Disability Rights Arkansas

# Arkansas Human Development Centers

## Incident Overviews - Video Coverage

**January 1st - June 30th**

# 2023

# BACKGROUND

The Arkansas Division of Developmental Disabilities Services (DDS) serves Arkansans with developmental disabilities and delays. As part of their responsibilities the division operates five human development centers (HDCs) within the state that are designed to serve Arkansans with "profound intellectual and developmental disabilities." These facilities are state operated intermediate care facilities (ICFs).

Per Arkansas DHS Policy 1090, DDS utilizes an incident reporting system to report "[i]ncidents that may affect the health and safety of Department of Human Services (DHS) clients, employees, volunteers, visitors and others on DHS premises or while receiving DHS services, and occurrences that interrupt or prevent the delivery of DHS services." Reports received through the incident reporting system are referred to as IRIS reports.

The Office of Long-Term Care (OLTC) investigates complaints against facilities, including the HDCs. IRIS Reports are a form of self-reporting that can trigger the initiation of an investigation.

# INTRODUCTION

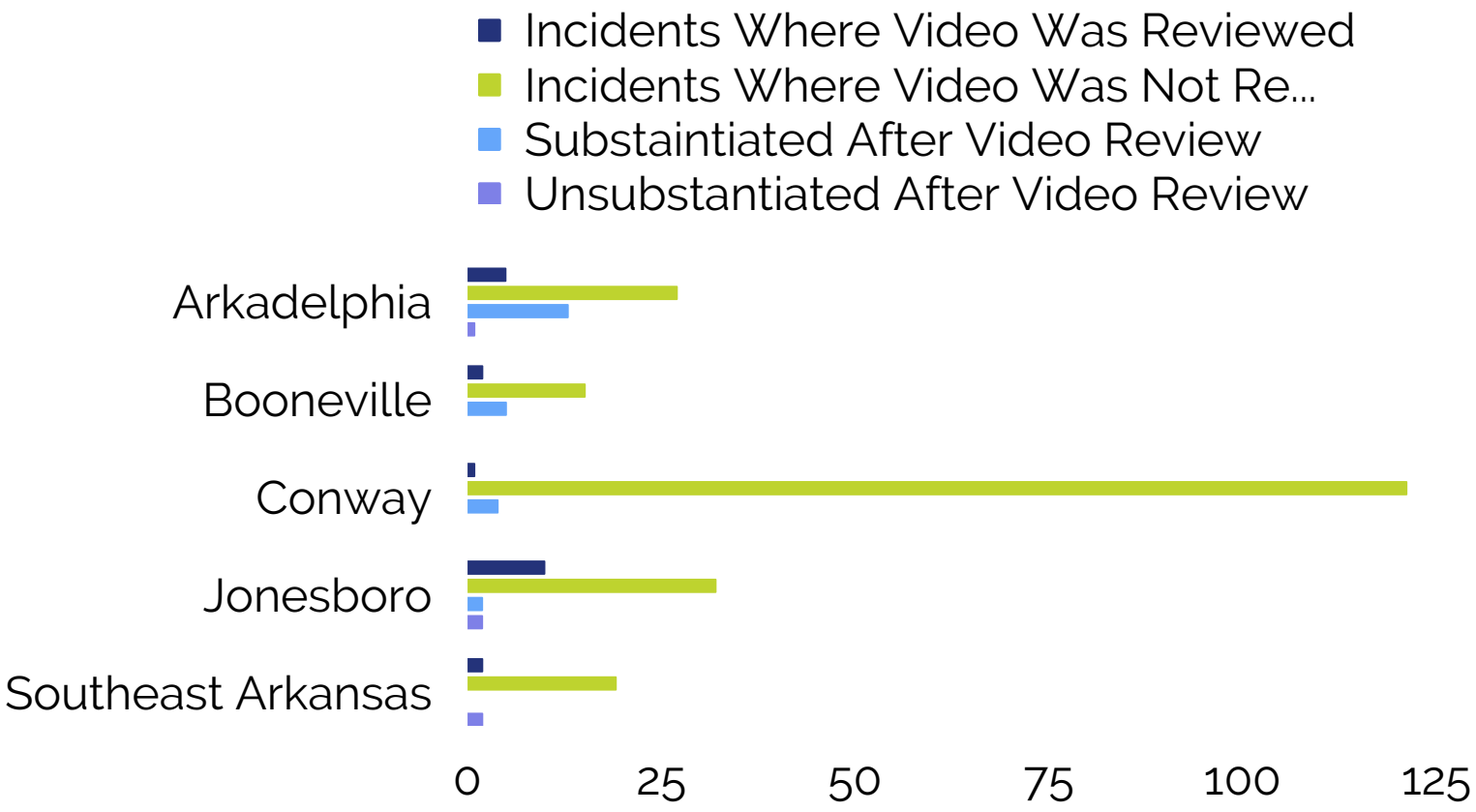
To develop a better understanding of what happens at the five HDCs in Arkansas (Arkadelphia, Conway, Booneville, Jonesboro, and Southeast Arkansas) we designed a mixed-methods analysis using Multiple Case Study methodology[1]. Each of the HDCs was treated as its own case and was first analyzed within its group and then between each of the other groups. Our data was collected from 242 IRIS reports spanning from January 1st, 2023 – June 30th, 2023. Average reporting metrics for each HDC was calculated at one fourth of the population meaning that for every four clients there is an average of one IRIS report (excluding Jonesboro which reported at an average of 0.16). Population size of each of the HDCs is similar with Conway HDC being the only outlier housing quadruple the number of clients (AHDC 101, BHDC 119 admitted 3 on respite, CHDC 429 admitted 9 on respite, JHDC 105 admitted 1 on respite, SEAHDC 89 admitted 3 on respite).[2] Analysis was conducted using the statistical software Dedoose. All IRIS reports were entered into Dedoose, coded, and then thematically analyzed.

