Division of Child Care & Early Childhood Education
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Corrective Action Agreement

Date: June 9, 2022

Update: January 25, 2023

To: Art Hickman

Owner Name: Woodridge Northwest, LLC

Facility Name: Perimeter Behavioral of the Ozarks

License #: 237

Mr. Hickman,

This document constitutes a formal Corrective Action Agreement (CAA) agreed upon by Perimeter Behavioral of the Ozarks and the Department of Human Services, Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. This CAA will be in effect for a minimum of six months (07/25/2023) from the date of signing by all parties. This agreement may be extended beyond six months should DHS determine any non-compliance with the CAA during the stated corrective action period.

UPDATE: Additional support is needed, therefore, CAA agreed upon on 6/9/2022 will be extended for a minimum of six month up to one year.

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 103 Central Registry and Criminal Records Checks

Perimeter Behavioral of the Ozarks has received citations on the following dates regarding the staff Central Registry and Criminal Record Checks.

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

- **12/14/2022-**
  - Personnel record review revealed that 7 out of 8 personnel records reviewed did not have all their regulatory checks conducted within ten days of hire. The HR Director reports that multiple staff have been found to have not had all required checks. The HR Director recently began work at the facility and will keep the Licensing Unit updated on the status of all staff still pending regulatory checks.

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.

- **Perimeter Behavioral of the Ozarks was cited on the following dates for allowing a staff to work with prohibited charges.**

  - **6/9/2022-**
    - Staff was allowed to continue to work after the Agency was informed that had a hit on the regulatory check.

<u>UPDATE</u>

Since the initiation of the CAA (June 2022), the facility was cited on the following date in reference to noncompliance with section 103 Central Registry and Criminal Record Checks:

- **10/3/2022-**A staff member was involved in an incident with a resident, did not have the required regulatory checks completed as required by the Minimum Licensing Standards.

<u>Minimum Licensing Standards (Residential): Section 910 – Grounds</u>

- **Perimeter Behavioral of the Ozarks was cited on the following dates regarding the facility grounds.**

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

- **6/3/2022-**
  - Dayrooms and bedrooms were seen with trash on the floors.

- Facility cited a second time for 910.1 regarding an incident that occurred on 5/31/22 in which a resident obtained glass and cut herself requiring stitches to close the wound.

UPDATE

Since the initiation of the CAA (June 2022), the facility was cited the following on the date in reference to noncompliance with section 910 Grounds:

- **12/29/2022-** A resident obtained a razor from the makeup bag of a staff member who had brought in makeup for the residents and used it to self-harm.

Minimum Licensing Standards (Residential): Section 911 - Buildings

Perimeter Behavioral of the Ozarks was cited on the following dates regarding the facility buildings.

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

- **3/1/2022-**
  - Several bedrooms were seen in disarray. Rooms had clothes laying on the floor, drink containers, and multiple empty food wrappers.
- **3/8/2022-**
  - Dayroom and bedrooms on the blue unit were messy with debris and used food wrappers on the floors. The orange unit was also seen in disarray. Multiple Amazon boxes were found in the rooms and staff report the girls use them as storage or trash cans. Profanity was seen on the ceiling and trim was peeling from the wall in the dayroom of the green unit. Water damage from a previous roof leak is being covered with a board. Showers were seen to have missing tiles. Specialist discussed how the tiles have had an order to be repaired for nearly one year. The dining room area was seen to have a baseboard trim falling off the wall and it was noted that the wall behind the trim was rotted out.
- **3/16/2022**-
  - Blue Hall had a dirty pile of towels on the floor in the walkway. Outlet on the wall was missing its cover.
- **4/13/2022**-

- Outlet cover was broken off in the hallway of the blue unit. Mold was visible in the ceiling of the shower in room 303.

- **5/10/2022**-
  - Specialist viewed shower basins that have pulled up tiles which could be used to cut or cause harm to residents.
  - Facility cited a second time for 911.6 due to a resident cutting herself with broken tile removed from a shower stall on 5/8/2022 requiring seven stitches to her arm.

