DHS Placement and Residential Licensing Unit
Office of the Secretary
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: 019126

Date of Incident: 2/10/2024

Date Received by PRLU: 2/12/2024

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Licensing

Report Description: On Saturday, February 10, 2024 client [redacted] DOB [redacted] became dysregulated while in the dorm. [redacted] was taken off the dorm and she then began to destroy property and attempted to elope. [redacted] kicked a door several times, which caused an alarm to sound, and broke the door that goes into a staff breakroom from the courtyard. [redacted] then pulled the fire alarm, police arrived shortly after the fire department. LRPD stated that [redacted] stated she had suicidal thoughts and per LRPD policy [redacted] was transported to Childrens Hospital by police and then was taken to Conway Behavioral. [redacted] is in DHS custody and her guardian was notified.

Interim Action Narrative: The police were called and transported resident to ACH. Resident was admitted to acute care.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator inquired about property damages. Facility reported resident will be returning to the facility. 2/15/2024, Program Coordinator reviewed camera footage. Facility reported resident will not be returning to the facility.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

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: 2/15/2024

Home Visit Date: 2/15/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 1:30 pm to 2:30 pm

Census: 30

Licensing received provider reported incident on 2/10/2024 for ELS Incident #019126.

Program Coordinator reviewed camera footage for the provider reported incident with Ms. Barbara McCrory, Chief Administrative Service Officer.

Residents were sitting in the day area watching television and one resident was sitting by a staff member writing, ratio: 1:5. Resident was observed getting up walking toward the door and banging the door with her body. Resident also kicked the door before standing up in a chair and messing with the ceiling.

Staff member was observed on the walkie talkie before other staff members (5) arrived. Resident was observed throwing a water bottle at staff and throwing a laptop on the floor. The other residents were escorted out of the dorm. Resident attempted to run out of the door while residents were leaving.

When resident was unable to leave the dorm she began throwing items at staff again. A staff member was observed removing a cord from the workstation. Resident was able to get a surge protecter (from the workstation area) and wrapped the cord around her hand, ratio 6:1. Staff members were observed talking with resident. A staff member was observed reaching for the surge protector, resident refused to give the staff member the surge protector but gave it to another staff member.

Resident sat on a table while staff continued to talk to her. The other residents were brought back to the dorm and the resident was escorted out the door by staff. Resident ran out the door to the courtyard to the gate, ratio 2:1. Resident was observed walking around the courtyard with staff following in her direction.

Other staff members were observed on the courtyard, ratio 6:1. Resident was observed kicking a door and fence. Resident used her body to bang against the fence also. Resident was able to bust through the door leading into the lobby area. Staff were right behind her. Program Coordinator observed resident being aggressive towards staff.

Resident ran down the administration hall. Program Coordinator was unable to observe resident down the administration hall due to no cameras in that area. Ms. McCrory reported that while on the administration hall, resident pulled the fire alarm. Program Coordinator observed the lights flashing in the building. Resident continued to attempt to get away from staff but was unable to due to staff intervening each time she tried, ratio 5:1.

When the police arrived, resident was observed being escorted out of the administration building. Ratio: 3:1, it was a total of three police officers escorting the resident out of the building.

Ms. McCrory reported that resident will not be returning to the facility. A new door has been ordered for the administration building.

Provider Comments:

CCL Staff Signature :

Date: 2/15/2024

Provider Signature :

Date: 2/15/2024

Barbara McCoy