# INCIDENT OVERVIEW

| | Arkadelphia | Jonesboro | Conway | Booneville | Southeast Arkansas |
|---|---|---|---|---|---|
| IRIS Report | 32 | 42 | 123 | 17 | 21 |
| Video In Use | 11 | 10 | 1 | 1 | 2 |
| Physical Maletreatement | 7 | 12 | 16 | 2 | 9 |
| Neglect | 2 | 4 | 3 | 0 | 4 |
| Failure to Intervene | 1 | 1 | 1 | 5 | 0 |
| Failure to Report/Failure to Timely Report | 3 | 0 | 0 | 5 | 3 |
| Client Injuries | 13 | 5 | 84 | 10 | 4 |
| Concussion/Head Injury | 4 | 1 | 32 | 0 | 0 |
| Fracture | 4 | 3 | 16 | 5 | 1 |
| Fall | 8 | 2 | 39 | 6 | 2 |
| Unknown Origin | 0 | 0 | 22 | 0 | 0 |
| Hit by Car | 0 | 0 | 0 | 1 | 0 |
| Staples Required | 2 | 0 | 17 | 0 | 0 |
| Stitches Required | 1 | 0 | 7 | 2 | 0 |
| Hospital Required | 14 | 15 | 36 | 7 | 5 |

The table above highlights the specific and significant points of the data collected. Colors of the boxes are based on a gradient with warmer colors reflecting higher counts and cooler colors reflecting lower counts. Of interest was the variety of incident types reported across the state. Specifically, there have been 116 injuries, 77 of which resulted in hospital visits this year alone. The table also highlights specific injuries that appear to be outliers, but remain notable, such as a client being hit by a staff member's car. However, after our initial data collection and analysis, a much larger issue presented itself; only a small number of incidents were investigated via video review. As we started to pay specific attention to this phenomenon, we noticed a positive correlation between incidents reviewed by video and substantiated incidents. This report highlights this phenomenon.

Using Dedoose analysis was conducted; from this analysis the theme of 'video surveillance' emerged as significant. After reviewing the corresponding codes and excerpts, we identified a common trend amongst all the HDCs; an exceedingly small portion of all incidents receive video review (only 9% of all incidents that occurred were reviewed by video across all HDCs). Of the incidents where video was reviewed 82.7% were substantiated.




This graph represents the number of incidents where video evidence was reviewed, the number of incidents where video evidence was not reviewed, the number of incidents that were substantiated after review of video evidence, and finally the number of incidents that were unsubstantiated after review of video evidence for each of the HDCs. A quick glance at the graph illuminates the shortcomings of the current processes regarding review of video evidence at the HDCs by highlighting the reality that for an overwhelming number of incidents video is either not captured or not reviewed.

