

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: 025249

Date of Incident: 10/31/2024

Date Received: 11/5/2024

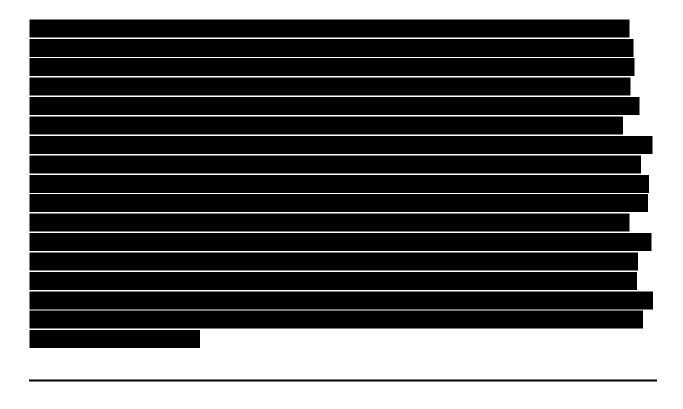
Facility Name: Millcreek of Arkansas PRTF

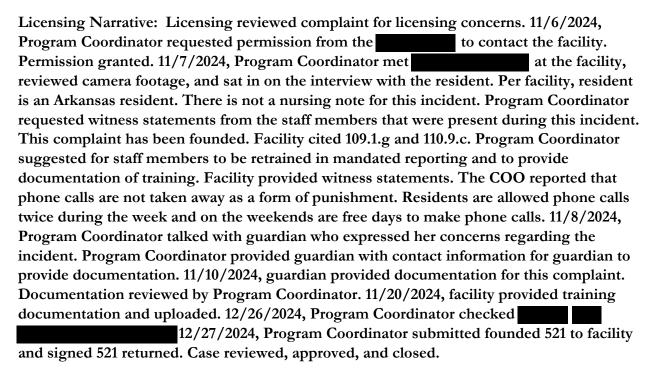
Facility Number: 233

Incident Type: Dual

, asked Mr. CJ if he could sit at the
nt to get up so she could clean the table.
ere. called the resident "A gay
shed him against the wall, Mr. CJ
an and informed guardian of the
stated for resident to tell his guardian
phone call and called back and spoke
an of the incident and stated that
eported. Guardian stated an email was
nformation for someone to provide
the guardian and reported that
t not being reported to the guardian
I things had been really busy.
normally works 3rd shift but came in
dian everyday but prior to yesterday.
nesday. Guardian was made aware that but is not sure why the resident has
7.

Interim Action Narrative: Facilty reported staff members were terminated.







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: Millcreek of Arkansas PRTF

Facility Number: 233

Licensee Address: 1828 INDUSTRIAL DR

FORDYCE AR 71742-7110

Licensing Specialist: Kendra Slade

Person In Charge: Emerald Burris

Record Visit Date: 11/7/2024

Home Visit Date: 11/7/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not

limited to the following:

Finding Description: The female staff member was observed placing her hands around the resident's shoulder

area and continued while he was up against the wall.

Action Due Date:

Action Due Description: Staff member was terminated.

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous,

exploitative, or physically harmful to children.

Action Due Description: Staff member was terminated.

Regulation Number: 100.110.9.c

Regulation Description: Any owner, operator, employee, foster parent, or volunteer in a child welfare agency

shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has

Finding Description: Staff members observed the staff member placed her hands around the resident's shoulder area against the wall and did not make a child abuse hotline report.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: If they observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 10:15 am to 11:30 am

Census: 160

Licensing received a complaint on 11/4/2024 for ELS Case #025249.

Program Coordinator Slade and Investigator Flint spoke with Ms. Burris and Mr. Butler. Mr. Butler provided camera footage for this incident. The location of this incident was at Rockhill in the dayroom area. There were three (3) staff members present. The residents were watching television and walking around the area. One staff member was sweeping the floor, one male staff member was observed in the corner of the dayroom talking with residents, and the other male staff member was in and out of camera view.

