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: 025380

Date of Incident: 11/9/2024

Date Received: 11/11/2024

Facility Name: Dacus RTC

Facility Number: 108

Incident Type: Licensing

Report Description: Client: [REDACTED] Nurse Jessica Lassiter Staff Present: Shantelle Moore Staff Present: Terra Boose Client [REDACTED] attempted to charge peer in dining room. Staff intervened by separating Client [REDACTED] and peer. Client [REDACTED] started destroying peers belongings in dining room. The nurse (Jessica) opened the door that led to the kitchen to obtain something from out of there, when the client [REDACTED] pushed past the nurse (Jessica L.) and ran out the exit door of the kitchen and across the street into the overgrown woods. Police were notified. Bono police detained the client [REDACTED] and brought him back to the facility to the bedroom. When officers exited the building the client [REDACTED] began vandalizing property and destroying doors and beds. The officers returned inside and tried talking to the client [REDACTED] who refused to speak. The police arrested the client for criminal mischief, and he was taken to Craighead County detention center.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 11.12.24- Licensing Specialist reached out to the Facility inquiring about the damages and footage as well as the safety plan. 11.13.24- Facility responded with:

es, there is video footage of the incident. The property damage to the facility has been repaired. The peers belongings will be replaced. [redacted] has returned to the facility and is on safety precautions including strict EP (elopement precautions); AP(assault precautions);strict LOS (line of sight) meaning constant staff supervision 11/19/2024, Program Coordinator reviewed camera footage. Facility reported that all nursing staff will be retrained on crisis procedures and documentation will be provided to licensing.

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: Dacus RTC

Facility Number: 108

Licensee Address: 211 CHURCH STREET
BONO AR 72146

Licensing Specialist: Kendra Slade

Person In Charge: Waynette Banks

Record Visit Date: 11/19/2024

Home Visit Date: 11/19/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 11:00 am to 12:30 pm

Census: 14

Licensing received a provider reported incident on 11/9/2024 for ELS Case #025380.

Program Coordinator Slade reviewed camera footage on 11/19/2024 with Mrs. Banks.

The provider reported incident happened in the dining hall. The residents were getting ready to eat dinner. At 5:00 pm staff and residents were observed entering the dining hall.

Residents were observed entering the dining hall sitting at the tables waiting for the window to open to get their dinner trays. The ratio started off at 2:5 with the ending ratio being 3:11.

When the kitchen staff opened the window, residents were observed walking to the window getting their dinner trays and sitting down to eat. A peer was observed walking past the resident. As the peer was observed walking to the opposite side of the dining hall, the resident was observed running toward the peer, at 5:07 pm. Once the peer reached the back wall staff was observed intervening by stepping between the peer and the resident.

The peer was observed being guided by a staff member while another staff member was observed blocking the resident from going in the peer's direction. The resident was observed throwing items across the dining hall, pacing the floor while tearing up paper and throwing it in different directions.

The other peers continued to eat their dinner and did not engage in what was going on. Staff continued to walk with the resident as he paced. The resident walked to the back of the dining hall away from his peers.

As the resident was walking in the opposite direction of the entrance to the kitchen. A nurse was observed walking toward the door, once the nurse opened the door, the resident was observed running in the direction of the nurse. It appeared that the resident may have pushed his way past the nurse.

A staff member was observed running out the door toward the transitional hall and another staff member was observed using her phone. Per Mrs. Banks, the staff member called the police and the Program Consultant. The timeframe of this incident was from 5:00 pm to 5:10 pm.

Mrs. Banks reported that the nurse thought the situation was under control and that was why she had entered the kitchen. Mrs. Banks informed Program Coordinator that nursing staff will be retrained on crisis procedures. Documentation will be provided to licensing once completed.

Provider Comments:

CCL Staff Signature :

Date: 11/19/2024

Provider Signature :

Waynette Y. Bulter, Program Director

Date: 11/19/2024