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: 024735

Date of Incident: 10/15/2024

Date Received: 10/15/2024

Facility Name: Little Creek Behavioral Health

Facility Number: 255

Incident Type: Dual

Report Description: AVs are [redacted] AO is unknown. AVs are [redacted] from [redacted] who are residing at the Little Creek Behavioral Center. The concern is that AVs are being over-medicated. The following was observed [redacted] has had a [redacted], she has had substantial weight gain. She was observed to be in a sedated state, her [redacted] reported that she can?t refuse any of her medications or if she does, they give her a shot. [redacted]. [redacted] had visible shaking of her hands and was staring into space. She complained that she can?t stay awake during school because of feeling sedated. [redacted]. [redacted] appeared to be shaking and trembling, [redacted]. [redacted] is on Zyprexa and Metformin, she expressed concern about the medication. [redacted] appeared very sedated and couldn?t keep his eyes open. He is unable to participate in school because of sleepiness, [redacted] appeared to be sedated and had slurred speech, [redacted]. [redacted] appeared to with hand shaking, [redacted]. [redacted] reported that her medication makes her stomach hurt. She has had a 50lb weight gain, [redacted]. [redacted] complained that her medication makes her sleepy. She appeared sleepy and in a sedated state, [redacted]. AVs were all observed during a visit to the facility, they all have an extensive list of medications. AVs were all observed to be sleepy and have slurred speech, they were described to be ?sedated.? AVs get medicated every day.

Interim Action Narrative:

[redacted]

Licensing Narrative: 10/15/2024- Program Manager, Program Administrator, and Director participated in a meeting with [redacted] to discuss entry into the facility and aiding [redacted] Program Coordinator received an email from [redacted] and reviewed complaint. 10/16/2024- Program Coordinator spoke with [redacted] and she indicated that the residents were going to be interviewed [redacted] reported that the [redacted] resident had discharged. Program Coordinator and licensing specialist will visit the facility today to review chemical restraint records and medication lists for all the residents named in this complaint. Program Coordinator, Licensing Specialist Horton, and Nurse Melissa West, OLTC. Licensing reviewed the MAR of residents listed in this complaint. restraint logs for September 2024 and October 2024, and physician orders. Licensing also walked the facility to see what the residents were doing. Facility provided documentation on nursing documentation, post psychotropic stat/emergency medication usage, PRTF Individiualized Behavioral Contingencies, staff training requirements, Special Procedures Information Sheet, PRN

Medication Consent Form and possible side effects, physical escort policy, and personal restraint. 10/17/2024, Licensing returned to the facility and observed residents in their classrooms and observed 5 residents laying their heads on their desks. Licensing requested copies of the nurses' licenses and background checks. The facility provided copies of the Handle with Care training rosters for December 2023 and June 2024. Licensing reviewed and gathered more documentation from the residents' files named in this complaint. 10/18/2024, Program Coordinator and Nurse West completed a walkthrough of the educational hall and observed some residents who appeared sleep, nodding, or laying their heads down. Facility provided the census that consist of each resident's name and the state they are from. Nurse West spoke with the nurses at the nursing station and asked questions regarding the med pass process. Documentation was provided. 10/21/2024, Program Coordinator uploaded documentation for this complaint. 10/25/2024, Staffed with Program Manager regarding background checks. Email sent to background to see if checks had been ran. Program Coordinator requested contracts/agreements from states they provide services to. 10/28/2024, facilty provided copies of out of state agreements. 10/29/2024, spoke with Cinty and she reported 4 staff members backgrounds were not approved. Per Cindy, background chesk were ran but not approved due to missing the maltreatment and HR and to start over. Facility informed that staff members [redacted] could not work until their backgrounds were approved. 11/13/2024, facility reported that their HR representative reported that staff members backgrounds were approved. Licensing will follow up with Cindy. 11/14/2024, Cindy informed that all employees have been cleared to work via email. 11/15/2024, checked [redacted] case is still pending.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: Little Creek Behavioral Health

Facility Number: 255

Licensee Address: 161 SKUNK HOLLOW
CONWAY AR 72032

Licensing Specialist: Kendra Slade

Person In Charge: Jlynn Price

Record Visit Date: 10/16/2024

Home Visit Date: 10/16/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 1:00 pm to 4:45 pm

Census: 63

Licensing received a complaint on 10/15/2024 for ELS Case #024735.

