Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S150, Little Rock, AR 72203-1437
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Recommendation of Probationary License

Perimeter Behavioral of the Ozarks (Woodridge Northwest, LLC)

License Number 237

2466 S. 48th St.

Springdale, AR 72766

10/26/2022

Facility Background:

Licensed Psychiatric Residential Treatment Facility

Date Licensed: April 26, 2016

PRTF Capacity: 32

Current Residents: 29

Arkansas Residents 19

DCFS Residents 6

Out of State Residents 10

Recommendation:

The Placement and Residential Licensing Unit recommends a probationary license for continued failure to comply with the Minimum Licensing Requirements in the following areas: Central Registry and Criminal Record Checks, Unprofessional Conduct, Inspections, Investigations & Corrective Action, Behavior Management, and Ratio & Supervision. Perimeter Behavioral of the Ozarks was placed on a Formal Corrective Action Agreement on June 9th, 2022. Since that time incidents have continued to occur. There have been serious concerns regarding unprofessional conduct and maltreatment responses that have developed during the course of the Formal Corrective Action Agreement. The Formal Corrective Action Agreement no longer presents as a sufficient solution due to the serious nature of the citations being issued to the facility. Therefore, the Licensing Unit is submitting this information as a formal recommendation for a Probationary License to be issued to Perimeter Behavioral of the Ozarks (Woodridge Northwest, LLC) effective immediately.

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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).

Perimeter Behavior of the Ozarks has had numerous and severe deficiencies putting children at risk. Their Corrective Action and severe deficiencies are described below.

The Formal Corrective Action Agreement dated June 9th 2022, was based on the following:

Section 103.8 - Child Maltreatment Central Registry Checks and Arkansas State Police/FBI Criminal Record Checks shall be initiated within ten (10) days of employment.

Section 103.11- No person guilty of an excluded criminal offense pursuant to A.C.A. §9-28-409 shall be permitted to have direct and unsupervised contact with children, except as provided in the statute.

Section 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.

Section 907.3- Staff to child ratio shall be at least one to six (1:6) during waking hours and one to eight (1:8) during sleeping hours.

Section 910.1- The grounds of the facility shall be kept clean and free of safety hazards.

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

Section 911.15.f- Areas used by children shall be designed, constructed, and furnished to reduce risk of suicide and assault including without limitation: (f) Children's personal items that contain cords, pull-ties, strings, or other parts that could be used to inflict self-injury shall not be left in the child's room unless the dangerous component has been removed.

Section 912.4-The bathroom shall be clean and sanitary.

While on the Corrective Action the following licensing requirements have been violated.

Section 109.1.g- **Unprofessional Conduct states-** "Unprofessional conduct in the practice of child welfare activities shall include without limitation: (g) Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children." **110.9- "**Any owner, operator, employee, foster parent, or volunteer in a child welfare agency shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has (a) Been subjected to child

maltreatment (b) Died as a result of child maltreatment (c) If they observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment." **110.12**- "The agency shall notify the Licensing Unit by the next business day when a report of child maltreatment is accepted by the child abuse hotline against the owner, operator, employee, foster parent, volunteer, child, or other person in a child welfare agency." **110.14**- "The agency shall take steps to prevent harm or retaliation against the child while an allegation of child maltreatment is being investigated."

Section 905.4 – Behavior Management states- "The following actions shall not be used, including as discipline: (d) Derogatory comments about the child, the child's family, race, or gender". **905.9** states "Physical restraints shall be performed using minimal force and time necessary..."

Section 907.3 – Ratio & Supervision states- 907.3 states "Staff/child ratio shall be at least 1:6 during waking hours and 1:8 during sleeping hours."

Compliance History:

6/20/2022 Complaint Founded: Licensing received notification from the agency that they had terminated a staff member after she acted unprofessionally towards a resident. The agency reported that a staff member was angry with a resident [redacted] The staff then told the resident, in front of Perimeter staff and residents, she could not believe she "told on" the alleged offender and she "got him fired". The witnessing staff stated that the staff went on to say that the resident has "touched my butt and my Yooha". The agency was cited for the following regulations:

- **109.1.g-** [redacted].
- **905.4.d-** [redacted].
- **110.14-** [redacted].

6/22/2022 Monitor Visit: During a buildings and grounds walkthrough, residents were seen out of ratio with staff 1:8. The agency was cited for the following regulation:

- **907.3** – Staff seen out of ratio with residents on the Green Hall Unit 1:8.

7/13/2022 Placement and Residential licensing staff provided an Intent Training regarding to the facility on section 900 of Minimum Licensing standards. All staff were not able to attend at once, so the meeting was recorded and intended to be showed to all other unavailable staff by management along with any new hires moving forward. Seventeen staff attended the intent training with Licensing.

7/20/2022 Monitor Visit: During a buildings and grounds walkthrough, the bathroom by the seclusion room was seen to be dirty, potential ligatures were in rooms 301, 302, and 303. Children's records were

reviewed for three residents and found that a treatment plan was not created within 30 days of admission for one resident, and no birth certificates or attempts to receive them were documented for two residents. The agency was cited for the following regulations:

- **911.15.f-** Ligatures were found in rooms 301, 302, and 303.
- **912.4-** Bathroom by seclusion room was dirty.
- **902.13-** Birth certificates or documentation of attempts to receive them were not in the chart for two residents.
- **903.4-**Treatment plan was not developed within 30 days of admission.

