

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: 024022

Date of Incident: 9/16/2024

Date Received: 9/17/2024

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Licensing

Report Description: On 9/16/2024 EMAC client DOB:
(PRTF Client) was in a physical altercation with another client. After the altercation
was seen by the nurse and complained of pain to her back. The on-call provider
ordered to be transported to Arkansas Childrens Hospital.
from and her guardian was notified of the incident. was
discharged from ACH and diagnosed . The police were not
called for this incident.
Interim Action Narrative: Resident was assessed by the nurse and evaluated at ACH. Residents were placed on assault precautions.
Maltreatment Narrative:

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Program Coordinator inquired abour camera footage and will review on 9/18/2024. 9/18/2024, Program Coordinator reviewed camera footage of provider reported incident. Facility reported that peers involved were placed on assaultive precautions.



Division of Child Care & Early Childhood Education

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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 Slade
Person In Charge: Paul Hofstad
Record Visit Date: 9/18/2024
Home Visit Date: 9/18/2024
Purpose of Visit: Self Report Visit
Regulations Out of Compliance:
Regulations Needing Technical Assistance:
Regulation Not Applicable:
Regulations Not Correctable:
Narrative:
Time of visit: 9:00 am to 10:30 am

Census: 57

Licensing received a provider reported incident on 9/17/2024 for ELS Case #024022.

Program Coordinator discussed and reviewed camera footage with Centers' staff members. The provider reported incident took place at EMAC on Dorm 4 in a bedroom. The resident was observed standing by the staff member. Peers were observed walking around the bedroom, sitting on beds, or standing in the doorway of the bedroom, ratio 1:4 then 1:6.

Resident was observed standing by the staff member and it appeared that some kind of communication was going on with her and her peers. When her peers were walking toward the resident, the staff member was observed guiding the resident behind him. The peers were observed trying to strike the resident with the staff member blocking the strikes.

The staff member was observed guiding the resident into the bathroom for safety. The peers were observed trying to get to the bathroom but were unable to due to the staff member blocking the door. The peers were observed leaving the bedroom. There were two (2) peers that were not involved in the verbal/physical altercation who remained on the beds.

Per staff, the peers were placed on assaultive precautions.

Program Coordinator was unable to determine how the resident's back was injured.

Provider Comments:

CCL Staff Signature :

Provider Signature:

Barbara McCrory

Date: 9/20/2024

Date: 9/20/2024