# HDC VIDEO STATUS

Currently, the five HDCs do not have adequate video surveillance within the common areas in cottages, training areas, outdoor areas, and other buildings throughout the campuses.

The DDS Behavioral Consultation Committee published a report in May of 2021 that outlined the implementation status of recommendations made by the committee. One of the recommendations was to ensure video coverage in common areas in all HDCs or "install video cameras on campus." The status of camera installation for each HDC was listed as ongoing and detailed as follows:

- Booneville HDC - cameras being purchased, installation plan submitted for approval
- Arkadelphia HDC - cameras in place - planning to upgrade and increase coverage
- Conway HDC - cameras in place - planning to upgrade and increase coverage
- Jonesboro HDC - cameras in place - planning to upgrade and increase coverage
- Southeast Arkansas HDC - cameras in place - planning to upgrade and increase coverage

The report was re-released in April of 2022 and revised in January 2023. The status of installing video cameras and expanding coverage on each campus remained vague and unchanged in each subsequent report.

# IN SUPPORT OF VIDEO

The Centers for Medicare and Medicaid Services have acknowledged the role video cameras can play in "ensuring that the clients are free from physical, verbal, sexual or psychological abuse, mistreatment or punishment" and supported their use.[3] The national group, Voice of Reason, of which Arkansas' statewide parent-guardian association, Families & Friends of Care Facility Residents (FF-CFR) is an affiliate, has advocated for the use of video monitoring to protect facility clients.[4] They have also actively supported the creation of federal legislation that promotes the use of "cameras in common areas, entranceways, and vans or buses used to transport individuals" in order to "greatly decrease incidents and clarify the nature of incidents where a caregiver might be unjustly charged with abusing a client.[5]

Video footage, when available, has been vital in identifying and substantiating abuse and neglect, upholding maltreatment findings, and aiding in the prosecution of bad actors. As detailed below, the use of video footage is a vital component in corroborating maltreatment allegations at the HDCs. In the last six months, video footage has aided in substantiating maltreatment allegations against HDC staff at Arkadelphia, Booneville, Conway, and Jonesboro.

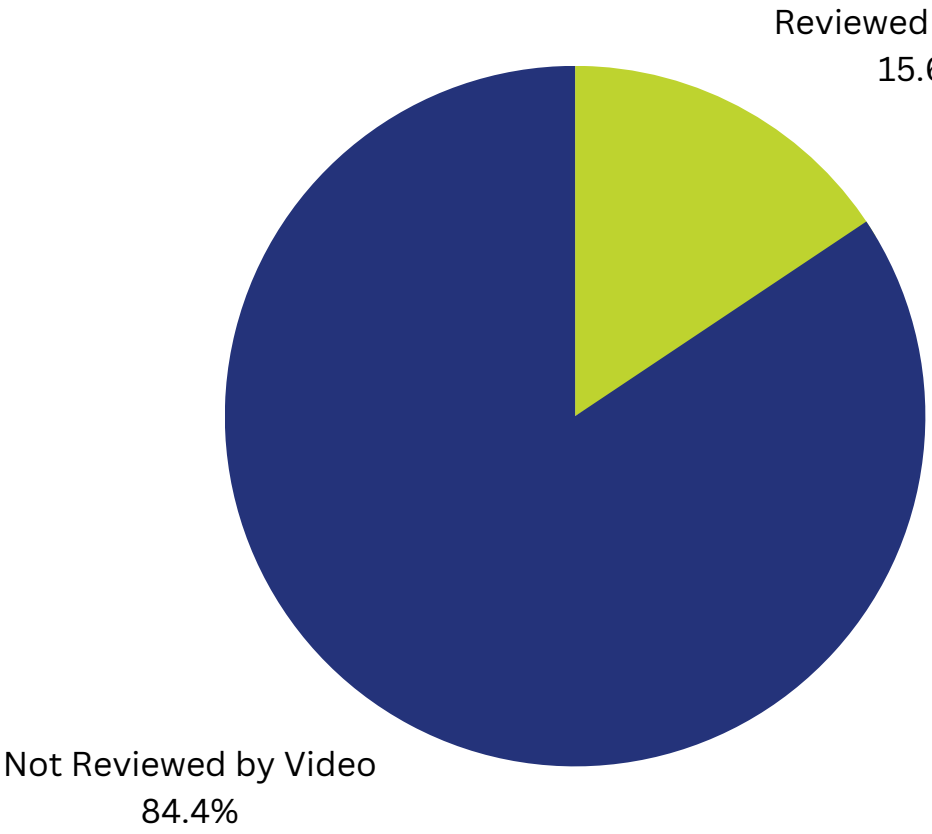
In five separate incidents it was found that multiple staff members failed to report incidents or wrote false and misleading statements regarding the incidents. Due to the availability of video footage, the four HDCs were able to substantiate allegations against 19 staff members that would have otherwise gone unpunished.

