Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Date of Incident: 1/27/2023

Date Received by DCCECE: 1/31/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: o Name: [redacted], DOB: [redacted]7, Guardian: DHS (TX) - notified o Incident: 01/27/23 approximately at 1807 o Precaution safety plan: Self-Harm, Constant LOS o Police were called: N/A o On 1/27/23, [redacted] was seen self-harming by using their fingernails to scratch away the scab and skin on their left forearm from their previous self-harm injury. Staff attempted to communicate with [redacted], but they were not responding. Staff attempted to use blocking techniques to prevent injury and [redacted] became agitated and began punching themselves in the head and face. The resident attempted to bite and kick the staff member that was using blocking techniques. Additional staff and this RN responded to the unit and attempted to communicate with [redacted] but they would not respond. Other residents were becoming dysregulated on the unit so [redacted] was removed from the unit and brought to the milieu. [redacted] continued to attempt to kick and bite staff. A physical hold was initiated to maintain the safety of herself and staff and was released when [redacted] agreed to safe behaviors towards self and staff. Afterwards, RN noted that [redacted] had reopened their previous fingernail-scratching-abrasion-injury to their left forearm. Resident refused to have it cleaned/covered; no first aid required. Alternative staff member was brought in to process the incident with the patient. [redacted] will remain on their current self-harm precaution safety plan with constant line of sight until safe behaviors are observed.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 2/1/23- Program Coordinator spoke to the CEO, Cassie Sowder, and discussed why the incident was reported late to the licensing unit per the current Corrective Action Agreement. The CEO reported that a floor nurse quit without notice so the ADON, who typically reports incidents, had to work the floor and was unable to report the incident in a timely manner. The Program Coordinator informed the CEO that licensing will be issuing a technical assistance for 109.1.f for all six incidents reported to us on 1/31/23 but moving forward any reports that do not meet the requirements of the corrective action agreement will be cited. Inspection # 058831 02/3/23--Licensing specialist Sutton completed a buildings and grounds visit at facility. Resident [redacted] was observed within LOS of staff in the hallway. She has processed with therapist about this incident. Standing order to cut and trim resident's fingernails as needed. CEO stated that facility is in the process of educating staff about different de-escalation interventions and is continuing to work on programmatic changes to keep residents engaged during the day.