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

Report Description: Resident, [redacted], asked Mr. CJ if he could sit at the table and color. [redacted] came over and told resident to get up so she could clean the table. Resident responded that he had permission to be there. [redacted] called the resident "A gay lil bitch boy" and grabbed him by the collar and pushed him against the wall, Mr. CJ intervened. On 11/4/2024, resident called his guardian and informed guardian of the incident. Ms. Kiyah was monitoring phone calls and stated for resident to tell his guardian the incident was reported. Guardian completed the phone call and called back and spoke with Ms. Kiyah and Mr. CJ. Mr. CJ informed guardian of the incident and stated that [redacted] was still employed and that the incident was reported. Guardian stated an email was sent to Ms. Shay (therapist) and requested contact information for someone to provide additional information. Chris Butler reached out to the guardian and reported that [redacted] had been terminated and apologized for the incident not being reported to the guardian sooner [redacted] Mr. Butler reported things had been really busy. [redacted] normally works 3rd shift but came in earl y to relieve Mr. CJ. Resident normally calls guardian everyday but prior to yesterday. Resident has not spoken to guardian since last Wednesday. Guardian was made aware that resident had been involved in a episode on that day but is not sure why the resident has been restricted from phone calls since last Thursday.

Interim Action Narrative: Facilty reported staff members were terminated.

[redacted]

Licensing Narrative: Licensing reviewed complaint for licensing concerns. 11/6/2024, Program Coordinator requested permission from the [redacted] to contact the facility. Permission granted. 11/7/2024, Program Coordinator met [redacted] at the facility, reviewed camera footage, and sat in on the interview with the resident. Per facility, resident is an Arkansas resident. There is not a nursing note for this incident. Program Coordinator requested witness statements from the staff members that were present during this incident. This complaint has been founded. Facility cited 109.1.g and 110.9.c. Program Coordinator suggested for staff members to be retrained in mandated reporting and to provide documentation of training. Facility provided witness statements. The COO reported that phone calls are not taken away as a form of punishment. Residents are allowed phone calls twice during the week and on the weekends are free days to make phone calls. 11/8/2024, Program Coordinator talked with guardian who expressed her concerns regarding the incident. Program Coordinator provided guardian with contact information for guardian to provide documentation. 11/10/2024, guardian provided documentation for this complaint. Documentation reviewed by Program Coordinator. 11/20/2024, facility provided training documentation and uploaded. 12/26/2024, Program Coordinator checked [redacted] 12/27/2024, Program Coordinator submitted founded 521 to facility and signed 521 returned. Case reviewed, approved, and closed.

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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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: 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.g**The female staff member was observed placing her hands around the resident's shoulder area and continued while he was up against the wall and**110.9.c**Staff 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