Video footage has also played a crucial role in maltreatment determinations and the upholding of maltreatment findings against long term care facility employees. In *Lewis v. Arkansas DHS*[6] the maltreatment determination against a former HDC employee was upheld, with the Arkansas Court of Appeals stating, "f]ollowing a review of the video footage, the ALJ found appellant's version of events unreliable. We agree...we affirm the administrative agency's finding that appellant committed adult maltreatment." In another case where the Court of Appeals upheld the maltreatment finding against a long term care facility employee, Snyder v. Arkansas DHS[7], the record indicates video review was instrumental, with the Circuit Court determining, based on video review, the action was “way out of line”.

The importance of video coverage and review in the HDCs cannot be overstated. It is necessary to  ensure the safety of clients and staff. As the incidents highlighted below show, identification and thorough review of incidents often depends on the availability of video footage.

In too many instances, staff beyond those directly implicated in abuse have been complicit in the actions of other staff and proven they could not be relied on to step in or report to protect the clients. Addressing the staff culture that contributes to the perpetrating and acceptance of abuse will no doubt require changes and resources beyond camera installation. While the existence of cameras coupled with regular, random review can act as a deterrent to would-be bad actors, their utility is largely in ensuring abuse is identified and addressed, not prevention.

**Full camera coverage in all common spaces cannot continue to be delayed.**




- During morning training a staff member reportedly attacked a client by pulling their jacket over their head, knocking the client to the ground, and hitting them with his fists resulting in multiple rib fractures.
    - Although, the incident occurred in a training area that was not covered by video, the client reporting his injury, other clients reporting the incident to staff and being threatened for doing so, the injured client visibly struggling to breathe, and the disregard for the client's well-being by nursing staff were all captured on video and able to be used to support maltreatment violations against seven staff members.

**Staff told client to shred or he would get in trouble leading to an altercation where staff pushed the client to the ground, pulled his jacket over his head and started punching him. Staff walked away while the client was still on the floor crying. The client later got himself off the floor and continued shredding paper.**

