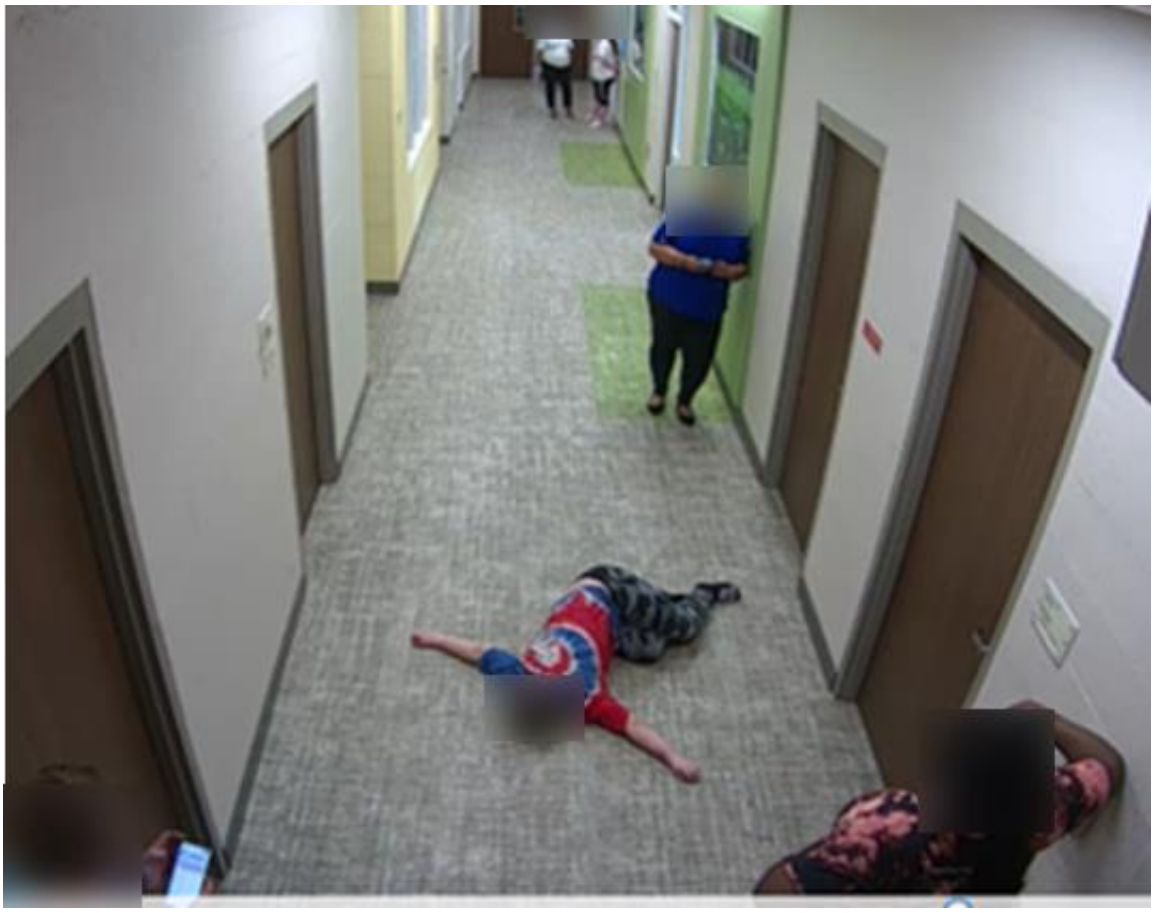
 # 20 - Resident sits calmly with her head down and staff on either of side of her holding her arms.




#21 and #22- Resident becomes upset when she sees the nurse with the injections

#23 - Resident is restrained by a male staff and female Program Consultant while the nurse administers the injections.

#24 - Resident's entire body goes completely limp and she is laid on the floor.

