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: 028123

Date of Incident: 3/8/2025

Date Received: 3/10/2025

Facility Name: Dacus RTC

Facility Number: 108

Incident Type: Licensing

Report Description: Client: [redacted] Insurance: [redacted] Foster Care- Washington County DCFS- Caseworker Tami Kelly Resident of Arkansas Staff: [redacted] Staff Present: [redacted] Resident [redacted] walked out of the dayroom and into the cafeteria at 4:10pm where he proceeded to sit on the floor. Another resident (resident 2) was also in the cafeteria. At 4:11pm, staff member, [redacted] instructed resident [redacted] and resident # 2 to leave the cafeteria and return to the dayroom. [redacted] did not respond. Staff member [redacted], at a distance, bent down to converse with resident [redacted]. At 4:12pm, staff and resident are seen standing erect face to face in a conversation. Staff member, [redacted], arrives at 4:13pm and is seen conversing with the resident [redacted] and staff [redacted]. Within the same minute, resident [redacted] began aggressively punching the door to the nurse's office door as well as kicking the door leading to the transitional hallway. Staff [redacted] made attempts to put resident [redacted] in a restraint. Resident [redacted] strikes staff member multiple times in the face. As [redacted] is striking/swinging and staff attempting to block hits, both resident and staff fall to the floor. Staff member [redacted] [redacted] returns to the cafeteria again after checking on residents in the dayroom. Staff member [redacted] is seen observing resident [redacted] . At 4:16pm, resident [redacted] strikes again with staff making attempts again to restrain resident [redacted]. At 4:18pm, Administrative Care manger, [redacted], arrives to the scene. [redacted] member [redacted] leaves the vicinity of the client by going into the Dayroom. [redacted] contacts the Program Consultant whom gave authorization to contact law enforcement. Resident [redacted] is seen in nursing station until [redacted] arrive at 5:07pm. Program Director is notified upon arrival of law enforcement. Officer [redacted] takes resident [redacted] to JDC. Resident [redacted] returns to the facility the following day 03/09/25. He is placed on precautions for safety. Staff member [redacted] will be retrained on CPI and de -escalation techniques.

Interim Action Narrative:

[redacted] **Narrative:**

Licensing Narrative: Police documentation requested. Police documentation received and Licensing Specialist informed. 3.12.25- Specialist emailed facility requesting video footage availability. Facility will retain footage 3.18.25- Specialist visited facility and reviewed footage. Footage reviewed is documented in Inspection# 085128

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Placement and Residential Licensing Unit
Division of Provider Services & Quality Assurance
P.O. Box 1437, Slot S530, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.682.8155

521 Visit Compliance Report

Licensee: Dacus RTC

Facility Number: 108

Licensee Address: 211 W CHURCH ST
BONO AR 72416-9578

Licensing Specialist: Andrea Adamson

Person In Charge: Waynette Banks

Record Visit Date: 3/18/2025

Home Visit Date: 3/20/2025

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing Specialist and Director reviewed footage regarding the incident on 3.8.2025

Below is what was seen:

1611-2 residents are seen in the cafeteria, one sitting down and the other pacing the length of the room.

Ratio is 1:2

1612:02-A staff member is seen instructing residents to leave the cafeteria and return to the dayroom. Resident 1 is seen sitting down ignoring staff, Resident 2 is sitting quietly at the lunch table on the opposite side of the room and does not move for the duration of the video viewed. Staff is seen bending down to Residents level and conversing with him.

1612:31-Resident stands suddenly and so does staff, they are standing very closely face to face talking to one another.

1613-Second Staff member arrives at 4:13pm and is seen conversing with the Resident and staff member. Suddenly, the Resident begins aggressively punching and kicking the door to the nurse's office door as well door leading to the transitional hallway.*Ratio is 2:2*.

1614-Staff then engages in physical restraint of the Resident, however Resident manages to strike staff member multiple times in the face. Staff attempts the physical restraint again but fails and both resident and staff fall to the floor. Staff and Resident stand up and continue talking. Second staff member is seen checking on the residents in the next room and returning within 3 seconds to stay as a witness the altercation.

1615:02-Other staff come into dayroom to maintain ratio so initial secondary Staff member can stay with Resident and staff as they talk and attempt to de-escalate. Second resident who had been sitting at the cafeteria table is moved into dayroom.*Ratio 1:2*

1615:32-Resident begins pacing and swinging arms again, Staff is seen talking to resident to attempt to de-escalate him.

1616-Resident strikes staff and staff attempts again to restrain resident and manages to keep Resident in hold. Nurse is seen coming out of Nurses station.*Ratio 1:3*.

1618-Administrative Care manger, Tiffany Harris, is seen entering cafeteria. Staff member disengages hold and leaves the cafeteria by going into the Dayroom to keep ratio there. Tiffany Harris contacts the Program Consultant who gives authorization to contact law enforcement. Resident sits on the floor at the nursing station until Bono Police arrive at**1707.**

Resident remained at Juvenile Detention Center overnight and returned to the facility the next day.

Staff that engaged in the physical restraint will be re-training on CPI courses.

******* 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: 3/20/2025

Provider Signature :

Date: 3/20/2025

Waynette Banks