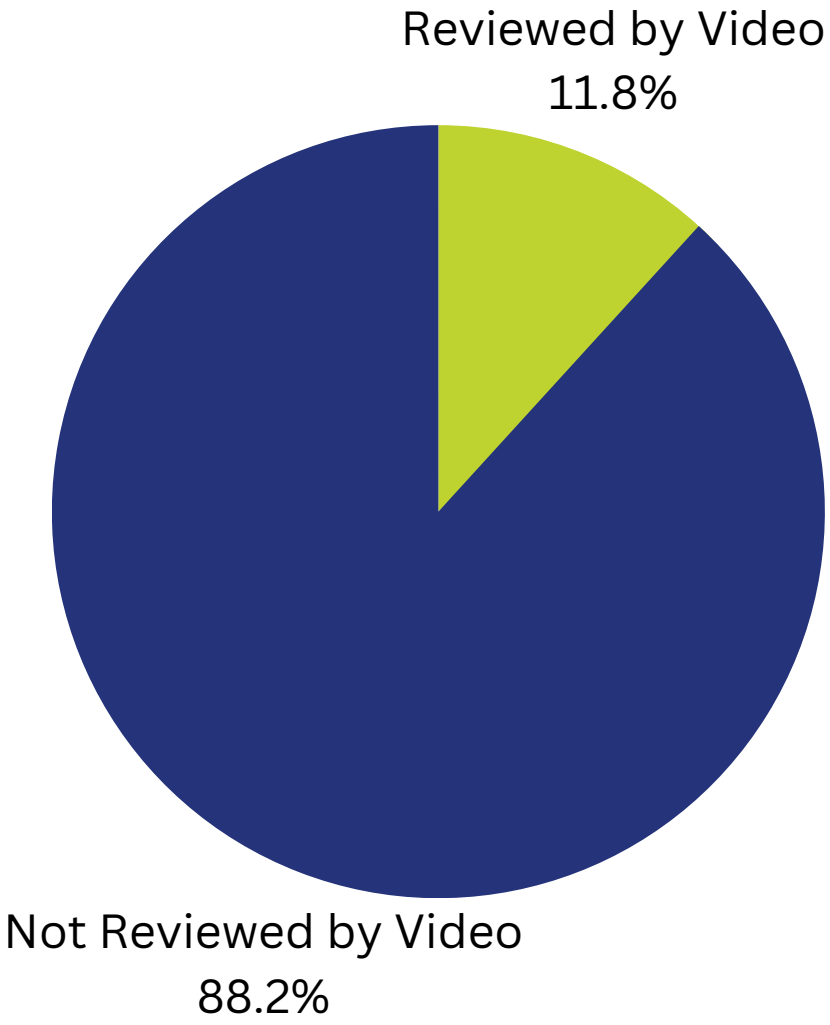
- Video identified and substantiated:
  - After being returned to the cottage and left alone inside, the client walked outside where a home staff member was sitting and stated that "they hurt him."
  - A separate client described the incident in detail to a home staff member who responded “I don’t care, I wasn’t down there, I don’t care.” A third client corroborated the staff member hitting the first client and stated that staff threatened to hurt them if they said anything.

**When clients attempted to report staff abuse the staff responded “I don’t care, I wasn’t down there, I don’t care” and threatened to tell the staff member allegations were being against.**

- Staff reported to nursing that "when he got up he was walking like this (visual provided on video) and...when he lays down, his breathing gets real short and he can't breathe. He sits up and he still hurts. Ain't something right.." LPN proceeded to tell client to "Stand up straight" and when client could not, the LPN grabbed the client by the shoulders and forced the client to straighten his shoulders. Client asked LPN to let him go and grimaced in pain.
- Client told a nurse that he was hurt by a staff member. The nurse grinned at client and stated “What are you looking at me for?”

**Staff member on video pulling client across the floor by the client's arms while saying "Everybody going to be gone except for [client]. I don't reward bad behavior. I'm not adding him to my group."**

- Video footage provided evidence of both physical and verbal maltreatment by a staff member towards one client. The video showed the staff member pull the client across the floor while making verbally abusive statements to the client. The same video provided evidence that another staff member failed to protect the client by failing to intervene and failing to report the physical abuse.
    - While reviewing the video, another incident was discovered in which the same staff member who pulled the client by the arms was captured on video at a later time physically maltreating a different client at a different time.



