Placement and Residential Licensing Unit
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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Notice of Serious Incident

Case Number: 024543

Date of Incident: 10/5/2024

Date Received: 10/7/2024

Facility Name: Dacus RTC

Facility Number: 108

Incident Type: Licensing

Report Description: Client: [redacted] Private Payor-Guardian-father-[redacted] Insurance-[redacted] State of Residency-[redacted] Staff Present: Ricayla Townsend Staff Present: Autumn Hurst Behavioral instructor, Autumn Hurst, was informed by facility residents that [redacted] (client) swallowed an unknown number of pills. At approximately 7:42pm Autumn Hurst called RTC nurse, Mike Collier, who was assisting another resident in the facility's cafeteria at the time. At approximately 7:47pm as behavioral instructor Ricayla Townsend was checking on client [redacted] in the bedroom, [redacted] fell to the floor. Emergency services (911) were immediately called. Behavioral instructor Ricayla Townsend then moved [redacted] to the RTC hallway. At 7:50pm RTC nurse assess client and remain with him until Emergency services arrive. Emergency serves arrived at approximately 7:55pm. At 8:03 Emergency services transported to client [redacted] to St Bernard's Hospital in Jonesboro, AR.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist emailed Facility with follow up questions, how did resident obtain pills, safety plan moving forward, nursing notes, hospital discharge paperwork. 10.7.24- Facility replied: [redacted] was sent to St. Bernards hospital on 10/05/24.

From St. Bernards, [redacted] was sent to Pinnacle Pointe on 10/06/24 where he is currently. Client did not return to Dacus, RTC after being transferred to St. Bernards hospital on 10/05/24. RTC nurse, Laura Carter, contacted St Bernards hospital on 10/05/06 and on 10/06/06 whom informed her [redacted] vitals and levels were all normal. However, per hospital (St Bernards) policy, the client is not allowed to return to the same facility after an alleged or reported overdose. The client obtained the meds from the medication he "cheeked" earlier in the day. Safety plan- Nurse will continue to ask each client for name and D.O.B before handing client medication and water. After client swallows' the medication, nurse will complete an oral check to ensure medication has been swallowed. Licensing Specialist requested video footage if available. Program Manager provided TA on improving staff procedure, nurse staying with a client in distress, not allowing other children to be hands on during medical emergencies. Also spoke with CEO about having floater staff on the floor during 7pm to 11pm. The Facility was given 7 days to retrain staff. 10.15.24- Facility emailed Licensing Specialist copies of the retraining for staff and nurse.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Andrea Adamson

Person In Charge:

Record Visit Date: 10/8/2024

Home Visit Date: 10/8/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing specialist and program manager reviewed camera footage for case 024543 starting at 7:35pm on the little boy's hallway and ended at 8:02pm on 10/5/2024.

Licensing specialist and program manager saw three staff located in the hallway with one staff in the doorway of where the resident was located. Several other peers were seen on the hallway moving about with one being agitated and continuously attempting to enter the bedroom where the resident was located. Staff stood in the doorway to not allow the peer into the room with the resident.

The male staff standing in the doorway of the resident's room leaves the hallway at 7:45pm and the resident's peers started to go in the room off camera. The female staff is seen on her phone attempting to get the children out of the room and call for assistance. At 7:48pm a female staff and two of the resident's peers carry the resident out of the bedroom and lay him on the hallway floor. The resident appears to be disoriented but moved some. The staff and residents continue to stand around the resident as he lays on the floor. At 7:51pm the nurse is seen coming to the hallway, looks down at the resident, and then leaves the area. First responders are seen at 7:55pm and begin to provide aid. EMS is seen arriving at 8:01pm.

Licensing discussed concerns with the facility management regarding staff not removing the residents off the hallway to avoid further escalation and potential further trauma to those witnessing the incident, nursing staff not staying with the resident during a potential medical crisis, and not allowing children to be hands on with other residents during a medical emergency. The facility reports that on the weekends, they only have two shifts per day in which three staff will work from 7am-7pm then 7pm-7am. Licensing discussed having a fourth staff on the weekends to aid the staff on the floor in the event of an incident specifically during waking hours. The facility management stated they would take this into consideration for possible implementation.

The facility will retrain all staff involved, including the nurse on the facility's policies related to medical emergencies. Training certificates will be sent to the licensing specialist by 10/15/2024.

Provider Comments:

CCL Staff Signature : Andrea Adamson Date: 10/10/2024

Provider Signature : Waynette Banks Date: 10/10/2024