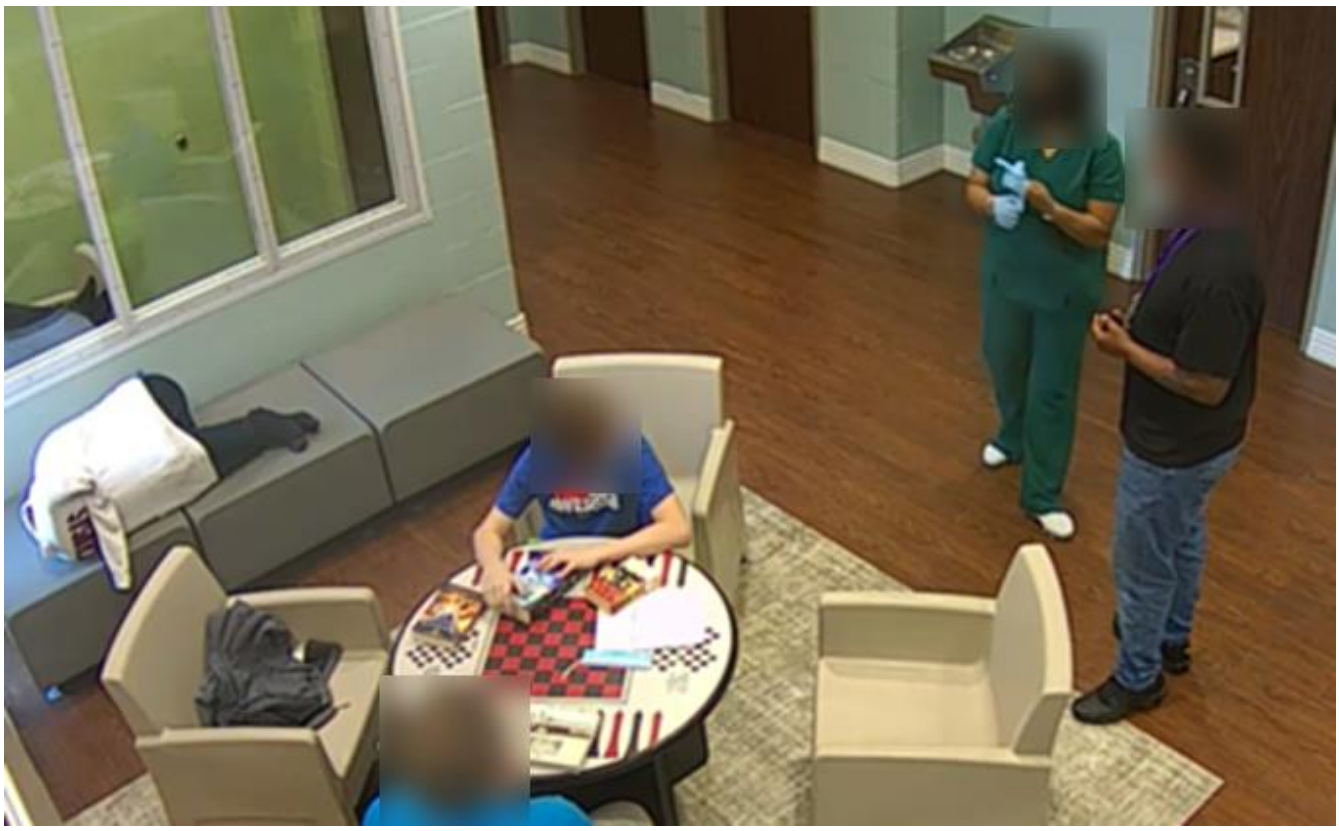


#25 - Resident is laid face down on the floor with both arms stretched out straight to the side.

#26 - Resident laying on floor, no staff observing resident.

#27- Program Director and a resident step over resident laying on floor to continue down hallway.

On 06/15/21 a resident received a chemical restraint after sitting calmly in the foyer for more than 10 minutes and appearing calm for the entire 22 minutes prior to the restraint we were able to review. It appears to have been given as a punitive response to the resident possibly kicking open the exit door.

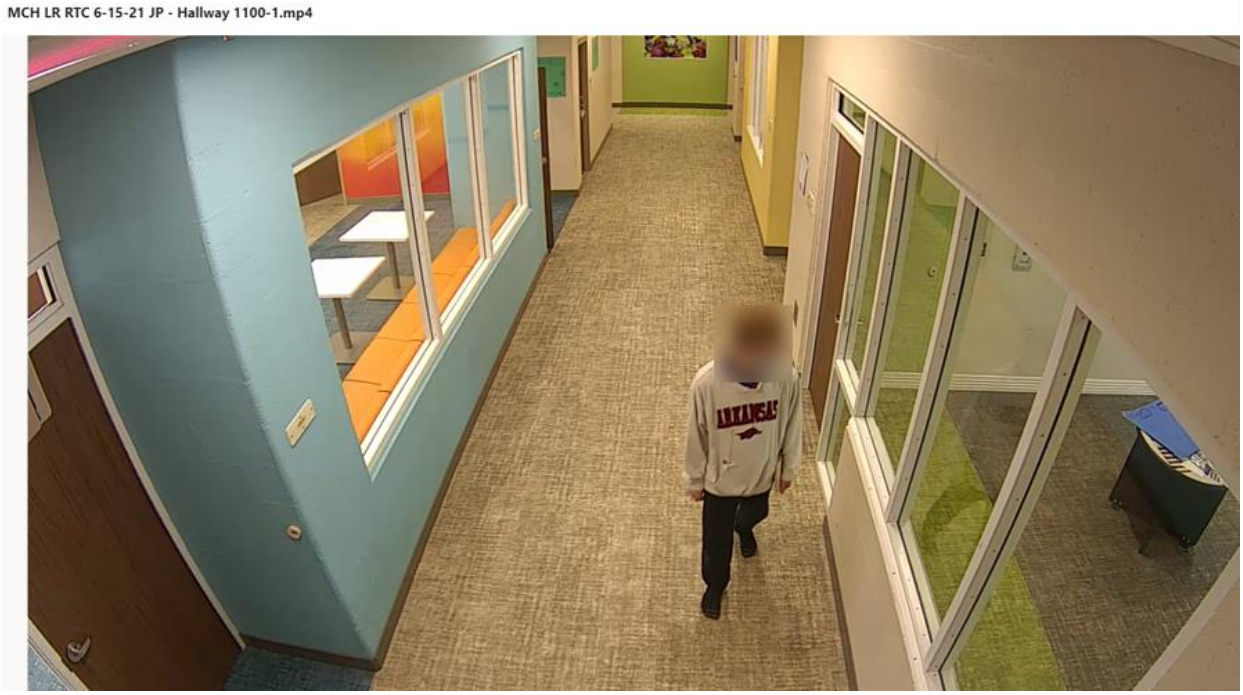


#28 and #29 – Resident sits calmly in foyer on bench and then at a table.