Per camera footage reviewed, the incident happened on 10/25/2024 around 7:51 pm. The actual timeframe of the incident was possibly 2 minutes. Program Coordinator observed the staff member named in this complaint sweeping the floor in the dayroom area. The resident was observed coming from the side of the room where the staff member was sweeping. It appeared that the resident said something to the staff member.

The staff member was observed walking toward the resident and placed her hands around the resident's shoulder area. The resident appeared to be up against the wall in the dayroom area and words were exchanged

again between the staff member and resident. The staff member removed her hands from the resident's shoulder area and walked away. The resident was observed walking toward the staff member and the staff member walked back toward the resident.

It appeared that both the staff member and resident exchanged words. The staff member walked away from the resident. As the resident was walking toward the staff member, a peer was observed blocking the resident from moving forward. A male staff member was observed guiding the resident from the dayroom area toward his bedroom.

The facility will be cited for:109.1.gThe female staff member was observed placing her hands around the resident's shoulder area and continued while he was up against the wall and110.9.cStaff member/s observed the staff member placed her hands around the resident's shoulder area against the wall and did not make a child abuse hotline report.

Per facility, the staff member named in this complaint has been terminated.

Provider Comments:

This incident does not reflect the high standards and de-escalation techniques that Millcreek Behavioral Health is dedicated to upholding. Our facility provides comprehensive training to ensure staff are fully equipped to interact with and support our residents with compassion, safety, and professionalism. The actions cited were taken by an individual staff member who disregarded the established training and protocols we implement to safeguard resident well-being.

We take incidents of this nature and resident safety with the utmost seriousness. All staff members are trained as mandated reporters, and we stress the critical responsibility each team member has in identifying and reporting any behavior or incident that could compromise the safety or dignity of our residents. Any deviation from these responsibilities undermines the trust placed in us by residents and their families.

As this individual's actions fell outside their assigned responsibilities and violated our policies, we have made the decision to terminate their employment. They will not be eligible for rehire at any time. Millcreek Behavioral Health remains firmly committed to upholding the rigorous standards and practices our residents deserve, and we will continue to emphasize the importance of mandated reporting to protect those in our care.

CCL Staff Signature : Date: 11/7/2024

Provider Signature:

Date: 11/7/2024



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521 Visit Compliance Report

Licensee: Millcreek of Arkansas PRTF
Facility Number: 233
Licensee Address: 1828 INDUSTRIAL DR FORDYCE AR 71742-7110
Licensing Specialist: Kendra Slade
Person In Charge: Emerald Burris
Record Visit Date: 12/27/2024
Home Visit Date: 12/27/2024
Purpose of Visit: Revisit Complaint
Regulations Out of Compliance:
Regulations Needing Technical Assistance:
Regulation Not Applicable:
Regulations Not Correctable:
Narrative:
No in-person licensing visit was completed on 12/27/2024.

Licensing received a complaint on 10/31/2024 for ELS Case #025249.

This complaint was**FOUNDED**by Licensing and the facility was cited for 109.1.g and 110.9.c on 11/13/2024.

The other staff members were on trained mandated reporter responsibility on 11/13/2024.

Provider Comments:

At Millcreek Behavioral Health, we hold ourselves to the highest standards of care, safety, and professionalism in serving our residents. We are committed to maintaining an environment that prioritizes the well-being and dignity of every individual entrusted to our care.

This incident does not reflect the standard practices or the de-escalation techniques that our facility rigorously implements to train staff in resident interaction and management. The actions mentioned in the citation were conducted by an individual staff member who strayed from the extensive training and established protocols of our facility.

We take incidents of this nature, as well as patient safety, with the utmost seriousness. After a thorough review, it was determined that the actions of this employee were outside of their assigned responsibilities and deviated significantly from our company policies. As a result, we made the decision to terminate their employment to reinforce our unwavering commitment to safety and integrity.

Millcreek Behavioral Health will continue to evaluate and enhance our training programs and protocols to ensure that incidents like this are avoided in the future. Our focus remains on providing exceptional care and support for the residents we serve.

CCL Staff Signature:

Date: 12/27/2024

Provider Signature:

Date: 12/27/2024