



Division of Child Care & Early Childhood Education
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Corrective Action Agreement

Date: February 18, 2022
To: Charlotte Lockhart
Owner Name: Woodbridge Behavioral Care of Forrest City, LLC
Facility Name: Perimeter Behavioral of Forrest City
License #: 142

Ms. Lockhart,

This document constitutes a formal Corrective Action Agreement (CAA) agreed upon by Perimeter Behavioral of Forrest City and the Department of Human Services, Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. Due to the need for additional support, the CAA agreed upon on 7/19/2021, **will be extended to 4/19/2022.** This agreement may be extended beyond six months should DHS determine any non-compliance with the CAA during the stated corrective action period.

The purpose of this agreement is to gain and maintain a high degree of compliance with licensing requirements. The following non-compliance areas have been cited during the past six months:

Minimum Licensing Standards (Residential): Section 911 - Buildings

911.6 All buildings and furnishings shall be safe, clean, and in good repair.

- **Perimeter Behavioral of Forrest City has been cited or given technical assistance on the following dates regarding the condition of the facility.**

- **9/20/2021-**
 - Wire found that could be used for self-harm
 - Room in SRU unit had door in which wood was coming apart and could be a potential safety hazard.
 - Floor tiles in the seclusion room are coming up and need to be repaired
 - Baseboard and trim off the wall by the closet had nails sticking out of the wall.
 - Wire outside on the electrical pole is fraying and needs to be repaired by the electric company.

- **10/4/2021-**
 - Large hole in wall of room 103. Bedroom is dirty with clothes and trash on the floor of room 403.
 - Screws sticking out of beds in rooms 102 and 407.

- **11/10/2021-** Bathroom toilet curtain had brown splatter across it. Bathroom smells strongly of urine.

- **11/23/2021-**
 - A/C unit screen is detached from the wall.
 - Sink in the bathroom is missing a screw and completely detached from the wall.
 - Light switch cover is missing in room 104 showing exposed wires.

- **12/16/2021-** A/C unit is detached from the wall in room 305 and magnetic lock on the outer 300 hall door is busted off exposing wires.

- **1/7/2022-** A/C unit detached leading to a resident needing emergency medical care after cutting his hand.

The facility has made several repairs to the building and grounds through the course of the CAA including repairing the broken air conditioning units to working order, reinforcing exit doors with a second magnetic lock, extending fencing around the perimeter of the recreation areas, installing new cameras throughout the facility, and acquiring new beds for the residents.

Minimum Licensing Standards (Residential): Section 908 Health and Medical

908.8- The administering of all medications, including over the counter, shall be logged at the time the medication is given, by the person administering the medication.

- **Perimeter Behavioral has received citations on the following dates regarding the improper documentation of medication distribution to the residents.**
 - **8/19/2021-** Medications Clonidine and Buspar were not marked as given to the IC (Involved Child) on 8/18/21.
 - **8/31/2021-**Chart review and a check on Nurse's station 1 showed multiple missing initials for medication administration to several residents.
 - **10/4/2021-** Medications not marked as given for two residents on the night of 10/3/2021.
 - **11/10/2021-** Medication logs prefilled prior to the medication being administered to the residents.
 - **12/16/2021-** Medication logs prefilled prior to the medication being administered to the residents.

Minimum Licensing Standards (Residential): Section 907 Ratio and Supervision

907.2- Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

- **Perimeter Behavioral has received citations on the following dates regarding ratio and supervision concerns.**

- **7/23/2021-**
 - Staff failed to provide the level of supervision and care necessary to ensure the safety and wellbeing of the resident.
 - Staff was out of ratio with the residents at the time of the incident.
- **9/15/2021-** Staff failed to provide the level of supervision and care necessary to ensure the safety and wellbeing of the resident.
- **11/10/2021-** Staff left a resident on the hall for 34 minutes unattended as the resident was sleeping.

The agency is required to complete the following:

- The facility management shall continue to conduct a minimum of once per week walkthroughs of the agency to determine what repairs need immediate attention. These repairs shall be documented and sent to the Licensing Specialist monthly.
- The agency shall provide education to their nursing department to ensure all nursing staff understand how to properly document medication administration and that it must be documented at the time it is administered. Additionally, the Director of Nursing will continue weekly audits of MARs to ensure medication distribution has been documented properly. Documentation that all nurses, including contracted or pool nurses, have been trained will be provided to the Licensing Specialist. Completed on 2/17/2022 via DON.
- The agency shall conduct a minimum of ten random video checks throughout each month to ensure ratio and appropriate supervision are being maintained by staff. These checks shall be documented and provided to the Licensing Unit with their findings monthly.
- The agency is encouraged to research and develop a plan to address programming weaknesses in an effort to decrease the number of altercations between residents. If programming changes are made, the agency shall update the Licensing Specialist at that time.
- The agency shall only take new admissions at a rate that ensures the required staff-to-resident ratios are maintained.

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication.

Please be advised that any serious non-compliance cited during this corrective action period may result in a recommendation for adverse action on the license. Any serious violation of this corrective action plan will result in recommendation for adverse action on the license.

Please do not hesitate to contact the Placement and Residential Licensing Unit if you have any questions or concerns regarding ongoing compliance with this agreement or any other licensing requirement.

The signature of the licensee constitutes full acceptance of the provisions of this agreement.

Charlotte Dockhart, CEO
Owner/ Administrator/Agency Representative

2-22-22
Date

Chelsea Vardell
Licensing Specialist

2/22/22
Date

Sharra Singleton-Litzsey
Program Manager

2/22/2022
Date