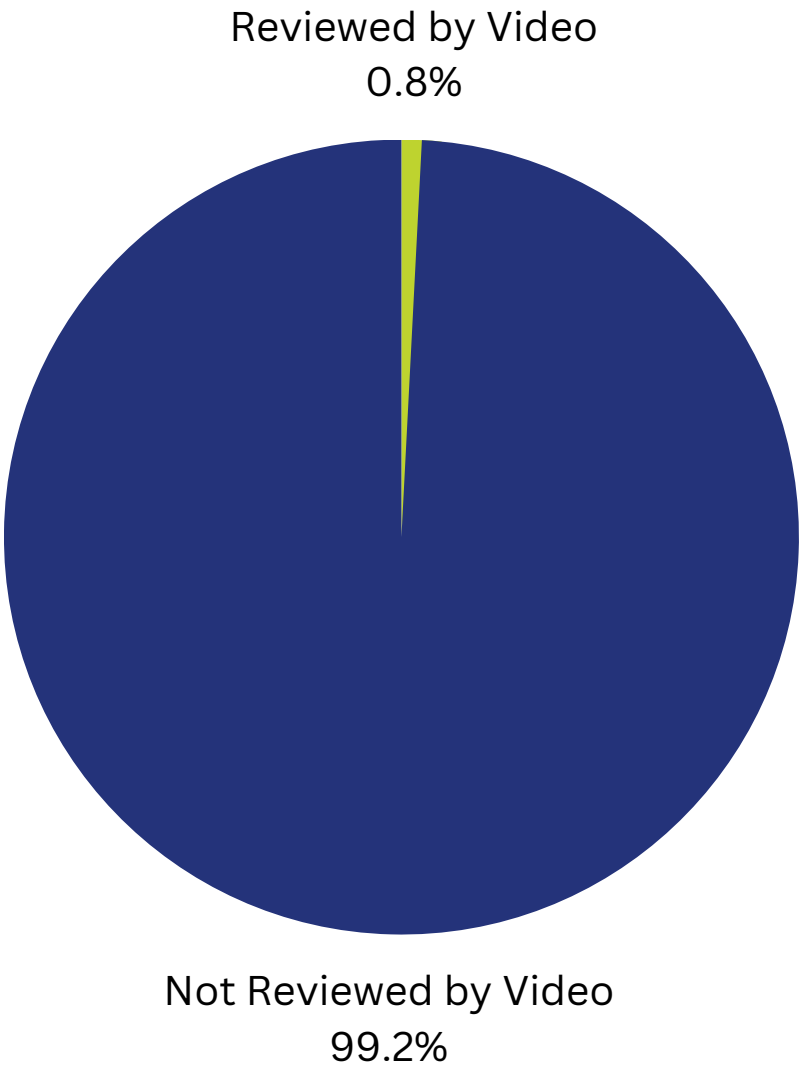

- Video footage provided evidence that five staff members physically maltreated, failed to intervene, and failed to report an incident against a client.
    - The client complained that a staff member threatened to put snakes in her bed. Investigation into the allegation identified a behavior report indicating an emergency personal hold had been used the previous night in response to "aggressive behaviors."

- When the video was reviewed the footage showed staff placing the client in a chokehold face down on the table, dragging the client by her arms and legs down the hallway, and four staff entering the client's room and closing the door behind them.

**"[Staff] did not follow trained methods of de-escalation, emergency personal hold, or mechanical restraints. [Staff] removed [the client's] eyewear in anticipation for a struggle."**

- Staff witnessed client walking along street to training building. While client was standing on grassy area on the right side of the street, another staff member drove past and grazed the client with the passenger window.

**"[Staff] held [the client] inappropriately with a choke hold around [the client's] neck with her torso on the table face down."**



