



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: 026835

Date of Incident: 12/27/2024

Date Received: 1/14/2025

Facility Name: Elizabeth Mitchell Centers

Facility Number: 157

Incident Type: [REDACTED]

Report Description: AV is [REDACTED]. Out of home AO is staff member at Centers for Youth and Families, Unknown name. [REDACTED] is currently in [REDACTED] and court ordered to receive residential services at Centers for Youth and Families. On [REDACTED]/24 [REDACTED] was brought to [REDACTED] for attempted suicide at Centers. During her initial session with her therapist at the hospital, [REDACTED] shared that after her attempt was interrupted at Centers, a staff member ([REDACTED] cannot remember her name but knows it starts with a [REDACTED] describes her as heavy set, [REDACTED]) said "that is how it be sometimes" and proceeded to hit [REDACTED] first multiple times, leading the two to get in altercation. Other girls ran to get help and by the time other staff came back, [REDACTED] said, "[REDACTED] beat her repeatedly". [REDACTED] grabbed [REDACTED] by throat during this altercation and [REDACTED] had handprint and scratches on her face and neck. She requested to have photo taken of injuries but was denied by staff. [REDACTED] also stated that [REDACTED] hit another child ([REDACTED]).

Interim Action Narrative: Staff member suspended pending the facility's investigation.

[REDACTED] Narrative: AV is [REDACTED]. Out of home AO is staff member at Centers for Youth and Families, Unknown name. [REDACTED] is currently in [REDACTED] and court ordered to receive residential services at Centers for Youth and Families. On [REDACTED]/24 [REDACTED] was brought to Methodist Behavioral Hospital for attempted suicide at Centers. During her initial session with her therapist at the hospital, [REDACTED] shared that after her attempt was interrupted at Centers, a staff member

() cannot remember her name but knows it starts with a [redacted] and describes her as [redacted] () said "that is how it be sometimes" and proceeded to hit [redacted] first multiple times, leading the two to get in altercation. Other girls ran to get help and by the time other staff came back, [redacted] said, "[redacted] beat her repeatedly". [redacted] grabbed [redacted] by throat during this altercation and [redacted] had handprint and scratches on her face and neck. She requested to have photo taken of injuries but was denied by staff. [redacted] also stated that [redacted] hit another child ().

Licensing Narrative: 1/14/2025-Licensing received [redacted] [redacted]. [redacted] determined that licensing was never made aware of this report through ELS [redacted]. Licensing was provided with a copy of the video footage for review and has requested nursing notes and witness statements from the facility. [redacted], and they reported that they were not made aware [redacted] until 1/14/2024. However, after review of information [redacted], it was determined that a staff member at the facility was contacted regarding the [redacted] on 1/2/2025, but it was not reported to licensing. Per facility: This allegation is part of the incident on 12/26/24. The client made the allegation while in acute care and Centers was not aware of the alleged staff involved until today when the investigator came for a visit. [redacted], and [redacted] could continue working. [redacted], [redacted]. 01/16/2025 Licensing Specialist Horton inquired of the facility witness statements or nursing notes on this case. 1/21/2025, case staffed. Licensing Specialist will interview some residents. 1/23/2025, licensing interviewed 3 residents regarding this incident. Program Coordinator spoke with Ms. Barbara and informed her that the staff member could not participate in any restraints until retrained. Ms. Barbara informed licensing that staff member would most likely be sent home until she can be retrained. Licensing requested for an update once a decision was made. Ms. Barbara was informed of licensing concerns regarding the staff member being disrespectful toward the residents. Program Coordinator reviewed the nurse's note and observed where an injection was ordered but there was not a reason why. Program Coordinator requested restraint packet and witness statements from the staff members present. [redacted].



Division of Child Care & Early Childhood Education

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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: Chelsea Vardell

Person In Charge:

Record Visit Date: 1/21/2025

Home Visit Date: 1/21/2025

Purpose of Visit: Revisit Complaint

Regulations Out of Compliance:

Regulation Number: 100.110.12

Regulation Description: The agency shall notify the Licensing Unit by the next business day when a report of child maltreatment is accepted by the child abuse hotline against the owner/operator, employee, foster parent, volunteer, child, or other person in a child welfare agency.

Finding Description: [REDACTED] regarding a staff at the facility on 12/30/2024 and the facility was made aware [REDACTED] on 1/2/2025 but failed to report it to the PRLU by the next business day.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing complaint 026835 is being investigated by the PRLU.

A report was received on 1/14/2025 that on 12/27/2024 a resident attempted to self-harm and the intervening staff struck her multiple times.

Licensing reached out to the facility to determine why the agency did not report [REDACTED] to the PRLU by the next business day as required in the Minimum Licensing Standards 110.12 *"The agency shall notify the Licensing Unit by the next business day when [REDACTED] against the owner, operator, employee, foster parent, volunteer, child, or other person in a child welfare agency."* The facility stated that they were not made aware of the [REDACTED] until 1/14/2025. However, the PRLU has received documentation supporting that staff was contacted on 1/2/2025 by the [REDACTED] and informed [REDACTED]

Once the staff was notified [REDACTED] the facility was required to report it to the PRLU by the next business day according to 110.12.

Due to the failure to report to the PRLU by the next business day, the facility will be cited for regulation 110.12. Licensing spoke with the staff at the facility via phone on 1/21/2025 who reported that they will ensure that the facility reports any [REDACTED] by the next business day moving forward.

The PRLU is continuing to investigate all other concerns related to this complaint and is not prepared to leave a finding at this time.

******* 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 : *Chelsea Vardell*

Date: 1/21/2025

Provider Signature :

Date: 1/21/2025

Barbara McCrory



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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: 3/25/2025

Home Visit Date: 3/25/2025

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

521 for ELS Case #026835

No in-person licensing visit was completed 03/25/2025.

Licensing received a complaint on 01/14/2025 for ELS Case #026835.

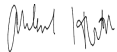
This complaint has been unfounded by Licensing.

***** 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: 3/25/2025



Provider Signature :

Date: 3/25/2025

Barbara McCrory