Program Coordinator Slade, Licensing Specialist Horton, and Nurse West were escorted to the café/dining room to review files due to the conference room being preoccupied. Licensing spoke with Director of Risk Management and the Director of Nursing regarding the restraint logs, policies and procedures.

Licensing reviewed the MAR, physician orders, restraint logs for September 2024 and October 2024 for each resident named in this complaint. In September 2024, three (3) residents had chemical restraints. In October 2024, two (2) residents had chemical restraints.

The facility provided procedure documentation for medication changes, restraints, follow-up care following a chemical restraint, and de-escalation.

Director of Risk Management and Licensing walked throughout the facility. Director of Risk Management informed Licensing that some residents were away from the facility due to being taken to a forensic interview. The following was observed:

- Classroom (Art Club) ratio 6:15, residents were working on their art project that consisted of taking the cream of an Oreo cookie to make a picture.
- Starfish Dorm – ratio 2:6, residents were returning from art club and hanging out in the dayroom area. One (1) resident was completing hygiene.
- Angelfish Dorm – ratio 2:6, residents were observed playing cards with staff while peers were watching. One (1) resident was observed eating a snack. Two (2) other residents were in a meeting.
- Guppies Dorm – ratio 2:5, peers were observed taking a resident's hair down from braids. A resident was observed sitting in a chair with her legs to her chest. The resident had a sweatshirt over her legs (she had on pants also). When asked if she was cold the resident stated "yes." Two other residents were either with a case manager or participating with a club.
- Minnows Dorm – ratio 3:5, the residents were observed watching television in the dayroom area. One (1) resident was asleep while another resident was in her bedroom drawing. Per staff the resident had been sleeping for about ten (10) minutes. Another resident was observed standing by the door.
- Trout Dorm – ratio 2:5, residents were watching television. One (1) resident was asleep. Per staff, the resident had been sleeping for 15 minutes. Staff reported that a resident was with a case manager.
- Brim Dorm – ratio 2:6, two (2) residents were class. Other residents were eating a snack or watching television. Two (2) residents were sleeping and had been sleeping for about ten (10) minutes.
- Bass Dorm – ratio 2:7, residents were observed watching television and playing catch with staff. One (1) resident was taking a nap. Staff reported that the resident had been asleep for about 20 minutes.
- Snappers Dorm – ratio 2:8, residents were sitting in the dayroom area watching television. One (1) resident was showing his peers a magic trick and Licensing observed.

Licensing is not prepared to leave a finding at this time.

Provider Comments:

CCL Staff Signature : Date: 10/21/2024

Provider Signature : Date: 10/21/2024

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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 Slade

Person In Charge: Jlynn Price

Record Visit Date: 10/17/2024

Home Visit Date: 10/17/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 9:00 am to 4:45 pm

Census; 63

Licensing received a complaint on 10/15/2024 for ELS Case #024735.

Program Coordinator Slade, Licensing Specialist Horton, and Nurse West were escorted to the café/dining room to review files due to the conference room being preoccupied. Director of Risk Management and Director of Nursing assisted with more information to questions asked regarding medication and restraints. .

Program Coordinator requested background information, licenses, and proof of Handle with Care training from the Director of Human Resources.

Walking to the café, six (6) residents were observed in the classrooms laying their heads down on their desks. Three (3) of the residents were residents named in this complaint.

Per DON, medication is given at the following times: 6:45 am to 7:00 am, 11:00 am to 1:00 pm, 2:00 pm to 3:00 pm, 4:00 pm, and 7:30 pm to 8:00 pm. Nurse West inquired about the residents' medication and diagnosis.

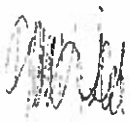
Licensing made copies of each resident's MAR, restraint packets, physician orders, and physician progress notes.