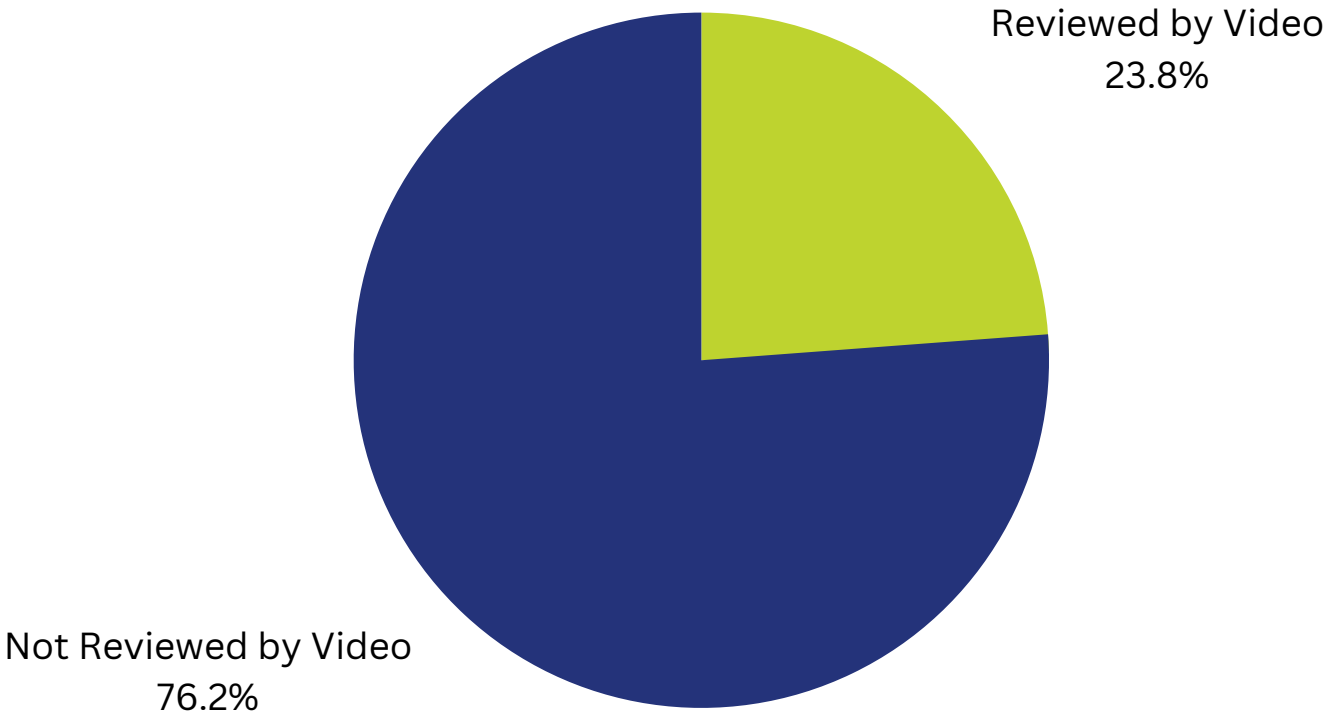

- Staff witnessed another staff member drag a client by the arm across the floor and curse at the client. The incident was substantiated by CHDC. However, due to lack of evidence which includes no video footage and conflicting witness statements, criminal charges were not able to be pursued.

## Video footage contradicted written statements of four staff involved in incident that involved dragging a client by the arms and legs.

- Video footage contradicted staff statements and provided evidence of an incident in which four staff members physically maltreated and neglected a client, resulting in substantiated maltreatment violations against all four.
    - Video footage showed a staff member dragging the client off of the couch. Another staff member joins in and the two staff members drag the client by the legs to the client's bedroom while two other staff members observed the incident but fail to intervene.

## Video evidence showed staff dragging client off couch to bedroom.

- The Conway Police Department closed an investigation pending the availability of video evidence related to the discovery of a "white powdery substance" on the campus.