MCH LR RTC 6-15-21 AC - Unit 1 Foyer.mp4

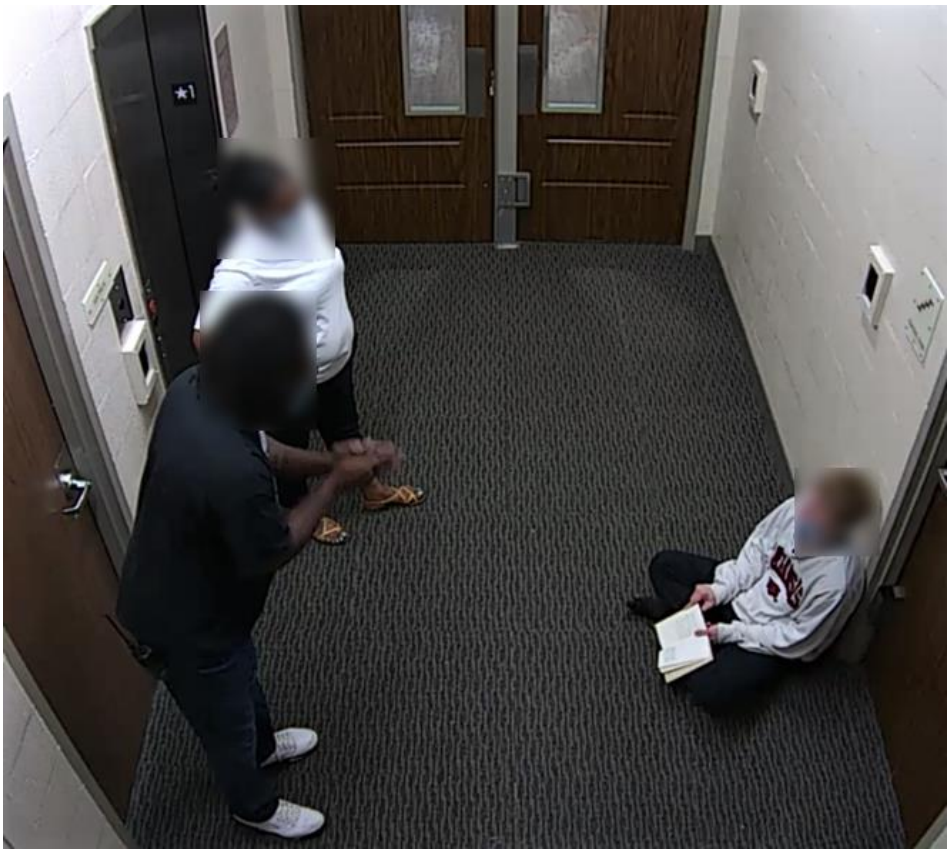
#30 - Nurse and a staff member direct him to the bathroom and he receives a chemical restraint.

On 06/15/21 a resident is placed in the seclusion room, administered a chemical restraint, and then left in the seclusion room for approximately one hour. In the videos leading up to resident being placed in the seclusion room he is sitting on the floor reading a book in the elevator vestibule, wandering the hallway unattended, and being corralled by 6 staff at the end of the boy's hallway. He does not appear to be displaying any aggression.



#31– Resident walking around in the hallway unattended after walking out of the dayroom.

#32, #33 – Resident standing in the elevator vestibule while staff talk *at* him.



#34 – Resident sitting in the elevator vestibule reading a book while staff talk *at* him.

#35- Resident reading in the elevator vestibule.

#36 – Resident sequestered at the end of the hallway by the gym by 6 staff members.

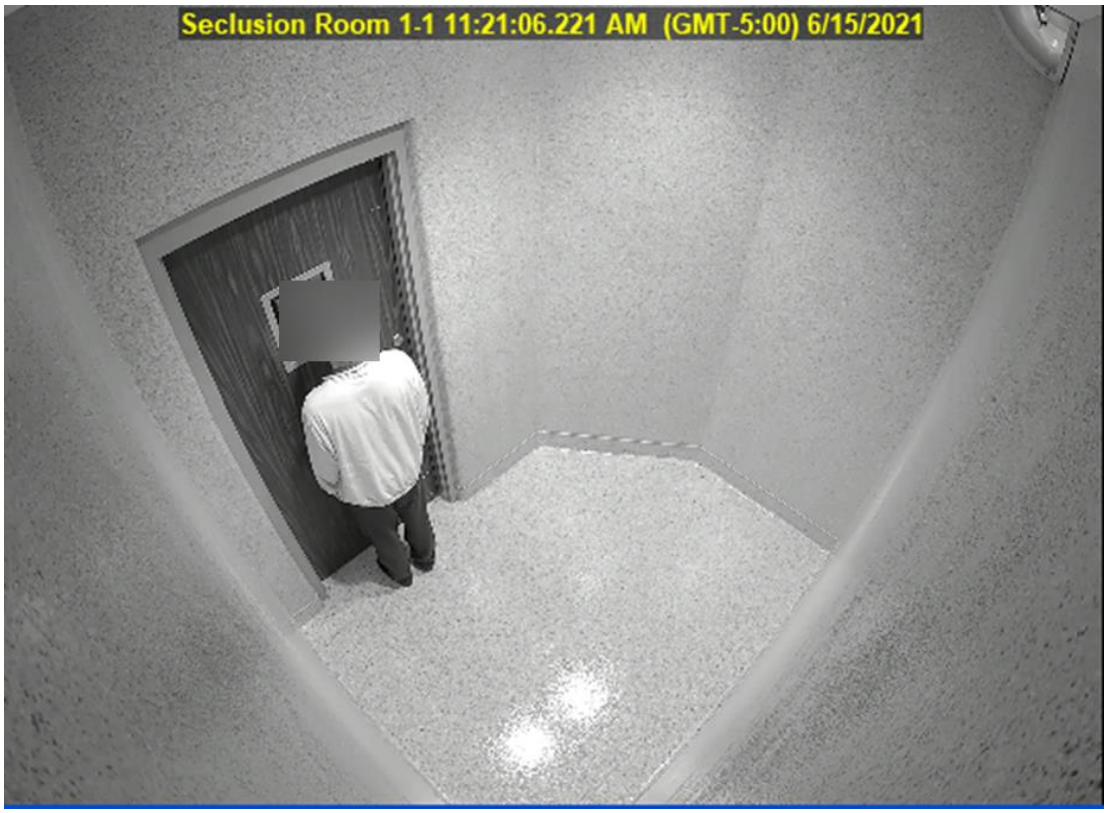
#37 – Staff blocking resident at end of hallway.

#38 - Office Manager blocking and pushing resident back.

#39 - Two residents on the boys' unit running, jumping up, and attempting to kick through the windows of the phone area while all but one unit staff left to assist in keeping a resident at the end of the hall.

