Letter of Reprimand

Perimeter Behavioral of Forrest City (Woodridge Behavioral Care of Forrest City, LLC) 1521 Albert St. Forrest City, AR 72335

May 2, 2022

Dear Ms. Charlotte Lockhart,

On April 27th, 2022, the Division of Child Care and Early Childhood Education recommended to the Child Welfare Agency Review Board that a Letter of Reprimand be issued to Perimeter Behavioral of Forrest City based on noncompliance of the Minimum Licensing Standards. The Child Welfare Agency Review Board unanimously voted to issue this letter. The authority for the Board to grant a Letter of Reprimand is listed within the License Status Section of the <u>Minimum Licensing Standards for</u> <u>Residential Facilities</u>. It states, "The Board shall have the power to deny an application to operate a child welfare agency or to revoke or suspend a previously issued license. The Board may also issue Letters of Reprimand or Caution to a child welfare agency." The Division of Child Care and Early Childhood Education will provide status updates to the Board regarding this matter per the Board's request.

The agency has failed to maintain substantial compliance with Minimum Licensing Standards. Areas of concern are centered around Buildings/Grounds, Behavior Management, Ratio/Supervision, and Unprofessional Conduct. This lack of sustained compliance has resulted in a Corrective Action Agreement (CAA) placed on the agency. The original CAA began in July 2021 and is still in effect. If the Agency does not substantially comply with the CAA, a Probationary License may be issued by the Child Welfare Agency Review Board. A Probationary License may be issued to an agency that has not maintained compliance with Minimum Licensing Standards, but that the Board believes that compliance can be restored and subsequently maintained. This license maybe issued for up to one (1) year, at the discretion of the Board. (Arkansas Code Annotated §9-28-401, Minimum Licensing Standards for Child Welfare Agencies).

The attached CAA reflects the excessive citations and lack of sustained compliance at Perimeter Behavioral of Forrest City. Because of this, youth are not receiving the required care as intended by the Minimum Licensing Requirements.

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The Child Welfare Agency Review Board does acknowledge the efforts Perimeter Behavioral of Forrest City is making to meet the CAA. Efforts to correct and sustain those improvements can be a huge undertaking and we understand that retraining staff does take time. Reducing new intakes to ensure staff are properly trained and hiring additional management to work the evening shift might also serve to improve your CAA efforts and foster sustainment of the work you are doing to meet licensing requirements.

Regards,

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William A. (Andy) Altom Chairman of Child Welfare Agency Review Board

Cc: Tonya William-Division Director Dawn Jeffery, Assistant Director Michelle Bridges-Bell, OCC Attorney Division Administrative Staff

Recommendation of Letter of Reprimand

Perimeter Behavioral of Forrest City (Woodridge Behavioral Care of Forrest City, LLC)

1521 Albert St

Forrest City, AR 72335

April 27, 2022

Facility Background:

Licensed Psychiatric Residential Treatment Facility and Sexual Rehabilitative Program

PRTF Capacity: 66

Date Licensed: November 18, 2008

Recommendation:

The Placement and Residential Licensing Unit recommends a Letter of Reprimand for continued failure to comply with the Minimum Licensing Requirements in the areas of Behavior Management, Ratio & Supervision and Inspections, Investigations & Corrective Action. The Board shall have the power to deny an application to operate a child welfare agency or to revoke or suspend a previously issued license to operate a child welfare agency. The Board may also issue letters of reprimand or caution to a child welfare agency. If the agency does not substantially comply with the Minimum Licensing Standards, a Probationary License may be issued by the Child Welfare Agency Review Board. A Probationary License may be issued to an agency that has not maintained compliance with Minimum Licensing Standards, but the Board believes that compliance can be restored and subsequently maintained. The license may be issued for up to one (1) year, at the discretion of the Board. (§ 9-28-401, Minimum Licensing Requirements for Child Welfare Agencies).

Section 905.4 – Behavior Management states, "The following actions shall not be used, including as discipline: (C) Lewd or obscene language, (G) Physical injury or threat of bodily harm, 905.9 states "Physical restraints shall be performed using minimal force and time necessary..." 905.10 states "Physical restraints 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..." There have been eight citations issued to the facility for failure to comply with Behavior Management Minimum Licensing requirements since September of 2021.

We Care. We Act. We Change Lives. humanservices.arkansas.gov Section **907.2** and **1007.2** – Ratio & Supervision states, "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". **907.3** states "Staff/child ratio shall be at least 1:6 during waking hours and 1:8 during sleeping hours." There have been ten citations issued to the facility for failure to comply with Ratio and Supervision Minimum Licensing requirements since September of 2021 that have resulted in elopements and residents being physically harmed.

Section **109.1g**- Unprofessional Conduct states "Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following: **(G)** Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children." There have been three citations issued for failure to comply with Unprofessional Conduct Minimum Licensing requirements in April 2022.