8/3/2022 Monitor Visit: During a record review, five personnel and two children records were reviewed. The agency was cited for the following regulations**:**

- **105.15.a**- Staff did not have verification of qualifications in the personnel file.
- **105**.15.g-Four staff did not have references in their personnel files.
- **903**.4- Resident treatment plan was not developed within 30 days of admission.

8/12/2022 Incident Citation: The agency failed to report an incident in which a resident began attempting to self-harm and harm staff. The police were called to the agency and the resident was arrested on 7/31/22 for verbally and physically being aggressive to staff. Licensing did not receive notification of the arrest of the resident until 8/8/2022. The agency was cited for the following regulation:

- **110.17-** Agency failed to report the arrest of a resident by the next business day.

8/12/2022 Complaint Citation: On 8/10/22 [redacted] The agency was cited for the following regulation:

- **110.12-** [redacted]

8/16/2022 Monitor Visit/Complaint Visit: The licensing specialist completed a file review and buildings/grounds walkthrough. The specialist also ensured the ICA was being followed. No licensing concerned noted.

8/22/22 Complaint Visit: Founded: [redacted]

8/25/2022 Complaint Visit: Unfounded A complaint was received on 8/24/22 that there was water leaking on the blue unit, staff did not provide the last name of an alleged offender to an investigator investigating an alleged abuse, and the facility would not provide video footage to the investigator.

During the 8/25/22 visit, the blue unit was viewed to have no active leak. The facility states that the reason they did not comply with the investigators request for footage because they were asked for all shift footage of every time the alleged offender worked in the past year. This was a large amount of footage that would take several days to prepare. The facility reports that they are actively working on the footage but could not provide it the same day.

9/1/2022 Monitor Visit: Licensing Specialist completed a buildings and grounds walkthrough and confirmed that all shower bases have been covered with epoxy to prevent residents injuring themselves with shower tiles. No licensing concerns noted.

9/14/2022 Corrective Action Visit/Incident Follow Up: Licensing Specialist visited the agency to inspect and review the agency improvements to the showers (Green Hall). The Specialist discussed smoothing out the edges of the drains to prevent any harm to residents. The Specialist also discussed an incident in which a resident who self-harmed at the agency (using a piece of metal door frame). The Specialist pointed out the square strike plate on the door whereas the others are rounded. The agency reported they will replace the strike plate with a round one to prevent injury to a resident.

9/16/2022 Complaint Visit: Founded: Licensing Specialist followed up regarding the complaint received on 8/18/2022 and addressed during the complaint visit on 8/22/2022. [redacted].
The agency was cited for the following regulation:

- **109.1.g-** [redacted]

9/22/2022 Complaint Interview: Unfounded: [redacted] The resident did not disclose any abuse and the licensing complaint was unfounded.

9/28/2022 Monitor Visit: Licensing Specialist completed a buildings and grounds walkthrough noting discarded disposable cups in the outdoor recreation area and paint peeling from the walls on some of the walls. Technical assistance was provided**.**

9/30/2022 Complaint Visit: Licensing received a complaint on 9/30/2022 stating that the agency failed to report suspected abuse to the child abuse hotline and that management would not allow staff to report incidents to licensing as required by the Minimum Licensing Standards. Licensing Specialist Michelle Sutton conducted an assistance visit on 9/30/2022 and interviewed resident witnesses to the alleged abuse that was not called into the child abuse hotline. The Licensing Specialist was unable to view video footage because administrator, DON, and HR professional were out for the day. No staff present had password and/or key to video room. Licensing specialist was told at approximately 3 P.M. that administrator would come to facility to assist with viewing footage. At 4:30 PM administrator had

not arrived. Specialist spoke to him on the phone. He stated he could not come for another hour, so appointment was made to view footage on Monday. The Licensing Specialist was unable to leave a complaint finding at that time.

10/3/2022 Complaint Visit: Founded: A complaint was received that an inappropriate restraint was conducted on a resident the night of 9/25/2022 and the facility management declined to report the suspected abuse to the child abuse hotline or the Placement and Residential Licensing Unit. The licensing unit conducted witnesses' interviews, reviewed camera footage, and reviewed the personnel file for the alleged offender. The agency was cited for the following regulations:

- **109.1.g-** Staff engaged in unprofessional conduct that could be viewed as physically harmful to a resident.
- **110.9-** The Agency failed to report potential abuse to the child abuse hotline.
- **103.1-** [redacted]
- **105.3-** [redacted]
- **105.7-** [redacted].
- **905.9-** Staff did not use the minimal force or time necessary during the course of a restraint hold on a resident.
- **907.3**- Staff was out of ratio with residents on the green unit 1:10.

10/5/2022 Incident: [redacted]. The agency was cited for the following regulation:

- **110.12-** [redacted]

10/7/2022 Incident: [redacted]. The agency was cited for the following regulation:

- **110.12-** [redacted]

Dawn Jeffrey, Assistant Director
Division of Child Care and Early Childhood Education