#40 – Resident sitting in corner of seclusion room

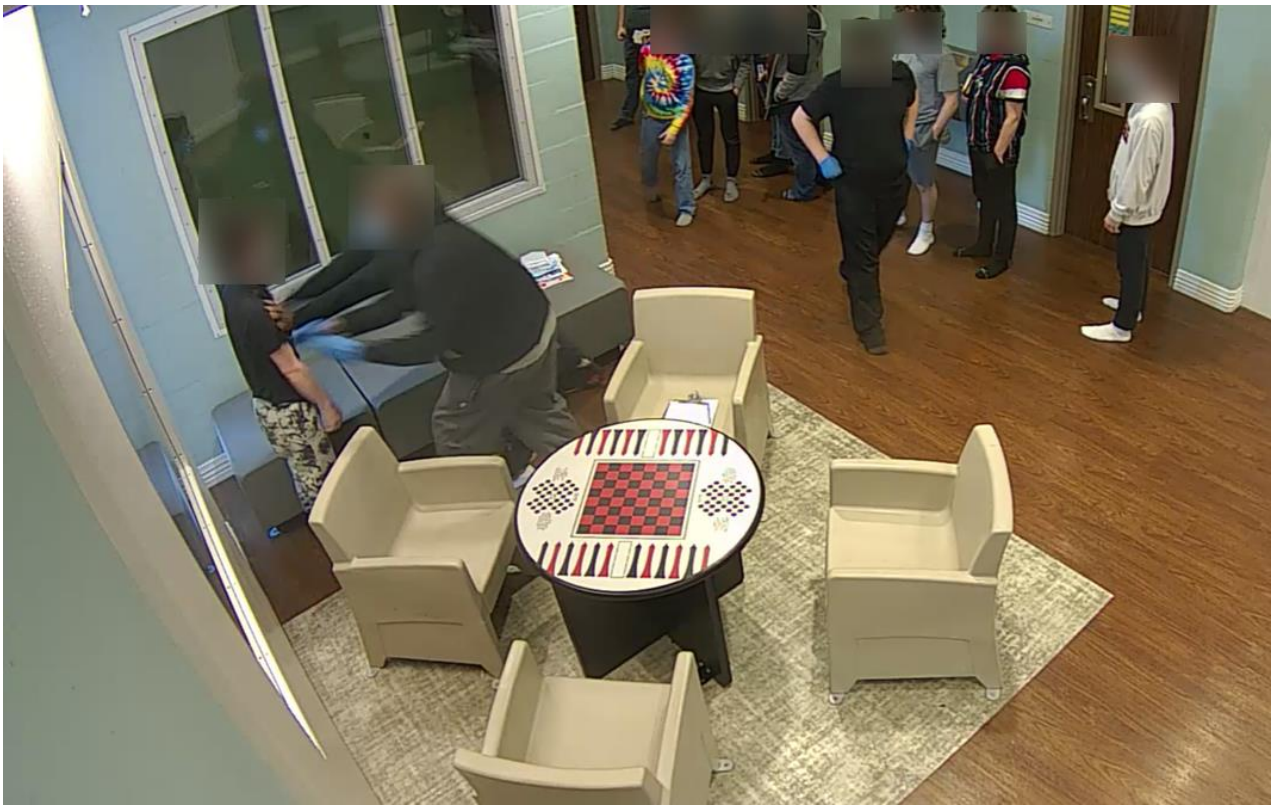
#41 - Resident held face first against the wall while two injections are administered.



#42 - Staff member laughing at resident through the window in seclusion room door.

#43, #44, and #45 – Staff members laughing, joking, and dancing outside seclusion room while resident stands calmly at door looking out.

On 04/04/21 a resident was restrained multiple times and given a chemical restraint. The resident was aggressive and resistant to being restrained however, during the altercation staff appear to antagonize him and can be seen pushing him against walls and to the floor, covering his mouth with their hands, appearing to put their elbows in his neck while on the ground, and holding his head down.



#46 - Staff shove resident into wall while attempting to restrain him.

#47 – Resident face down on floor with two staff members in restraint. Both staff members' elbows are pressing into his neck. One staff member appears to have his foot against the wall for leverage.

#48 – Resident face down on floor with two staff members in restraint. Both staff members' elbows are pressing into his neck. Resident's face cannot be seen. Resident onlookers have repositioned.

#49 – Staff member lunging toward resident as he attempts to stand up after being released from restraint.

2021.04.04_100100 - Unit 1 Entrance.mp4

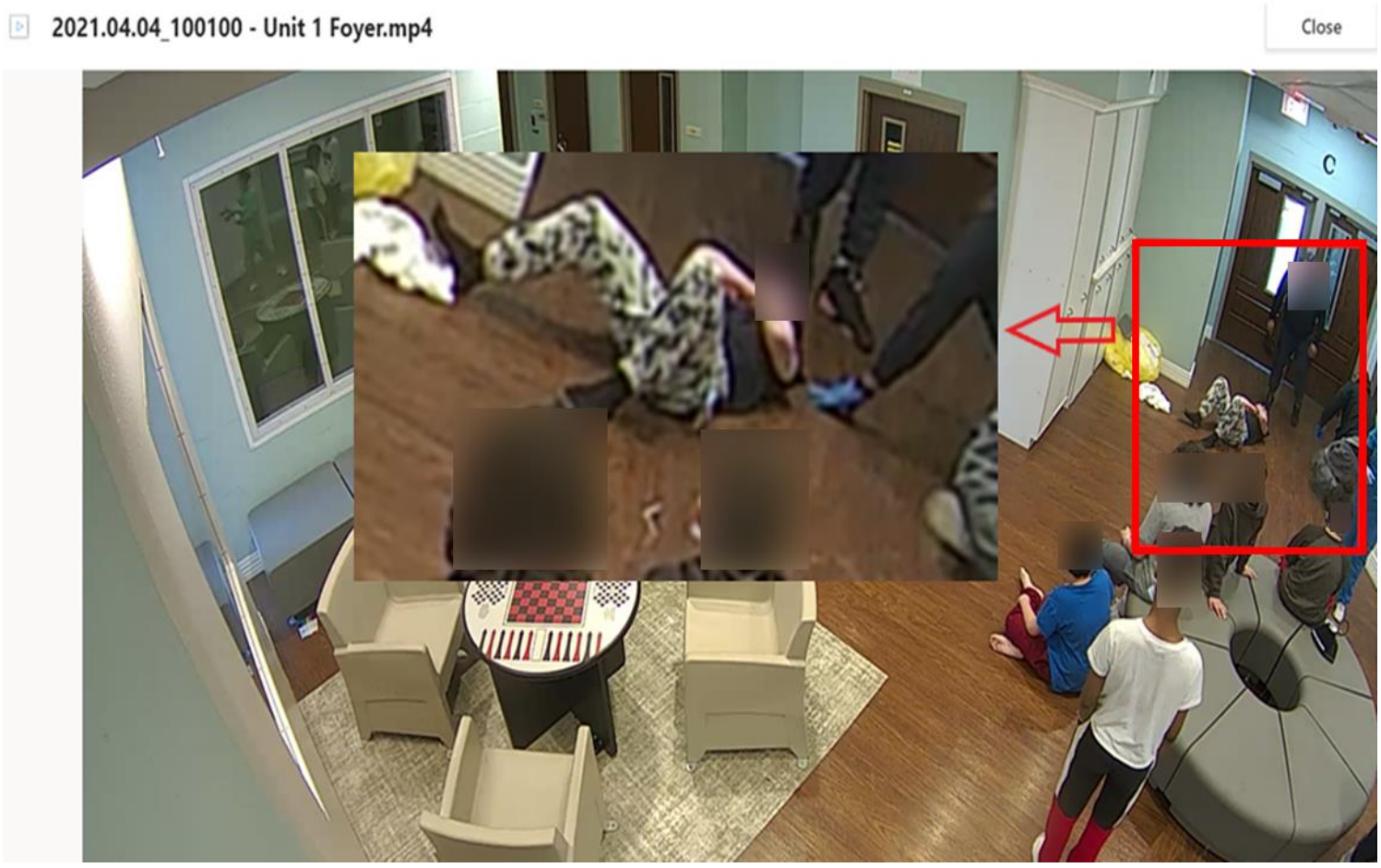
#50 – Staff members pushing resident into wall.

