Placement and Residential Licensing Unit
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: 019754

Date of Incident: 3/9/2024

Date Received: 3/10/2024

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Licensing

Report Description: On March 10, 2024 client [redacted] was transported to Arkansas Children's Hospital after an X-Ray was completed on March 9, 2024 due to [redacted] complaining of knee pain stemming from an incident that occurred on March 8, 2024 where [redacted] was dysregulated and kicking the doors in the dorm. [redacted] was seen by staff at Arkansas Children's Hospital and diagnosed with "Nondisplaced fracture of right tibial spine, initial encounter for closed fracture." [redacted] was given medication by ACH and will have a future follow up appointment with ACH Orthopedic clinic. [redacted] is an out of state client and her guardian was notified.

Interim Action Narrative: Resident was evaluated at ACH.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator will inquire on the state resident is from. The police were not called. 3/11/2024, Program Coordinator inquired about camera footage and if resident was placed in any restraints. Facility reported resident was not placed in any restraints/holds. Program Coordinator reviewed camera footage and requested nursing

note. 3/14/2024, Program Coordinator reviewed more camera footage, amended 521, and received documentation via email.

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: 3/11/2024

Home Visit Date: 3/11/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 2:30 pm to 3:45 pm

Census: 46

Licensing received a provider reported incident on 3/10/2024 for ELS Case #019754.

Program Coordinator reviewed camera footage with with Barbara McCroy, Chief Administrative Service Officer and Paul Hofstad, Director of Regulatory Affairs. The provider reported incident happened on Unit 2.

Residents were sitting in the common/day area folding laundry and walking around. One resident appeared to have completed hygiene. The ratio was 3:7.

Resident was observed walking around the common/day area and talking with peers. Resident was observed going out of view of the camera, but her shadow was observed on the wall in the corner part of the unit. It appeared that resident was moving around from her shadow but what she was doing could not be determined. Resident was observed going to the corner several times.

Resident was observed communicating with her peers and walking around with her hands on her head. Staff was observed communicating and interacting with other residents. After a few times leaving out of view of the camera, resident was observed limping as she left the corner. However, resident returned to the area out of view of the camera, returned to the common/day area, and continue to limp.

Program Coordinator observed resident communicating to a staff member as she limped around the common/day area. Resident returned to the corner out of view of the camera with a peer and back to the common/day area limping. After going back and forth to the corner, resident eventually limped to the door leading off the dorm and sat on the floor by a peer where a staff member was standing.

Program Coordinator was unable to observe what resident was doing in the corner when out of view of the camera.

Provider Comments:

CCL Staff Signature :

Date: 3/11/2024

Provider Signature :

Date: 3/11/2024

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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: 3/11/2024

Home Visit Date: 3/11/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Number: 900.907.2

Regulation Description: Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

Finding Description: Staff did not provide level of treatment to resident who was observed limping on the unit.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulation Number: 900.907.3

Regulation Description: Staff/child ratio shall be at least 1:6 during waking hours and 1:8 during sleeping hours.

Finding Description: Staff to child ratio was observed 1:8 during waking hours.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 2:30 pm to 3:45 pm

Census: 46

Licensing received a provider reported incident on 3/10/2024 for ELS Case #019754.

Program Coordinator reviewed camera footage with with Barbara McCroy, Chief Administrative Service Officer and Paul Hofstad, Director of Regulatory Affairs. The provider reported incident happened on Unit 2.

Residents were sitting in the common/day area folding laundry and walking around. One resident appeared to have completed hygiene. The ratio was 2:8.

Resident was observed walking around the common/day area and talking with peers. Resident was observed going out of view of the camera, but her shadow was observed on the wall in the corner part of the unit. It appeared that resident was moving around from her shadow but what she was doing could not be determined. Resident was observed going to the corner several times.

Resident was observed communicating with her peers and walking around with her hands on her head. Staff was observed communicating and interacting with other residents. After a few times leaving out of view of the camera, resident was observed limping as she left the corner. However, resident returned to the area out of view of the camera, returned to the common/day area, and continued to limp.

Program Coordinator observed resident communicating to a staff member as she limped around the common/day area. Resident returned to the corner out of view of the camera with a peer and back to the common/day area limping. After going back and forth to the corner, resident eventually limped to the door leading off the dorm and sat on the floor by a peer where a staff member was standing.

Program Coordinator was unable to observe what resident was doing in the corner when out of view of the camera. Resident was observed communicating with a peer on the other side of the door through the window. While by the door, a peer was observed standing on furniture messing with the ceiling.

Staff was observed near the peer and appeared to be communicating with the peer. Facility reported that peer was attempting to remove the heat/air vent. Once peer detached the vent, staff was observed removing the vent from resident. Peer then moved to the workstation area for staff and stood on the desk and chair to remove another vent.

Staff was observed communicating with peer and on the radio while peer was standing on furniture. Peer eventually got down, walked around the room, and attempted to mess with the ceiling. During this time resident that was injured was still by the door of the unit. There appeared to be a lot going on with different residents that were on the unit.

Program Coordinator observed the following: residents having unknown objects taken/requested by staff, residents standing/jumping on furniture, residents sitting on furniture eating, and peers tending to the injured resident. Program Coordinator did not observe the staff members present assess the injured resident.

A few minutes later, Program Coordinator observed a staff member and resident leave off the unit. Ratio was 1:7, about a minute or so later staff and resident returned to the unit. The same staff member was observed leaving off the unit two more times, ratio 1:8. Program Coordinator observed the resident with assistance from a peer go into one of the bedrooms.

While resident and peer were in the bathroom, staff member was observed interacting with the other residents. Resident and peer came out of the bedroom and resident limped to a chair where she sat down. It appeared that resident was comparing her legs. From the camera footage, it appeared that the resident's right leg below the knee was swollen.

Other staff members were observed coming onto the unit. The supervisor was observed looking at the ceiling and the injured resident's leg. Another staff member was observed bringing afternoon snack. The last staff member observed brought a telephone to the unit for the residents to have their telephone time.

Injured resident was still sitting in the chair during this time. Program Coordinator observed resident and a peer looking at her leg. Resident was observed placing a pillow on her injured leg. During med pass, the nurse assessed the resident's leg. When the nurse returned, an ice pack was provided to the resident.

Facility is being cited for standards 907.2, staff did not provide level of treatment to resident after she was observed limping and 907.3 being out of ratio 1:8 during waking hours.

Provider Comments:

CCL Staff Signature : Date: 3/14/2024

Provider Signature : Date: 3/14/2024