The facility reported that the residents have the opportunity to participate in three (3) types of groups: clinical, therapy. and recreational

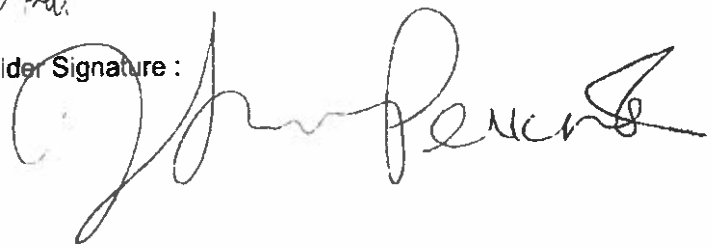
Licensing is not prepared to leave a finding at this time.

Provider Comments:

CCL Staff Signature : Date: 10/21/2024



Provider Signature : Date: 10/21/2024



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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 Slade

Person In Charge: Jlynn Price

Record Visit Date: 10/18/2024

Home Visit Date: 10/18/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 8:00 am to 10:30 am

Census: 63

Licensing received a complaint on 10/15/2024 for ELS Case #024735.

Program Coordinator and Nurse West inquired about incidents for the residents named in this complaint. The Director of Risk Management provided copies of incidents for the residents named in this complaint. Licensing also received the census to include the name and state of all residents.

Nurse Stacy explained the med pass process and how the nurses observe all restraints. Per Nurse Stacy, while a resident is a restraint the nurse communicates with the doctor the resident's behavior. The Director of Nursing provided Licensing and Nurse West with a copy of the Medication Management Procedures.

Walking through the educational hall, the following were observed:

- ALS – Deaf Connections – ratio 4:6. Three (3) staff members and one (1) teacher. A staff member was observed reading a book while the interpreter was signing. The residents were sitting down at tables watching the interpreter.
- Classroom 117 – ratio 4:14. Three (3) staff members and one (1) teacher. There were three (3) [redacted] in this classroom. They were observed participating in class and completing their assignments. [redacted] spoke with Licensing and [redacted] asked several questions. Licensing observed a female resident laying her head down on the table when spoken to, she raised her head up and then laid back down. Another resident was observed with her head against the wall and her back toward the door of the classroom. When spoken to, the resident spoke, turned back around, and placed her head back against the wall.
- Classroom 119 (Mr. Caleb) – ratio 5:15. Three (3) staff members and one (1) teacher. The classroom was watching CNN 10 news while sitting at their desks. There were two (2) [redacted] in this classroom. One (1) male resident [redacted] was observed nodding off.
- Classroom 118A (Ms. Amber) – ratio 4:13. Two (2) staff members, one (1) teacher, and the Director of Education. The residents were eating a snack and completing classwork. There were three [redacted] in this classroom.
- Classroom 118B – ratio 4:14. Three (3) staff members and one (1) teacher. The residents were watching CNN10 news. There was one (1) [redacted] in this classroom. There were two (2) residents [redacted] who appeared asleep.

Director of Risk Management reported that residents are given a directive to sit/wake up by staff and when they do not comply with the directive points are taken away.

Licensing is not prepared to leave a finding at this time.

Provider Comments:

CCL Staff Signature : Date: 10/21/2024

Provider Signature : Date: 10/21/2024

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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 Slade

Person In Charge: Jlynn Price

Record Visit Date: 12/9/2024

Home Visit Date: 12/9/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 900.905.11

Regulation Description: Chemical restraints shall be used only if ordered by a physician. A chemical restraint is an emergency behavioral intervention that uses pharmaceuticals by topical application, oral administration, injection, or other means to modify a child's behavior. Prescribed treatment medications that have a secondary effect on the child's behavior are not considered chemical restraint.

Finding Description: Chemical restraints were ordered but not signed off by the physician.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulation Number: 900.905.12

Regulation Description: Seclusion, mechanical, or physical restraints shall be used only if ordered by a physician.

Finding Description: Physical restraints ordered but not signed off by the physician.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulation Number: 900.908.8

Regulation Description: The administering of all medications, including over-the-counter, shall be logged at the time the medication is given, by the person administering the medication.

