



**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

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**Notice of Serious Incident**

Case Number: 028892

Date of Incident: 4/5/2025

Date Received: 4/10/2025

Facility Name: Delta Family Health and Fitness for Children

Facility Number: 172

Incident Type: Licensing

Report Description: [REDACTED]. AO is age/name unknown. AV is in DHS care and is currently at [REDACTED] in Little Rock, Arkansas and will be until her release on [REDACTED] 25. AV had been residing at Delta Family Center in Hamburg, Arkansas until [REDACTED] 25 when she was taken to [REDACTED]. AV reported that on [REDACTED] 25 she was placed in a restraint and then held down by four to five staff members. When questioned why so many staff were holding her down, AV stated that they needed that many to restrain her. AV reported that there was one staff member who took it too far and bruised her as well as putting their elbow in her throat and pushing down so that she couldn't breathe. AV does have three green bruises on her right arm and 2 bruises on her left arm. When discharged from [REDACTED] AV will not be returning to the Delta Family Center.

Interim Action Narrative: A/V sent to [REDACTED] placement 028847 reported to licensing.

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[REDACTED] Narrative:

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Licensing Narrative: 4/9/25-Received phone call from [REDACTED] who provided further information. A/V is at [REDACTED] and will not be returning to Delta. No A/O's named at this time. A/V scheduled for forensic interview today. Phone call made to [REDACTED] of Delta who stated there was video of incident. Visit scheduled for 4/15/25. 4/10/25-Received licensing complaint report and reviewed for licensing concerns. Report states incident

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occurred 4/5/25. Phone call made to [REDACTED] of Delta. Incident occurred 4/6/25. A/V was in no restraint nor had any incidents 4/5/25. Video has been saved for licensing to review. Email sent to [REDACTED]. No A/O's have been named at this time. Visit scheduled for 4/15/25. 4/14/25-Received email from [REDACTED] that two A/O's were named during [REDACTED]. Complaint against A/O 2 reported to have happened about 4 months ago. Complaint against A/O 1 refers to this complaint. Email and phone call made to facility to inform them that A/O's will need [REDACTED] before being allowed to work until investigation is complete. Phone call made to [REDACTED] of Delta. Both named A/O's are on leave pending approved [REDACTED] or close of investigation. 4/15/25-Facility visited with [REDACTED] 4/15/25. Video reviewed of recent incident. Documentation provided of reported complaint from 4 months ago. No citations. Licensing complaint unfounded. 4/18/25-[REDACTED] for both A/O's denied. 5/2/2025-[REDACTED] for staff [REDACTED] reviewed and lifted so that he may return to normal job duties. 5/7/25-[REDACTED] for staff [REDACTED] lifted. Retraining sent to licensing.



Division of Child Care & Early Childhood Education  
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## 521 Visit Compliance Report

**Licensee:** Delta Family Health and Fitness for Children

**Facility Number:** 172

**Licensee Address:** 815 EAST SAINT LOUIS STREET  
HAMBURG AR 71646

**Licensing Specialist:** Clayton DeBoer

**Person In Charge:** Dean Hill II

**Record Visit Date:** 4/15/2025

**Home Visit Date:** 4/15/2025

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

Facility visited from 10:15AM-PM in response to Case #028892. Census:19.

Video reviewed of cafeteria where incident took place on 4/6/25 from 2:23PM-3:20PM. Resident is seen picking up a chair and swinging it towards staff at which point a restraint is initiated by Staff 1, Staff 2, Staff 3 and Staff 4. Nurse brings a pad to place under resident's head and Staff 5 arrives and is present but not involved in the restraint. Staff 1 (A/O 1) is holding the left arm of resident, resident is lying on her back. During this restraint, resident is turned over at which point Staff 1 is holding the right arm of resident. At no time is Staff 1 seen with her arms around resident's neck or head area. This hold lasts approximately 30 minutes. Resident is then let up; resident sets the head pad on a table and jumps on the back of the nurse present for the restraint. Another restraint is initiated by Staff 1, 2, 3 and 4 with Staff 6 assisting. Staff 5 present. At no time is Staff 1 seen with her arms around resident's neck or head area. This hold last approximately 25 minutes. Resident calms down without further incident.

Licensing Specialist observed interviews with Staff 3, 4 and 5.

Staff 3 stated that she had resident's legs and at no time during this restraint did she see any staff put their arms or hands around resident's neck or throat area.

Staff 4 stated that she was directly across from Staff 1 on resident's other arm and at no time during this restraint did she see any staff put their arms or hands around resident's neck or throat area.

Staff 5 stated that at no time during this restraint did she see any staff put their arms or hands around resident's neck or throat area.

Resident also claims that about 4 months ago Staff 7 was physically harmful during a restraint. There was one restraint involving this resident and Staff 7 on 1/22/25. Incident report and nursing note provided to licensing and reviewed. Incident report states that Staff 7 stepped in front of resident after verbal de-escalation attempts had failed during an episode, preventing her from leaving a room, at which point resident became combative and tried to push her way past Staff 7 by "pushing and scratching his arms". Resident continued to be combative and "caused herself and Staff 7 to fall forward to the floor", at which point Staff 7 "implemented the CPI-APS supine team position". Nursing note after restraint reviewed which states "none noted or voiced by client at this time, 0 physical signs of injury".

Licensing Standards reviewed:

**109.1g**-Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

**905.4g**-The following disciplinary actions shall not be used: Physical injury or threat of bodily harm

**905.9**-Physical restraints shall be performed using minimal force and time necessary. Physical restraint means the application of physical force without the use of any device for the purposes of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort or holding a hand to safety escort a child from one area to another, is not considered a physical restraint.

**905.10**-Physical restraint shall be initiated only by staff trained by a certified instructor in a nationally recognized curriculum, and only to prevent injury to the child, other people or property, and shall not be initiated solely as a form of discipline. The agency shall maintain documentation that staff is deemed competent in physical restraint.

Case#028892 has been investigated and determined to be **unfounded** as evidenced by: In video reviewed, restraints were initiated to prevent harm to the child, other people or property. Restraints viewed to use minimal force necessary and could not be viewed as physically harmful to child. No disciplinary action of physical injury or threat of bodily harm was used.

In documentation reviewed, restraint was initiated to prevent harm to the child, other people or property. Restraint could not be viewed as physically harmful to child. No disciplinary action of physical injury or threat of bodily harm was used.

**Provider Comments:**

CCL Staff Signature :

Date: 4/15/2025



Provider Signature :

Date: 4/15/2025