- **6/8/2022-**
  - Resident used shower tile to reopen a previously stitched wound on her arm while in the shower using a tile from the shower.

911.15.f Areas used by children shall be designed, constructed, and furnished to reduce risk of suicide and assault including, but not limited to: (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

- **3/1/2022-**
  - A ripped-up clothing item was found in a bedroom that had been cut into a long strip that could be used as a ligature.

UPDATE

Since the initiation of the CAA (June 2022), the facility was cited the following dates in reference to noncompliance with Section 911 Buildings:

- **7/20/2022-** Ligatures were found in rooms 301, 302, and 303.
- **11/17/2022**- A complaint from a resident revealed that the showers on the unit were not draining properly causing them to flood. A Licensing Specialist turned on in a shower and determined to not be draining properly. The resident complained of mold in the dayroom and a black substance was found in the skylight on the blue unit. The resident complained of an outlet with exposed wires and a screw in it behind a chair on the orange unit, which was observed by the licensing specialist.
- **12/29/2022-** Facility cited for 911.6 for loose outlet covers in the cafeteria, a protruding screw in the window of a resident's bedroom, and a broken light switch cover which was used to self-harm by a resident.
- **1/19/2022-** A resident used a broken sink countertop piece in her bedroom to create a wound on her arm. This resident was already on "line of sight" self-harm precautions and the Specialist requested this counter be fixed during a monitor visit on 1/9/23.

Minimum Licensing Standards (Residential): Section 912- Bathrooms

Perimeter Behavioral of the Ozarks has received citations on the following dates regarding the conditions of the resident's bathrooms.

912.4- The bathroom shall be clean and sanitary.

- **3/1/2022-**
  - Several bathrooms were seen in poor conditions. Bathrooms had hair in the sinks, discarded toilet paper on the floors and on the back of toilets. Two toilets in rooms 204 and 301 were visibly clogged with feces. Room 301 toilet was overflowing onto the floor. The toilet in room 303 was seen to have a small leak around the base of the toilet with standing water on the floor.

- **3/8/2022-**
  - Bathrooms in the bedrooms were seen in poor condition with toilet paper on the floor, a used tampon on the back of a toilet, and hair on the sinks. The toilet in room 105 was clogged and there was visible mold seen in the bottom of the shower in room 305.

- **3/16/2022-**
  - Trash was seen on the floor of the restroom in room 103.

- **5/10/2022-**
  - Paper trash sacks are being used as garbage receptacles in bathrooms. Some of these trash sacks were seen to be overflowing onto the floors of the bathrooms.

UPDATE

Since the initiation of the CAA (June 2022), the facility was cited the following date in reference to noncompliance Section 912 Bathrooms:

- **7/20/2022-** Bathroom by seclusion room was dirty.

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

Perimeter Behavioral of the Ozarks has received citations on the following dates regarding ratio and supervision concerns.

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.

- **3/1/2022-**
  - Two staff failed to provide the level of care necessary to ensure the safety and well-being of a resident while she was being attacked by several peers on 2/27/2022.

- **4/13/2022-**
  - Camera review of an incident showed two residents left alone in a calm down room in which one resident took off her pants. The staff could be seen in the main room outside of the calm down room on his cellphone.

907.3 Staff/child ratio shall be at least 1:6 during waking hours and 1:8 during sleeping hours.

- **4/13/2022-**
  - Staff was seen out of ratio on the blue unit ten residents to one staff. Staff reported that no other staff was scheduled on the unit for the day and one staff is "always" assigned to the unit.
  - Staff was seen out of ratio on the green unit nine residents to one staff. Staff reported that no other staff was scheduled to the unit due to the facility being short staffed.

- **6/3/2022-**
  - A unit was seen out of ratio fourteen residents to two staff. Staff reported that there were only two scheduled for this unit, but they have a floater working who comes in if they need help.