#51 – Resident on ground. Staff member's hand on his face.

#52 – Resident on ground. Staff member's hand covering resident's mouth.

#53 – Series showing staff member grab resident and shove him across the room

#54 – Staff member pushing resident into cabinets.



#55- Resident in laying on the floor holding his neck and appears to be in pain after restraint.

On 01/28/21 in an attempt to keep a resident from entering and then leaving a unit he is subjected to aggressive staff tactics that escalated the incident and resulted in injury.

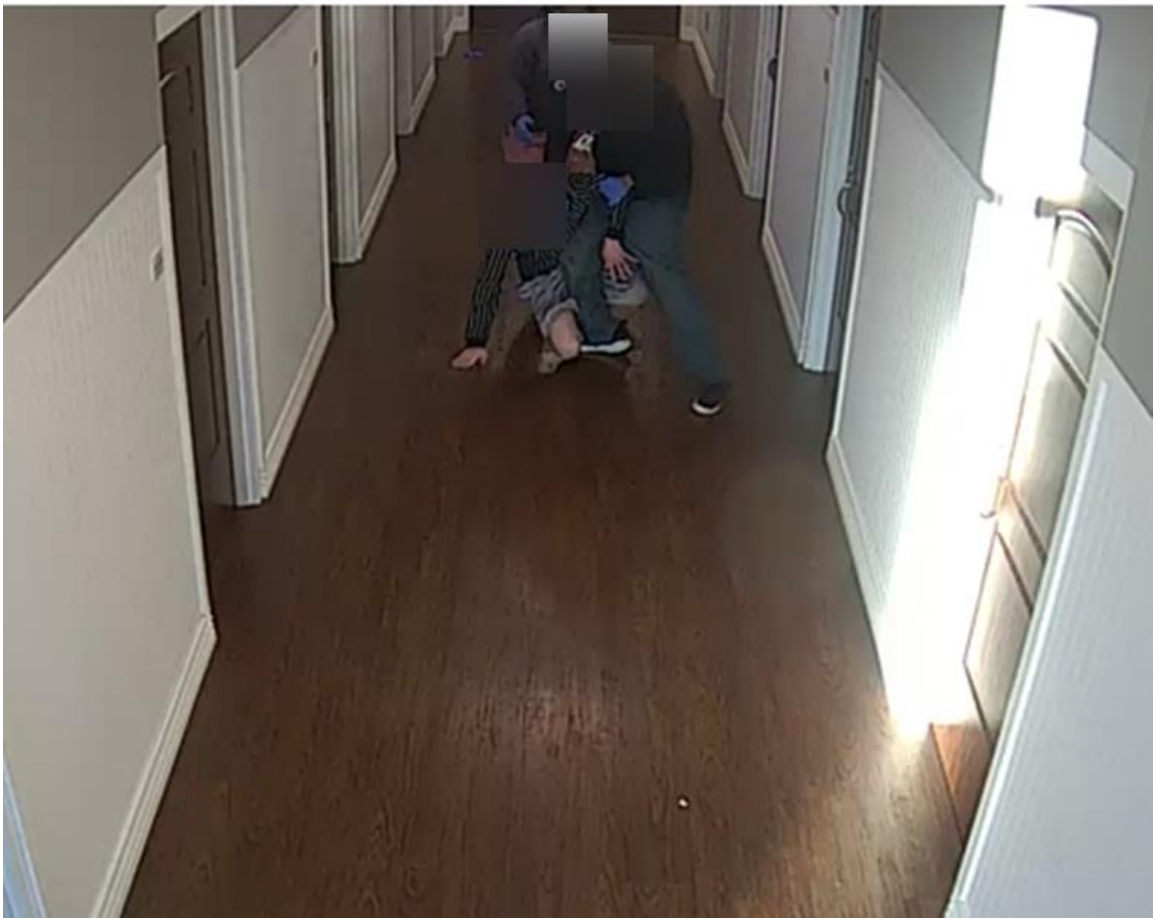
#56 – Staff grab resident arm and resident falls.

#57 – Staff member's gloved hand on another staff member's chest, pushing him back from resident.