The Licensing Unit met with the Administrators of this agency to discuss the increased number of incidents/complaints resulting in injuries, elopements, sexual activity amongst peers and inappropriate behavior guidance. The agency has retrained staff, but incidents have continued to occur. In response, the Licensing Unit extended the original Corrective Action Agreement that ended on 1/19/22 for an additional three months. During the extension, reports were received of inappropriate behavior guidance, supervision concerns, and inappropriate use of behavior management techniques. A meeting was then conducted with the Licensing Unit and Perimeter Behavioral of Forrest City. During the meeting, suggestions were provided by the Licensing Unit including reducing new admissions, designating a program consultant for difficult situations, adding a high-level employee to the evening shift, and following up after restraints to discuss different techniques. However, a Formal Corrective Action Agreement no longer presents as a sufficient solution due to the continued lack of compliance recorded during the extension of the original Formal Corrective Action Agreement. Therefore, the Licensing Unit is submitting this information as a formal recommendation for a Letter of Reprimand to be issued to Perimeter Behavioral of Forrest City, (LLC).

Compliance History:

9/13/2021 Complaint:

1007.2- A lack of supervision, which allowed clients to engage in non-consensual sexual activity in the bedroom.

11/7/2021 Incident:

1007.2 – A lack of supervision, which allowed a resident to remain on his unit alone for 34 minutes.

11/14/2021 Complaint:

905.10 – Staff preformed an unnecessary physical restraint hold on a resident who was not a danger to himself, others, or property.

11/14/2021 Complaint:

> 907.2 – Resident eloped through a gate that was left unlocked by staff.

1/14/2022 Complaint:

- 907.2 Camera review showed staff were not providing the level of care, supervision, and treatment necessary to ensure the safety and well-being of the residents at the time of the alleged peer on peer sexual abuse complaint occurred.
- 907.3 Camera review showed staff out of ratio during the time the alleged peer on peer sexual abuse complaint occurred.

2/28/2022 Incident:

907.2 –Staff failed to provide the level of supervision necessary to ensure the safety of a resident who snuck off his unit, hid in the restroom, and eloped from the facility.

2/28/2022 Incident:

> 907.3 – Staff were not in ratio at the time of a resident elopement.

3/2/2022 Complaint:

1007.2 – Staff failed to provide the level of supervision, care, and treatment necessary to ensure the şafety and well-being of a resident who was attacked by a peer resulting in the resident requiring staples for a head wound at the local emergency department.

3/31/2022 Incident:

905.4.c – During a facility walkthrough, the facility Quality Risk Director and the Licensing Specialist overheard a staff using profanity when reprimanding a resident for not following instructions.

4/5/2022 Complaint:

- 109.1.g Staff engaged in behavior that was physically harmful to the resident. Staff physically body slammed the resident to the pavement and began to physically fight the resident resulting in additional staff intervention to keep the resident safe.
- 905.4.c Staff statements report that involved staff used profanity towards a resident during a restraint hold.

905.4.g – Staff used physical injury as a form of behavior management when he physically body slammed the resident to the ground, then proceeded to attempt to punch/attack the resident on the ground.

4/7/2022 Complaint:

- 109.1.g Staff engaged in behavior that could be physically harmful to children when they pulled a resident out from under his bed and drug him by the hood of his hoodie down a hallway and to the nurse's station.
- 110.9 12 staff that witnessed the incident did not report the event to the Arkansas Child Abuse Hotline.
- 905.9 Staff did not use the minimal force necessary when attempting to escort a resident to the nurse's station.
- 905.10- Staff preformed a restraint hold on a resident who was not a danger to himself, others, or property when they drug him out from under his bed, down a hallway, and to the nurse's station by his clothing and leg.

4/17/2022 Incident:

- 907.2 –Staff failed to provide the level of supervision necessary to ensure the safety of four residents who eloped from their unit after staff left them unattended to respond to an acting out resident on another unit. The four unattended youth used a staff key card they were in possession of after staff failed to report the missing key card to management. Additionally, staff were unaware of the elopement for approximately 42 minutes when the local fire department contacted the agency to inform them of a resident who was "jumping in their driveway".
- 907.3- Staff was not in ratio at the time of the elopements of four residents left unattended on their unit.

4/18/2022 Complaint:

- 109.1.g Staff engaged in behavior that could be physically harmful to children when they put their arm around a resident's chest/neck area multiple times in attempt to forcibly redirect him.
- 905.9 Staff did not use the minimal force necessary when redirecting a resident who was flipping a light switch on and off.
 905.10– Staff restrained a resident who was not a danger to himself, others, or property when she placed her arm around the resident's chest/neck area multiples times to forcibly redirect him.

7/19/2021 Corrective Action Plan: Based on the following regulations

905.4.g The following actions shall not be used, including as discipline: (g) 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 safely escort a child from one area to another, is not considered a physical restraint.
- > 911.6 All buildings and furnishings shall be safe, clean, and in good repair.

2/18/2022 Corrective Action Plan Extension: Based on the following regulations

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

Chelsea Vardell, Program Coordinator

04/27/2022

04/27/2022

Date

Sharra Singleton-Litzee

Sharra Litzsey, Placement and Residential Program Manager Date

Cc: Tonya Williams, Division Director

Dawn Jeffery, Assistant Director

Michelle Bridges-Bell, OCC Attorney

Division Administrative Staff