<u>UPDATE</u>

Since the initiation of the CAA (June 2022), the facility was cited on the following dates in reference to noncompliance with Section 907 Ratio and Supervision:

- **6/22/2022-** Staff viewed out of ratio with residents on the Green Unit one staff and eight residents.

- **10/3/2022-** Staff viewed out of ratio with residents on the Green Unit one staff and ten residents.
- **11/3/2022-** The facility was cited for staffs' failure to provide adequate supervision to a resident who accessed a broom on the unit, took it to another resident's room and used it to damage a fire sprinkler causing the fire alarm to sound. The residents then left their assigned units to fight staff and elope from the facility. The police were called to the scene after staff called stating a riot had occurred and for the department to send "everyone they have." Multiple law enforcement officers and medical personnel responded to the scene to assist. Four residents and one staff had to be taken for emergency medical treatment.
- **11/23/2022-** The facility was cited for staffs' failure to adequately supervise two residents during a trip to the emergency room department. It was reported that during the trip to the emergency room on 11/21/22, a male staff member allowed the two female residents to vape. The contents of the vape are unknown as it was never recovered after a search of the facility grounds.
- **12/29/2022-** The facility was cited for lack of staff supervision when a resident obtained a razor from a staff makeup bag and used it to self-harm.
- **12/29/2022-** The facility was cited for lack of staff supervision when a resident obtained a staff key and used it to self-harm.
- **1/19/2023-** The facility cited for lack of staff supervision after a resident on "line of sight" self-harm precautions was able to use a broken sink countertop piece in her bedroom to self-harm. The Licensing Specialist had addressed this broken sink with the facility during a monitor visit on 1/9/2023. The resident self-harmed with it on 1/16/2023.

In addition to the non-compliance of the Minimum Licensing Standards listed above, new areas of non-compliance have also developed through the course of the current Corrective Action Agreement including the following:

<u>Minimum Licensing Standards (Residential): Section 109 Unprofessional Conduct</u>

Perimeter Behavioral of the Ozarks has received citations on the following dates regarding unprofessional conduct.

<u>1</u>09.1.f- Failing to comply with any stipulation or agreement with the board involving probation or a settlement of any disciplinary matters.

- **12/27/2022-**
  - Five incidents viewed in the incident log the previous week were determined to have not been reported to the licensing unit as per the Corrective Action Agreement. The facility was cited five times for 109.1.f

for each of the five incidents due to the failure to comply with this board agreement.

109.1.g- Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

- **6/20/2022-**
  - The facility cited after a staff member engaged in unprofessional conduct by verbally retaliating against a resident in front of other residents and staff regarding the resident's [redacted].
- **9/1/2022-**
  - The facility was cited after a staff member engaged in sexual contact with a resident.
- **9/16/2022-**
  - The facility was cited after a staff member engaged in sexual contact with a resident.
- **10/3/2022-**
  - The facility was cited after an untrained contracted worker was left alone with residents on the unit and engaged in unprofessional conduct that could be viewed as physically harmful to a resident.
- **10/17/2022-**
  - The facility was cited after a staff member engaged in sexual contact with a resident.

Minimum Licensing Standards (Residential): Section 110 Inspections, Investigations & Corrective Action.

Perimeter Behavioral of the Ozarks was cited on the following dates regarding Inspections, Investigations & Corrective Action.

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 or (c) If they observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

- **10/3/2022**
  - The facility was cited after failing to report suspected abuse to the child abuse hotline.

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.

- **8/12/2022-**
  - The facility cited after they failed to [redacted] call to the Licensing Unit by the next business day.
- **8/16/2022-**
  - The facility cited after they failed to [redacted] call to the Licensing Unit by the next business day.
- **10/5/2022-**
  - The facility cited after they failed to report the acceptance of a [redacted] call to the Licensing Unit by the next business day.

110.14- The agency shall take steps to prevent harm or retaliation against the child while an allegation of child maltreatment is being investigated.