#58 – Staff member keeping second staff away from resident.

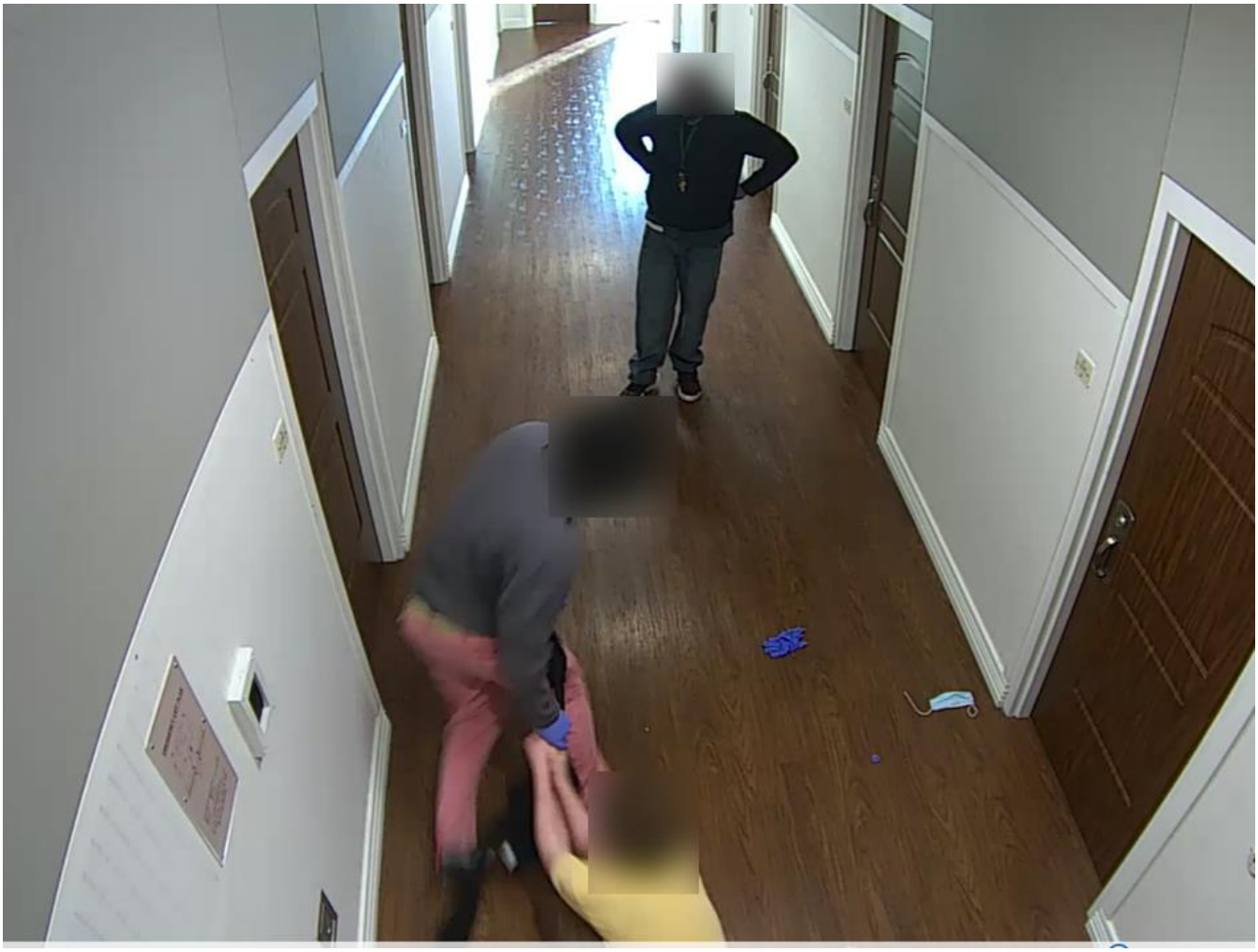
#59 – Series showing staff push resident, resident falling, and resident being pulled by his shorts.

#60 – Staff charging resident through the doors.



#61 – Staff pushing resident down.

#62 Resident falling after staff grab him.



#63 - Staff pulling resident's sweater off and resident falling during the scuffle.

#64 – Resident on ground.

#65 – Staff pushing resident's head back.

#66- Staff pushing resident's face.

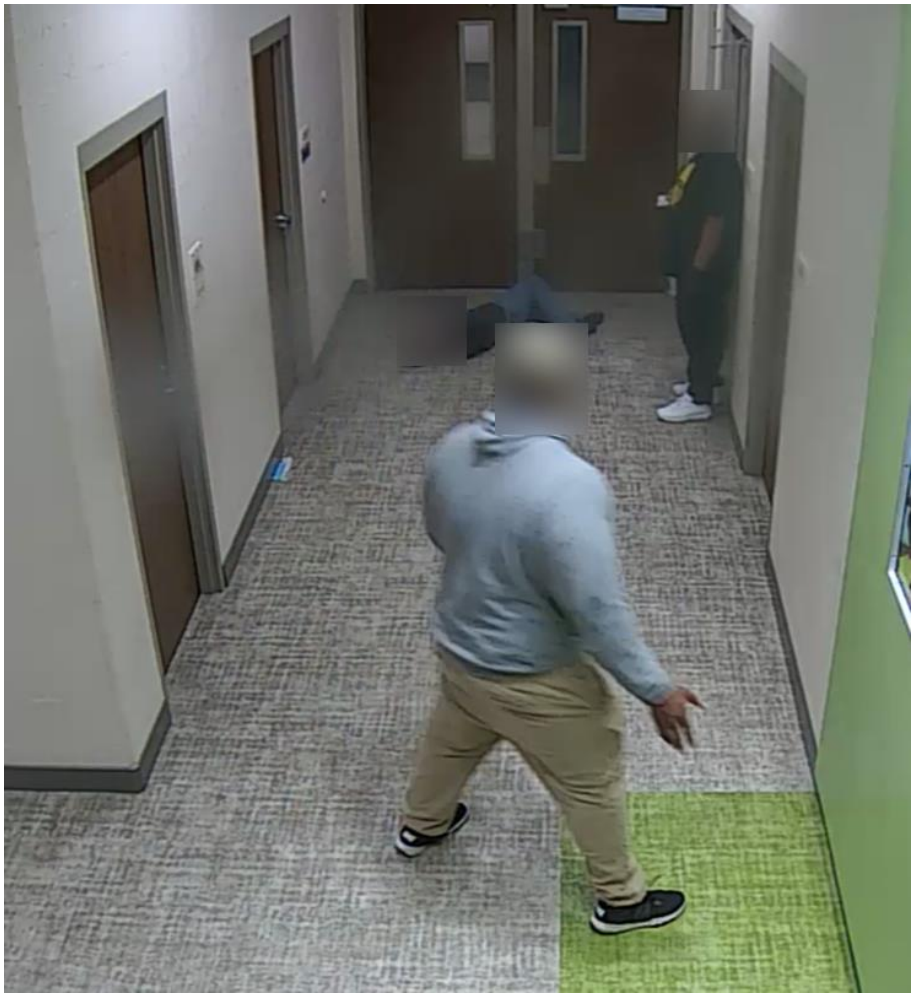
#67- Resident checking for blood from his nose.