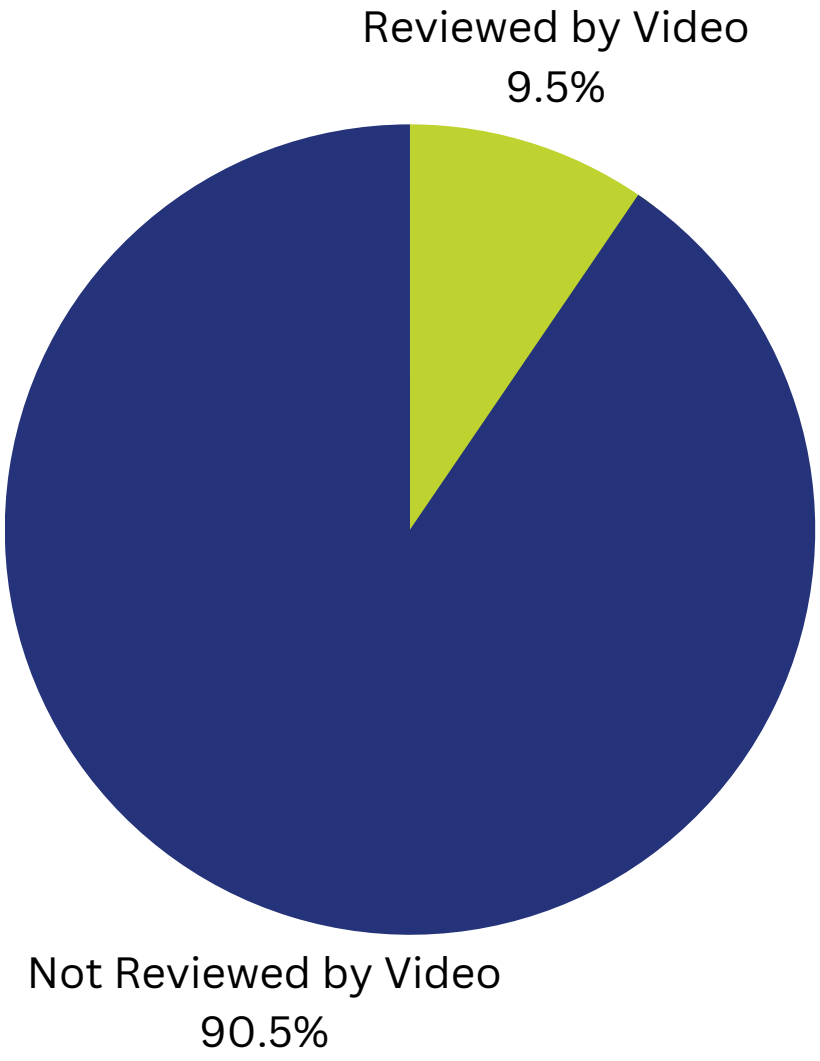

- Staff member pushed and held a client's head back, hit a client with a water bottle, and pushed the client, who was using a walker, from behind causing the client to fall and fracture their foot. Staff's actions were discovered by a review of video footage.
    - This staff member was previously investigated for posting a video of a client to a personal social media site. The allegation was confirmed, however the maltreatment was unsubstantiated because the video did not identify the client and it was "not confirmed [staff member] purposefully violated maltreatment standards by posting the video of a client on social media."

**Staff "push[ed] him and his walker from behind as he went toward the door, causing him to fall."**

**Staff antagonized client by saying "ha ha ha, shut up, this is why you are getting your helmet on" and telling him "that is what you get."**

- Staff encouraged a client to hit another client during a behavioral episode. The report states the staff member was heard “saying ‘you need to turn him [other client] so he can hit [client]’ and ‘get him, get him, get him’ when [other client] was hitting [client]. [The staff member] also antagonized [client] by saying ‘ha ha ha, shut up, this is why you are getting your helmet on’ and telling him ‘that is what you get.’” Staff member was terminated from employment. The IRIS report does not confirm video was used in the investigation, but by using direct quotes it is assumed video was used to confirm the incident.

**A staff member was heard “saying ‘you need to turn him [other client] so he can hit [client]’ and ‘get him, get him, get him’ when [other client] was hitting [client].**




- Video footage along with staff interviews were used to unsubstantiate an anonymous complaint to OLTC that alleged a client had undocumented marks and was being placed in unauthorized restraints.

- Video footage along with staff interviews were used to unsubstantiate an allegation of sexual maltreatment against a staff member.

- Staff member tied a client to a chair with a belt. Prior to illegally restraining the client, the staff member pushed the client to the sofa on at least three occasions and made “demonstrably untrue and misleading statements during the investigation.” Staff witness statement said “I saw [staff] slapping [client] and I told her she can’t be putting her hand on the clients, she said that [the client] kicked her... I told her that don’t matter and... I told her this ain’t the job for her if she can’t take a lick from a client.”

**"Staff member tied a client to a chair with a belt."**

# ENDNOTES


1. Stake, R. E. (2015). Multiple case study analysis. The Guilford Press.
2. Population numbers are based on the March 2023 DDS Board Report.
3. Hamilton, T. E. (2020, July 20). *The use of video cameras in common areas in intermediate care facilities for The mentally retarded (ICFS/MR): Guidance portal.* U.S. Department of Health & Human Services Guidance Portal. https://www.hhs.gov/guidance/document/use-video-cameras-common-areas-intermediate-care-facilities-mentally-retarded-icfsmr
4. A Voice of Reason. (2023, June 10). *VOR Facebook Post*. Facebook. https://www.facebook.com/people/VOR/100064300855240/
5. A Voice of Reason. (n.d.). *VOR's 2023 legislative requests*. A Voice of Reason. https://www.vor.net/images/stories/2022-2023/VOR_2023_Legislative_Initiative.pdf
6. *Lewis v. Arkansas Dep't of Hum. Servs.*, *Div. of Med. Servs.*, *Off. of Long Term Care*, 2021 Ark. App. 317, 8 (2021).
7. *Snyder v. Arkansas Dep't of Hum. Servs.*, *Div. of Med. Servs.*, *Off. of Long-Term Care*, 2018 Ark. App. 473, 7, 559 S.W.3d 771, 776 (2018).