Finding Description: A chemical restraint was not logged on the MAR.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

No in-person licensing visit completed on 12/9/2024.

Licensing received a complaint on 10/15/2024 for ELS Case #024735.

Program Coordinator Slade, Licensing Specialist Horton, and Nurse West completed reviewed children records and observed the residents on 10/16/2024, 10/17/2024, and 10/18/2024.

Licensing received the following documentation: incidents of WV residents for (September and October 2024, census including the state of each resident, restraint logs for all residents (September and October 2024), policies and procedures (chemical restraint and medication hold policy, restraint, medication, behavior management procedure), documentation of medication changes, background checks, physician orders/progress notes of WV residents, verification of qualification for nurses and therapists, and proof of behavior management training.

After reviewing the documentation provided, the facility will be cited for the following standards:

908.8 The administering of all medications, including over-the-counter, shall be logged by the person administering the medication at the time the medication is given. A chemical restraint was not logged on the MAR.

905.11 Chemical restraints shall be used only if ordered by a physician. A chemical restraint is an emergency behavioral intervention that uses pharmaceuticals by topical application, oral administration, injection, or other means to modify a child's behavior. Prescribed medications that have a secondary effect on the child's behavior are not considered chemical restraint. Chemical restraints were ordered but not signed off by the physician.

905.12 Seclusion, mechanical, or physical restraints shall be used only if ordered by a physician. Physical restraints ordered but not signed off by the physician.

Provider Comments:

CCL Staff Signature : Date: 12/9/2024

Provider Signature : Date: 12/9/2024

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

January 7, 2025

To: Brady Serafin
Facility: Little Creek Behavioral Health
License #: 255
Address: 161 Skunk Hollow Rd. Conway, AR 72032

Mr. Serafin,

Pursuant to Minimum Licensing Standards for Child Welfare Agencies, a compliance review was conducted on case 024735 and the 521-compliance report form issued to your agency on 12/9/2024 included:

- A review of ten client's incident reports, MARs for September 1, 2024, through December 13, 2024, physician orders, and emergency safety intervention/debriefings.
- The facility census, the facility September to October 2024 restraint log, medication pass procedures, medication management procedures, physical restraint policy, special procedures information sheet, medication hold policy, and chemical restraint policy.
- A copy of the employed therapists licensing verification, Handle with Care Training for staff, nursing license verifications, and verification of the psychiatrist's licensure were obtained.
- On site visits were conducted on 10/16/2024,10/17/2024,10/18/2024 and 12/13/2024. Case files were reviewed for 10 clients referred to as client's #1-10 on this report.

After review and reconsideration by the Placement and Residential Licensing unit, the citations listed on the 521-compliance form dated 12/9/2024 stand. Furthermore, a review of the records revealed additional areas of non-compliance with licensing

standards 905.16, 905.17, and 908.11. Please see below for further details regarding the findings.

905.11 Chemical restraints shall be used only if ordered by a physician. A chemical restraint is an emergency behavioral intervention that uses pharmaceuticals by topical application, oral administration, injection, or other means to modify a child's behavior. Prescribed treatment medications that have a secondary effect on the child's behavior are not considered chemical restraint.

- This standard was not met as evidenced by:
    - Based on the review of records, the physician's signature was absent for chemical restraints ordered for client #6 and client #9.
- Client #6
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 for chemical restraints ordered on 9/27/24 at 19:30, 10/11/2024 at 20:37 and 10/11/24 @ 22:04 do not have a signature by the ordering physician present. Additionally, client #6's physician orders were reviewed that show a verbal order was received for the chemical restraints administered on 9/27/2024 at 19:30, 10/11/2024 at 20:37 and 10/11/2024 at 22:04, but there is no physician signature.
- Client #9
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 for chemical restraints ordered on 9/20/2024 at 14:44, 9/30/2024 at 17:35, and 10/2/2024 at 16:42 do not have a signature by the ordering physician present. Additionally, client #9's physician orders were reviewed that show a verbal order was received for the chemical restraints administered on 9/20/2024 at 14:44, 9/30/2024 at 17:35, and 10/2/2024 at 16:42, but there is no physician signature.

