ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 025887

Date of Incident: 10/26/2024

Date Received: 12/3/2024

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: Dual

Report Description: A/V is [redacted] A/O is unknown staff at Elizabeth Mitchell Centers for Youth and Families (Little Rock, AR, Pulaski CO). PRFCs are bio mother [redacted] and [redacted]. [redacted] was at the facility from 10/22/24 until pulled out AMA on 11/25/24. [redacted] was removed because he was felt not safe there. He is back with his outpatient therapist and no further residential treatment recommended at this time. [redacted] is not having behavior issues (why initially at facility). [redacted] was seen Saturday (10/26/24) at facility and he had a bruise on his cheekbone and another bruise by his jaw. No picture was taken because visitors are not allowed to take electronics inside. [redacted] said his roommate hit him the face and threw a shoe at him. [redacted] told staff, but they did not do anything. Another time [redacted] was overheard while on the phone telling staff that the roommate continued to hit him and was going through his stuff. Nothing was done. Staff were overheard to berate a/v after just a few seconds of being told he had a phone call that he was not getting there fast enough, threatened to hang up. [redacted] said he was beat up 2 additional times by other minors in the facility (assaulted by 3 different minors). He was finally moved to a new area, but the physical assaults by other minors continued. [redacted] said staff only responded once to the assaults and that was when he was screaming because the roommate was trying to rip up his stuffed animal and hit him with the shoe. [redacted] was heard reporting the assaults over the phone and a staff nearby accused him of saying the ?n word?, but a/v denied it and said the only thing he said was that he would ?throw hands?. Concern he was targeted because he was white and a majority of the staff is black. [redacted] therapist at the facility was continually emailed during this time frame and therapist claimed everything was great. Therapist was told about [redacted] reporting that he had bruises up and down his arms, he ?could not feel? his arms (thought from being hit, a/v not very specific), had glasses broken, etc. due to the violence by other minors. Staff were hard to reach and they would try to claim not aware of issues though [redacted] was heard informing them. Staff would not contact mother about any

incidents. facility case manager, Addison Johnson, would not return calls until he was pulled from facility. had a small bruise on his arm and some bruises on his legs 11/25/24 visible from the peer abuse. is having nightmares and panic attacks from being in the facility, has to take anxiety medication if the name of facility is mentioned. Human feces was observed in the shower at the facility 11/25/24. Front desk staff indicated aware, but it was not addressed. said that was a regular occurrence (human feces not cleaned up). Concern about feces being left lying around and not cleaned up. was taken to PCP and diagnosed with under his lip and on his thumb. The was visible in a picture taken of him when leaving the facility and it spread to his thumb. 10/26/24, indicated having pressure on his chest/chest pains at night, feeling like he could not breathe. Nighttime staff would just tell him that to go to sleep and would not help. He was confirmed to not have any physical problems and was believed having panic attacks. would say he is a ?medium? (something bio father also claims to be) and the pressure is ?when spirits are trying to communicate with him?. He was finally put on anxiety medication and antipsychotic after mother complained about the chest pain not being addressed. He has been diagnosed with Staff falsified paperwork by claiming the parent and belongings were searched, but they actually did not.

Interim Action Narrative:

Licensing Narrative: Program Coordinator checked [redacted] No [redacted] was assigned. 12/4/2024, Program Coordinator checked [redacted] [redacted]. Licensing Specialist Horton inquired of the facility all nursing notes regarding this resident. Licensing Specialist Horton called [redacted] for information or concerns, but no one answered. Specialist will call again. 12/5/2024, Program Coordinator spoke with facility regarding requested nursing notes. Facility reported that documentation would be provided. Licensing visited the facility and completed buildings and grounds in regard to the complaint mentioning human feces this was not observed during Licensing walkthrough. Licensing Specialist did not complete a walkthrough of EMAC due to residents being positive for covid. Licensing will schedule a walkthrough for a later day and time. 12/5/2024 Licensing Specialist Horton called [redacted] for information or concerns, no one answered. Specialist left a message on 12/04/2024. 12/06/2024 [redacted] returned Licensing's telephone call regarding information or concerns. Licensing Specialist requested documentation from [redacted] 12/10/2024 Licensing contacted [redacted] regarding documentation she reported that she

would send via email to Licensing. Guardian reported that she would send documentation on today. 12/11/2024, Program Coordinator uploaded photos from [redacted] 12/18/2024 Licensing inquired of the facility all nursing notes regarding this resident. 12/19/2024 Licensing contacted [redacted] regarding concerns. [redacted] reported documentation via email to Licensing and it has been uploaded. 12/20/2024 The facility reported nursing notes documents via email. Documents were uploaded. 12/23/2024 Licensing Specialist Horton inquired of the facility when visitation take place where are visits held? Facility reported to Licensing visitation occurs in different places. Usually, it is in the conference room, the lobby, or outside if it?s a pretty day. 1/21/2025, case staffed. Licensing Specialist will complete buildings and grounds of EMAC and interview residents from EMAC and EMCC. 1/23/2025, licensing interviewed 2 residents from each dorm at EMCC. The resident was at EMCC during his stay. Program Coordinator will request of incident reports involving any altercations, communication with parent and if a diagnosis of [redacted] was given. 2/13/2025, per [redacted] and Licensing Specialist informed. This complaint was UNFOUNDED by licensing.