#68 – Resident discovering blood.

#69 – Staff calming resident after staff involved in incident leave the hall.

2/28/21

#70 - Resident being restrained up against the wall, feet not touching the ground.



#71 – Resident laying on floor after restraint.

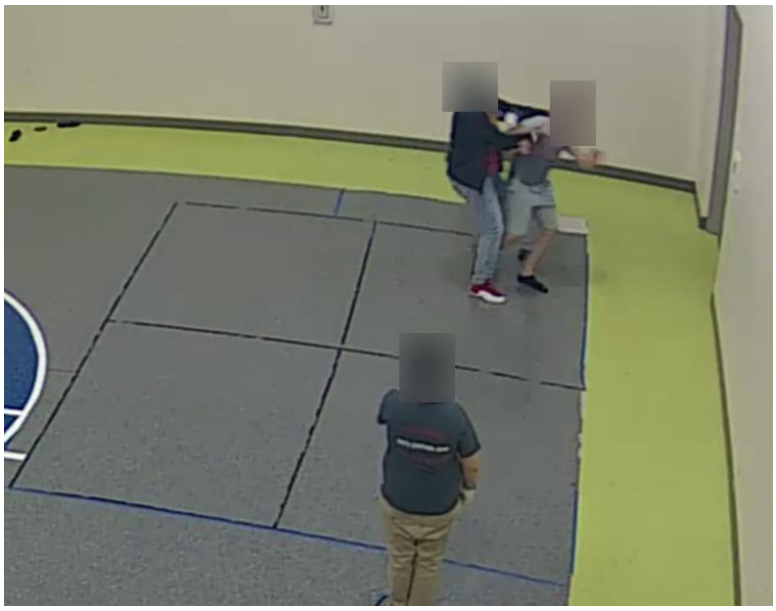
MCH LR RTC 02-28-21 - Hallway 1100-2.mp4

#72 - Resident showing staff his injury.

#73 - Resident showing staff his injury.

3/12/21– A resident hits a peer with a basketball and the peer goes for the resident. Staff grab the resident by the shirt or neck and try to escort him out of the gym.

#74 Staff pulling on resident shirt to keep him from running.



#75 Staff chased resident and he fell and slid into the wall.

#76 Staff shoving resident out the gym door.

#77 Resident landing on the floor after being shoved by staff.

#78 – Resident placing other resident in hold in attempt to assist staff.

#79 – Two still shots of staff restraining resident, resident kicking up his feet behind staff.

On 03/14/21 residents kicked through the elevator vestibule doors, dormitory hall doors, and ultimately an exit door.

#80 and #81 – Resident preparing to run and kick through door and resident kicking through door.

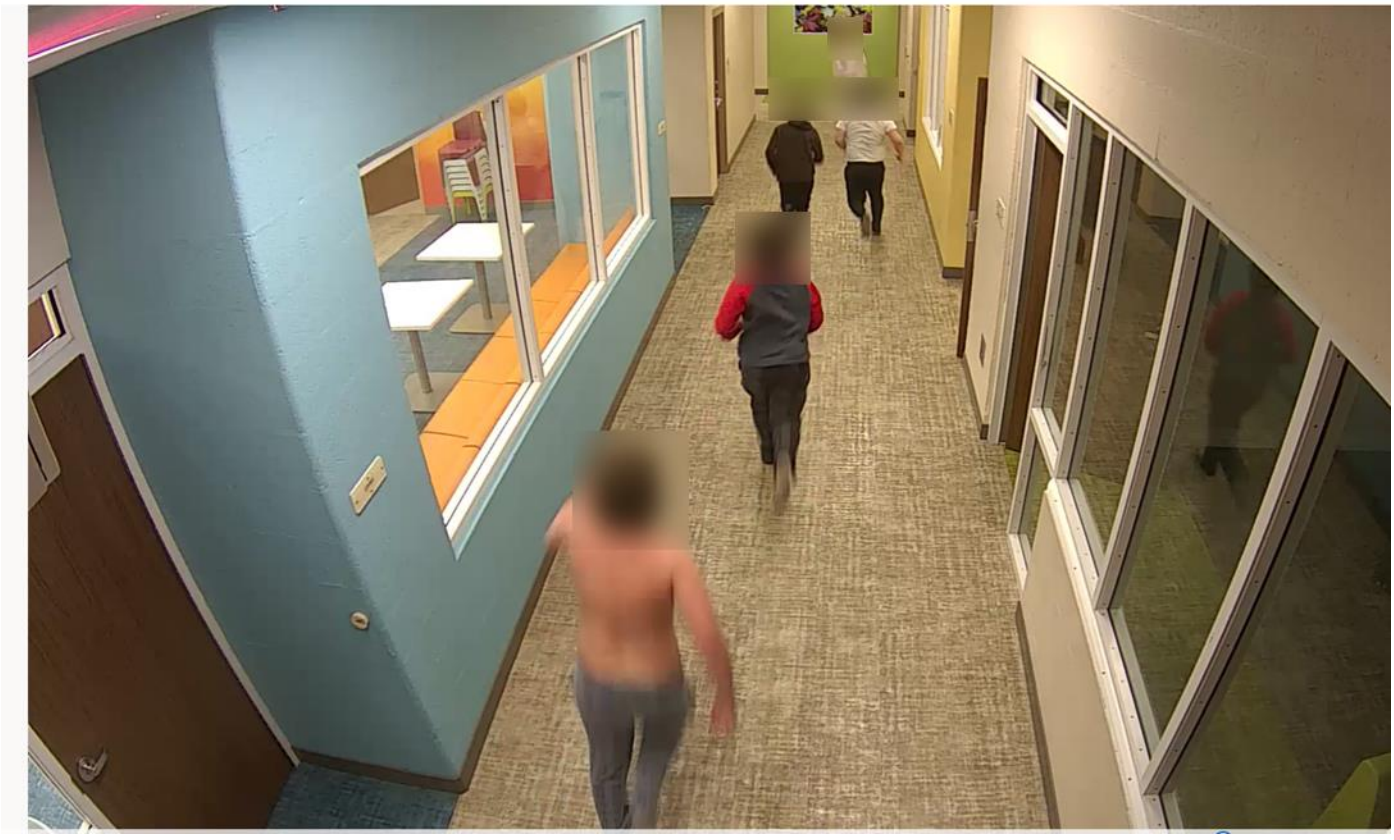
#82 and #83 - Residents running around unit and kicking through dormitory hall doors.

