ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 021071

Date of Incident: 5/4/2024

Date Received: 5/6/2024

Facility Name: Millcreek of Arkansas PRTF

Facility Number: 233

Incident Type: Dual

Report Description: [redacted] stated that him and a staff were horseplaying. He stated that he snuck up behind staff and staff turned around real quick and her keys on her lanyard swung out and cut him under his eye. Aiden was sent to Dallas County ER for medical follow up where [redacted] He was released to return to facility without restrictions.

Interim Action Narrative: Staff involved and two staff present all terminated.

[redacted].

Licensing Narrative: 5/7/24-Reviewed for licensing concerns. Email sent to facility to inquire if there is video footage of this incident. Email received that there is video footage of incident which will be reviewed next visit. 5/8/24-Facility visited and camera footage reviewed. Facility cited 109.1g and 907.2. Staff who participated in incident and two staff present for incident have all been terminated from employment at Millcreek 5/6/24. [redacted].

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: Millcreek of Arkansas PRTF

Facility Number: 233

Licensee Address: 1828 INDUSTRIAL DR
FORDYCE AR 71742-7110

Licensing Specialist: Clayton DeBoer

Person In Charge:

Record Visit Date: 5/8/2024

Home Visit Date: 5/8/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Regulation Number: 100.109.1.g

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

Finding Description: Staff [redacted] is seen grabbing client [redacted] hair, punching [redacted] and throwing him to the floor. Staff present, [redacted] [redacted] and [redacted] [redacted] did not intervene.

Action Due Date: 2024-05-06

Action Due Description: Staff ███ █ was terminated 5/6/24. Staff ███ █ and ███ █ were terminated 5/7/24.

Comply Date:

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

Action Due Description: Staff ███ █ was terminated 5/6/24. Staff ███ █ and ███ █ were terminated 5/7/24.

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 ███ █ ███ █ and ███ █ did not ensure the safety and well-being of client ██

Action Due Date: 2024-05-06

Action Due Description: Staff ███ █ was terminated 5/6/24. Staff ███ █ and ███ █ were terminated 5/7/24.

Comply Date:

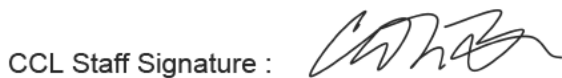
Action Due Description: Staff ███ █ was terminated 5/6/24. Staff ███ █ and ███ █ were terminated 5/7/24.

Narrative:

5/8/24-Facility visited and camera footage reviewed of facility reported incident involving client ██ and staff ███ █ which resulted in client ██ receiving emergency medical care. Camera footage shows staff ███ █ grab client ██ hair, punch ██ and throw him to the floor. Facility cited 109.1g and 907.2. Staff ███ █ who participated in incident, and two staff present for incident, ███ █ and ███ █ have all been terminated from employment at Millcreek. Client ██ reported this incident as an accident from horseplaying with staff, ███ ██ which witness statement reviewed supports. ███ the day video of this incident was reviewed, 5/6/24.

Provider Comments:

This incident does not reflect the standard practices or the de-escalation techniques that our facility rigorously implements to train staff in the interaction and management of residents in our care. The actions mentioned in this citation were conducted by an individual staff member who strayed from the extensive training and protocols our facility has established. Additionally, ███. As per our internal policies and DHS regulations, we have the authority to retrain, suspend, or terminate staff members. We take incidents of this nature and patient safety with utmost seriousness. The decision to terminate the employee was made independently by our facility, due to their actions that deviated from our company policies and were performed without proper authorization. The actions taken by this employee were outside of their assigned responsibilities. Our facility responded swiftly and decisively, terminating the employee within six hours of becoming aware of the misconduct.

CCL Staff Signature :  Date: 5/8/2024

Provider Signature : Date: 5/8/2024