- **6/20/2022-**
  - The facility cited after a staff member verbally retaliated against a resident in front of other residents and staff regarding the resident's [redacted]

110.17- The agency shall notify the Licensing Unit by the next business day of serious injuries requiring emergency medical treatment, agency vehicle accidents, arrests, elopements, suicide attempts, or deaths and maintain documentation of the incident and notification.

- **8/12/2022-**
  - Agency failed to report the arrest of a resident by the next business day.
- **10/7/2022-**
  - The facility cited after they failed to report the attempted suicide of a resident to the Licensing Unit by the next business day.

The agency was required to complete the following in the previous Correction Action Agreement dated June 2022.

- Perimeter Behavioral Health of the Ozarks shall send documentation to the Licensing Unit that all current staff have received all required regulatory checks in accordance with the Minimum Licensing Standards. **(The Agency ensured that a backlog of staff Regulatory checks were submitted incorrectly was cleared).** Additionally, notification

of any new staff hired, during the course of this Corrective Action Agreement, shall be sent to the Licensing Unit upon their hire with proof of their regulatory checks being initiated. **(Required as a part of the new CAA).**

- The Agency's 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 unit monthly. **(Walkthroughs were verbally communicated of completion, incidents have continued to occur. Documentation will be required as a part of the new CAA).**
- The Agency shall continue their Emergency Safety Procedures provided to the Licensing Unit on 6/7/2022 regarding the use of showers at the facility until all repairs are made to the bathrooms to ensure the safety of all residents. All staff should be trained on the new Emergency Safety Procedure immediately and a list of all staff trained shall be provided to the Licensing Unit by 6/24/2022. **(Completed)**
- In addition to all required incident reporting, the agency shall report all cases of self-harm by residents to the Licensing Unit by the next business day for the duration of this Corrective Action Agreement. **(In compliance)**
- The Licensing Unit will provide intent training to the facility regarding the 900 Section of the Minimum Licensing Standards. All facility staff shall be required to attend and a sign in sheet will be provided to the Licensing Unit. **(Completed. In addition, the Licensing Unit also provided Intent Training on sections 107, 108, 109, 110, and a second training on the 900 Section of the Minimum Licensing standards on 12/20/22 and 12/21/22).**

The Perimeter Behavioral Health of the Ozarks is now required to complete the following revised corrective actions:

- By the last business day of every month, the facility shall send notification to the Licensing Unit of any new staff hired that month for the course of this Corrective Action Agreement. **(Amended from previous CAA).**
- Perimeter Behavioral Health of the Ozarks management shall continue to conduct a minimum of once per week walkthroughs of the agency to ensure compliance with the Minimum Licensing Standards. These walkthroughs shall be documented and provided to Licensing upon request. **(Amended from previous CAA).**
- In addition to all required incident reporting, the agency shall report all cases of self-harm by residents to the Licensing Unit by the next business day for the duration of this Corrective Action Agreement.
- Perimeter Behavioral Health of the Ozarks shall ensure that any new staff submitting regulatory checks receives training from the DCCECE Regulatory Check Unit.

- Perimeter Behavioral Health of the Ozarks shall only take new admissions at a rate that ensures the required staff-to-resident ratios are maintained.
- All staff shall be trained on appropriate supervision of residents, primarily concerning residents on any type of safety precaution. The facility will provide documentation of all staff being trained to the Licensing Unit by 3/25/2023.
- Perimeter Behavioral Health of the Ozarks shall ensure that residents are given regular opportunities for involvement in activities. The activities calendar will be provided by the facility to the Licensing Unit by the first business day of each month showing all activities planned for that month.
- Perimeter Behavioral Health of the Ozarks shall develop new treatment interventions for de-escalation of their residents specific to each resident currently on a safety precaution plan.

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 will 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.

[signature], MBA CEO	1/27/23
Owner/ Administrator/Agency Representative	Date
Chelsea Vardell	1/30/2023
Licensing Program Coordinator	Date
[signature]	1/27/23
Licensing Program Manager	Date