

Arkansas Department of Human Services
Division of Child Care and Early Childhood Education
P.O. Box 1437, Slot S140 - Little Rock, AR 72203-1437
501-682-8590 - Fax: 501-683-6060 - TDD: 501-682-1550

521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City
Licensee Address: 603 KITTLE ROAD FORREST CITY, AR 72335
Licensing Specialist: Chelsea Vardell **Person In Charge:** Charlotte Lockhart
Monitor Visit Date: 7/7/2021
Purpose of Visit: Residential Non-Standard Review

Regulations Out of Compliance:

No regulations out of compliance.

Regulations Needing Technical Assistance:

No regulations needing technical assistance.

Regulations Not Correctable:

Regulation	Discussion/Observation
R109.1.g	Staff [REDACTED] acted unprofessionally and participated in behavior that can be seen as endangering and exploitative. Staff was terminated from employment on 7/5/21.

Narrative:

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Regulations Needing Technical Assistance:

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Regulations Not Correctable:

Regulation	Discussion/Observation
R905.4.g	Staff [REDACTED] was suspended pending [REDACTED] and then terminated from employment on 7/7/21

Narrative:

Licensing Specialist discussed incident report from [REDACTED]/21 involving staff [REDACTED] and resident [REDACTED]. Licensing Specialist reviewed camera footage of incident. Staff [REDACTED] can be seen attempting to take an object from resident [REDACTED] hand. [REDACTED] then directs him to his room down the hall at which point he knocks over a water cooler. [REDACTED] can then be seen forcibly shoving the resident into his room as she continues to charge into the room. There is no video of what occurred when she enters the room, but several staff immediately entered the room and removed [REDACTED] from the area.

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Regulations Not Correctable:

Regulation	Discussion/Observation
R905.9	Staff [REDACTED] did not use minimal force when conducting an improper restraint hold on resident [REDACTED] on [REDACTED]/21.
R907.3	Staff was out of ratio 1:7 prior to the incident per camera footage. [REDACTED] was assigned to this room, but left his post.
R905.4.g	

Narrative:

Licensing Specialist discussed the incident report from [REDACTED]/21 involving staff [REDACTED] and resident [REDACTED].

Licensing specialist reviewed the camera footage from the incident. Footage shows the dayroom as calm, but staff [REDACTED] was out of ratio 1:7. Suddenly, [REDACTED] enters the room and jumps into resident [REDACTED] face. [REDACTED] reacts suddenly by throwing his lunch tray which hits [REDACTED] in the face. [REDACTED] then grabs the resident and flings him around and forcibly on the ground. Resident [REDACTED] is not fighting back. Other staff, [REDACTED], does not assist. A third staff member enters the room to clear out other residents. Nursing enters the room, but does not assess the resident. After several minutes, the resident was let up and de-escalates speaking to other staff.

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Regulations Needing Technical Assistance:

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Regulations Not Correctable:

Regulation	Discussion/Observation
R905.10	Staff [REDACTED] violated this standard when he placed resident [REDACTED] in a restraint hold in effort to solely gain his compliance.

Narrative:

Licensing Specialist discussed incident involving staff [REDACTED] with resident [REDACTED]
No video footage of the incident is available so the specialist spoke to resident [REDACTED]