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: Elizabeth Mitchell Centers

Facility Number: 157

Licensee Address: 6501 W 12TH ST
LITTLE ROCK AR 72204-1511

Licensing Specialist: Arlene Horton

Person In Charge: Barbara McCrory

Record Visit Date: 12/5/2024

Home Visit Date: 12/5/2024

Purpose of Visit: Subsequent Building and Grounds

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 9:30 am to: 10:30 am

Census: 27

Licensing received a complaint on 12/3/2024 for ELS Case #025887.

Licensing Specialist Horton completed buildings and grounds visit for EMCC. Licensing was escorted by staff members Rachel Howard and Brent Ellison.

Rachel with the facility reported to Licensing that EMAC has three residents and a nurse who has Covid. Licensing inquired when facility became aware of the covid cases. Rachel reported to Licensing that it occurred over the weekend of 11/30/2024. Licensing Specialist did not visit EMAC due to the covid cases reported by the facility staff.

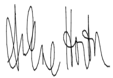
EMCC – The grounds of the facility observed were maintained. Licensing walked through and observed the following dorms: North, South, East, and New Dorm. No residents were present during the walkthrough of the dorms. Licensing observed the residents' bedrooms and bathrooms. All bathrooms including the shower areas were maintained. Licensing observed housekeeping making rounds while walking through the building.

Rachel reported the facility has several Christmas activities planned for the residents.

EMCC building met the minimum licensing standards for buildings and grounds.

Provider Comments:

CCL Staff Signature : Date: 12/5/2024



Provider Signature : Date: 12/5/2024

Rachel Howard

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: Elizabeth Mitchell Centers

Facility Number: 157

Licensee Address: 6501 W 12TH ST
LITTLE ROCK AR 72204-1511

Licensing Specialist: Arlene Horton

Person In Charge: Barbara McCrory

Record Visit Date: 1/23/2025

Home Visit Date: 1/23/2025

Purpose of Visit: Subsequent Building and Grounds

Regulations Out of Compliance:

Regulation Number: 900.912.4
Regulation Description: The bathroom shall be clean and sanitary.
Finding Description: Some bathrooms had tissue on the floor.
Action Due Date:
Action Due Description:
Comply Date:

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time: 10:00 a.m. – 12:00 p.m.
Census: 25

Licensing received complaint on 12/03/2024 for ELS case #025887.

Licensing Specialist Horton and Program Coordinator Rice were escorted through the EMAC facility by staff Mr. Brent Ellison.

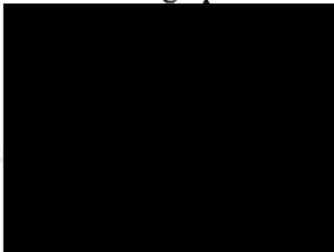
Licensing Specialist Horton observed 3 classrooms. The 3 classrooms ratios were 3:6 each. Licensing observed two residents and two staff members sitting in the dining area at different tables. The staff members and residents appeared to be in a session.

Mr. Ellison reported to Licensing that a room (previously a quiet room) in EMAC could possibly become a hair salon for the residents. Licensing observed Dorms 1, 2, 3, and 4 no residents were in their bedrooms during Licensing's visit. Licensing observed colorful handprints on the ceiling on Dorm 4. Mr. Ellison informed Licensing that he would investigate the matter and that it would be taken care of.

On Dorm 2, Licensing observed the ratio 1:1. A staff member and a resident were sitting at a table. They appeared to be having a session. Licensing Specialist Horton observed the recreational areas where the grounds were maintained.

Licensing observed that housekeeping had not made their rounds during Licensing's walkthrough. Licensing observed the bathrooms to be partially cleaned. The hygiene closets had some clothing and other articles on the floor. Some bedrooms had clothing on the floor that appeared dirty.

Licensing Specialist reviewed MAR records with nurse, Morgan Gathen, for the residents listed below:



MAR records reviewed were compliant with the licensing minimal standards.

Facility will be cited**912.4**some bathrooms had tissue on the floor.

***** 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.

Provider Comments:

CCL Staff Signature : Date: 1/23/2025

Provider Signature : Date: 1/23/2025

Barbara McCrory