905.12 Seclusion, mechanical, or physical restraints shall be used only if ordered by a physician.

- This standard was not met as evidenced by:
    - Based on the review of records, the physician's signature was absent for physical restraints ordered for client #6 and client #9.
- Client #6
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 for the physical restraint ordered on 10/11/2024 at 20:26 did not have a signature by the ordering physician present. Additionally, client #6's physician orders were reviewed that show a verbal

order was received for the physical restraint administered 10/11/2024 at 20:26, but there is no physician signature.

- Client #9
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 for the physical restraints ordered on 9/20/2024 at14:30, 9/30/2024 at17:32 and10/2/2024 at 11:18 did not have a signature by the ordering physician present. Additionally, client #9's physician orders were reviewed that show a verbal order was received for the physical restraints administered on 9/20/2024 at14:30, 9/30/2024 at17:32 and10/2/2024 at 11:18, but there is no physician signature.

905.16 Staff shall continually monitor each child in seclusion or restraints and shall document.

- This standard was not met as evidenced by:
    - Based on the review of records, the facility failed to monitor each child in seclusion or restraints and document for client #9.
- Client #9
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 shows that client #9 was ordered a chemical restraint on 10/2/2024 at 16:42. The restraint monitoring sheet of the emergency safety intervention packet has been left blank with no details regarding the monitoring of the resident after the chemical restraint was administered.

905.17 Documentation of all restraints shall be maintained and shall include the child's name, date, time, reason, staff involved, and measures taken prior to restraint.

- This standard was not met as evidenced by:
    - Based on the review of records, the facility failed to maintain documentation of the staff involved and measures taken prior to a restraint hold for client #9.
- Client #9
    - The findings are: The emergency safety intervention and debriefing forms collected on 10/16/2024 shows that client #9 was given a chemical restraint on 10/2/2024 at 16:42. The facility failed to document what nurse administered the chemical restraint, the time the chemical restraint was administered, and the measures taken prior to the chemical restraint.

908.8 The administering of all medications, including over the counter, shall be logged by the person administering the medication at the time that the medication is given.

- This standard was not met as evidenced by:
    - Based on the review of records, the facility failed to log the time that medication was administered to client #6 and client #7. Additionally, the facility failed to log the administration of a chemical restraint given to client #9.
- Client #6
    - The findings are: A review of the November 2024 MARs shows that the facility failed to log the time that that medication Vistaril 50mg was provided to client #6 on 11/11/2024.
- Client #7
    - The findings are: A review of the November 2024 MARs shows that the facility failed to log the time that that medication Mylanta was provided to client #7 on 11/26/2024.
- Client #9
    - The findings are: A review of the October 2024 MARs shows that the facility failed to log the administration of Haldol 10mg and Benadryl 100mg for client #9 on their MARs log the date of 10/2/2024.

908.11 Any stimulant or psychotropic medicine requiring intra-muscular injection shall be administered only by a physician, registered nurse, or LPN.

- This standard was not met as evidenced by:
    - Based on the review of records, the facility failed to ensure psychotropic medicines requiring intra-muscular injections are administered by a physician, registered nurse, or LPN for client #9.
- Client #9
    - The findings are: A review of the emergency safety intervention and debriefing form shows that the facility failed to log the name of the person who administered the intra-muscular psychotropic medications to client #9 on 10/2/2024.

******* Pursuant to A.C.A. § 9-24-406(e)(3-4): If you believe that the Department's notice of noncompliance is in error, you may ask for reconsideration. The request for reconsideration must be in writing and delivered to the Department by certified mail within twenty (20) business days of receipt of the notice of noncompliance. The request must specify the parts of the notice that are alleged to be in error, explain why you believe those parts are in error, and include documentation to support the allegation of error. Once received the Department shall issue a decision on your request within twenty (20) days after receipt of the request.**

Sharra Singleton-Litzsey

Sharra Singleton-Litzsey, PRLU Administrator

1/7/2024

Date