



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: 021546

Date of Incident: 5/26/2024

Date Received: 5/28/2024

Facility Name: Little Creek Behavioral Health

Facility Number: 255

Incident Type: Licensing

Report Description: On 05.26.24, [REDACTED] stole the staff car keys and hid them in her jacket pocket, and [REDACTED] [REDACTED] [REDACTED] [REDACTED] snatched a staff badge off her shirt. [REDACTED] and [REDACTED] proceeded towards the laundry area and ran eloped from the facility. Sheriff Cox located the girls two blocks over, called Little Creek and they were brought back to the facility by Little Creek staff.

Interim Action Narrative: The police were called. Residents were placed on elopement precautions and clinical restrictions.

Maltreatment Narrative:

Licensing Narrative: Facility informed Program Coordinator of incident via text message. 5/29/2024, Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator and Licensing Specialist Norton reviewed camera footage. Facility reported the Faulkner Co Sherriff Deapartment were called but no report number was provided. Staff member involved will received additional training. 6/3/2024, Program Coordinator will follow up with facility for documentation of staff member completing training. 6/6/2024, Program Coordinator followed up with facility regarding documentation

of training for staff member present during this incident. 6/10/2024, training documentation provided.



Division of Child Care & Early Childhood Education
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521 Visit Compliance Report

Licensee: Little Creek Behavioral Health

Facility Number: 255

Licensee Address: 161 SKUNK HOLLOW
CONWAY AR 72032

Licensing Specialist: Kendra Rice

Person In Charge: Jlynn Price

Record Visit Date: 5/29/2024

Home Visit Date: 5/29/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 12:45 pm to 1:45 pm

Census: 64

Licensing received a provider reported incident on 5/28/2024 for ELS Case #021546.

Program Coordinator Rice and Licensing Specialist Norton spoke with Ms. Jlynn Perkins, Director of Risk Management and PI regarding this provider reported incident and reviewed camera footage. This incident happened on Unit A1. The ratio was 1:6.

Licensing observed staff member and residents in the common area sitting down and what appeared to be communicating. There was a resident out of camera view reportedly in a bedroom. Staff member was observed walking around the common area and patting on her pockets. Staff member was heard questioning the residents about her keys.

Residents were observed moving around the room in different directions. Two (2) residents were observed moving against a wall behind the staff member, one (1) resident walked toward the door, two (2) residents were in front of the staff member with their backs towards her, and one (1) resident was sitting on the floor. Staff member was heard asking the two (2) residents in front of her about her keys.

One (1) of the residents with her back towards the staff member was observed with her hands in her pockets. Licensing was unable to see what the resident had in her pockets. The other resident with her back towards the staff member turned around, snatched the staff member's badge, and the two (2) residents took off running off the unit. The residents were observed running on foot and not in a vehicle.

Licensing heard staff member banging on the entry door attempting to get assistance. It was reported that staff member did not have her walkie due to a resident hiding it in the laundry room. Licensing observed the two (2) residents running outside to the back of the facility in an open field. Staff members were observed walking around the grounds.

The facility called the police and a neighbor called the police also after the residents appeared at their house. Reportedly the residents knocked on the neighbor's door asking for a ride.

Ms. Perkins reported that staff member involved will receive some additional training. Residents involved were placed on elopement precautions and clinical restrictions.

Provider Comments:

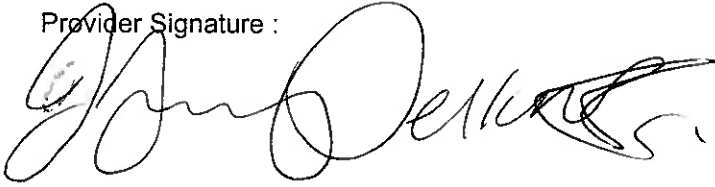
CCL Staff Signature :

Date: 5/29/2024

A handwritten signature in black ink, appearing to be "A. Jones", written in a cursive style.

Provider Signature :

Date: 5/29/2024

A large, stylized handwritten signature in black ink, appearing to be "John Decker", written in a cursive style.