#84 – Staff appearing confused as residents enter dormitory hall

#85 – Residents fighting in foyer as staff stands by watching

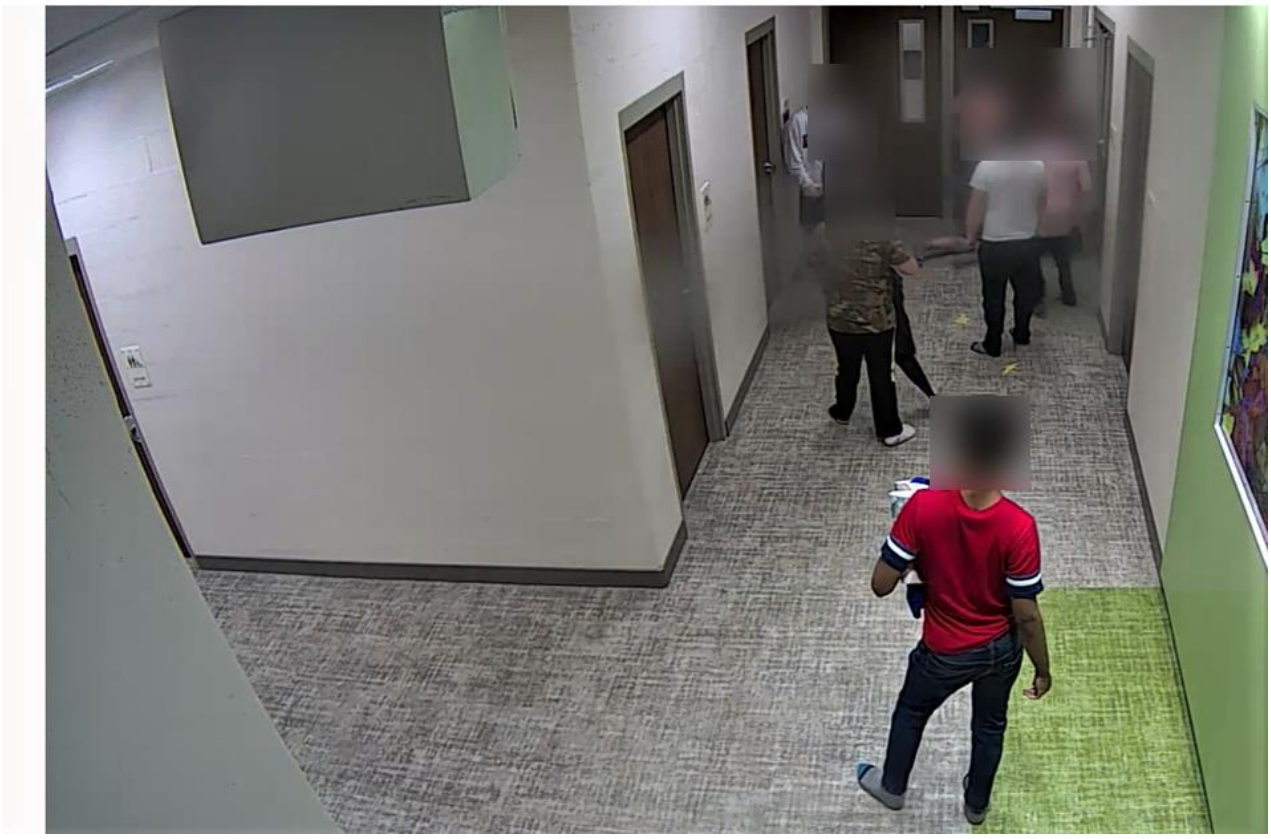
#86 – Staff throws her hands in the air seemingly defeated.

2021.03.14 - Hallway 1100-1.mp4



#87- Residents run down the hallway after kicking open the doors.

2021.03.14 - Hallway 1100-2.mp4



#88 – Residents attacking a resident that is on the ground in corner of the hallway. Only his legs can be seen.

2021.03.14 - Hallway 1100-2.mp4

#89 – Resident sitting in corner as other residents walk around after attacking him.

2021.03.14 - Hallway 1100-1.mp4

#90 – Resident running toward exit door as staff casually walks down hallway closing doors as she makes her way to the end of the hall.

Chairs in Group Room