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: 022593

Date of Incident: 7/12/2024

Date Received: 7/15/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] client in our PRTF program and resides in Rose House Incident Report date/ time: 07/12/24 at 11:29am Location of Incident: Rose House Incident Description: Client was left unattended in house for about 4 minutes. Staff Involved: [redacted] Events Leading: The house went to lunch, [redacted] was in her room asleep. Staff did not realize she was in her room asleep and left the client in the house unattended. Guardian was notified on 07/12/24 at 4:10pm: Guardian was notified that [redacted] may or may not have been unsupervised for a few seconds to a minute. Explained to guardian that this nurse met up/ran into rose girls as they were walking to lunch and this nurse was in route to rose house to pull a noon med. As this nurse entered rose house and the nursing office, [redacted] was found peeking around corners saying hello. She inquired where everyone else was and inquired if she was left. This nurse said they would escort her to lunch asked her to wash her hands and put on her shoes and we would walk together. A rose team member came to escort her to lunch. When giving mom this information, she chuckled and said [redacted] is sneaky. This nurse also informed her that while at lunch, [redacted] reported lost a loose baby tooth to a piece of broccoli.

Interim Action Narrative: Staff involved were written up for breaking the facility's code of conduct policy, was required to reivew the policy and were coached verbally on the proper way to conduct count backs.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator will inquire about internal incident form, if incident was called, how long the resident was left unattended, was the incident called into the hotline, did the staff involved receive any warning, and protocol for head count. 7/16/2024, facility reported resident was asleep in her bedroom when left unattended. Staff members involved were written up and verbally coached on the proper way to conduct count backs. Program Coordinator reviewed camera footage and received documentation of the staff members corrective action. 7/17/2024, Program Coordinator requested other signed correctived action form. 7/18/2024, Program Coordinator reviewed 521 to include citation, 907.2.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

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

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521 Visit Compliance Report

Licensee: Youth Home, Inc.

Facility Number: 128

Licensee Address: 20400 COLONEL GLENN ROAD
LITTLE ROCK AR 72210

Licensing Specialist: Kendra Rice

Person In Charge: Adria Riley

Record Visit Date: 7/16/2024

Home Visit Date: 7/16/2024

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: Resident was left alone in the house when staff members escorted the other residents to lunch.

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: 2:45 pm to 3:15 pm
Census: 7

Licensing received a provider reported incident on 7/12/2024 for ELS Case #022593.

Program Coordinator reviewed camera footage with Mr. Mask, Mr. White, and other staff members. This incident happened at Rose House. It was reported that the ratio at the time of this incident was 2:7.

Program Coordinator observed residents and two (2) staff members lining up for lunch. The residents were heard counting as they were walking out the door with a staff member in the front and back of the residents.

At 11:25 am, staff and residents left the house. 11:27 am, Nurse Valerie entered the house. Also, at 11:27 am, the resident appeared in camera view walking down the bedroom hallway. Resident was observed entering the nurse's office. Nurse Valerie was heard over the walking calling for a team member.

Per camera footage reviewed, it appeared that resident was left alone for two (2) minutes and a few seconds. Mr. Mask reported that the staff members involved received corrective action and documentation was provided.

REVISION: Facility will be cited for MLS 907.2, Resident was left alone in the house when staff members escorted the other residents to lunch.

Provider Comments:

CCL Staff Signature : Date: 7/18/2024

Provider Signature : Date: 7/18/2024

Beverly M. Foti