ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 3/10/2023

Date Received by DCCECE: 3/13/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: Name: [redacted] DOB: [redacted] Notified: [redacted] (Guardian) On 3/10/23 at approximately 2200, RN was called to unit where resident was visualized standing on a chair with glass from the lightbulb in the ceiling in hand, and ceiling tiles hanging above her. Staff was able to remove resident from chair and a physical hold was initiated to safely retrieve the glass from hand without causing further injury. Staff then visualized an object in her mouth. Resident released the object from mouth without further incident or injury. Dr. Froman notified of the event, and because of the extreme self-injurious behaviors, a one-time IM emergency medication was given to help de-escalate the situation. After a brief period of time, the resident was able to regulate her emotions and cooperate with RN verbal direction for safe behaviors. Resident was taken out to the nurses' station where resident's right hand was noted to have 2 new 1/2-inch superficial cuts. Cuts were cleaned, triple antibiotic was applied and covered with a bandage. Resident returned to unit without further incident and will remain on 1:1 observation per physician order.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative:Licensing specialist viewed camera footage for this incident. A resident broke one camera on the unit so incident could only be viewed from the camera at the end of the hallway, and field of vision was limited. Facility was observed to be in ratio on green unit with two staff members--Mr. Bill and Ms. Joy--working that evening. [redacted] was sleeping on a mattress in the dayroom out of camera view. Mr. Bill is observed getting up from his chair to completed q 15 checks down the hallway. The figure of [redacted] can be seen coming into camera view to grab the chair he was sitting in. The other staff member on the unit, Ms. Joy, can be seen immediately getting up from her chair to follow [redacted] out of the camera view. Staff Mr. Bill can be seen quickly returning to the dayroom after completing checks, and then he goes out of camera view in the direction of [redacted] and Ms. Joy. Nothing else can be ascertained from video footage. ADON stated that additional staff were called, and a restraint was initiated for the resident's safety. Following the incident, resident was placed on strict 1:1 intervention 24 hours a day (previously it had been during the day). She was observed wearing paper scrubs and programming 1:1 with staff member in the comfort room at time of visit. Facility has made referrals to acute care.

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521 Visit Compliance Report

Licensee: Perimeter of the Ozarks

Facility Number: 237

Licensee Address: 2466 SOUTH 48TH STREET
SPRINGDALE AR 72766

Licensing Specialist: Michele Sutton

Person In Charge: Cassondra Sowder

Record Visit Date: 3/15/2023

Home Visit Date: 3/15/2023

Purpose of Visit: Monitor Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Reviewed camera footage for incident involving resident [redacted] that occurred on 03/10/2023 at 2203. Facility CEO stated that one of the cameras on the green unit was broken by a resident, so the view was limited to

what could be seen from the back of the hallway. Licensing specialist observed 2 staff in the dayroom. Staff were observed walking down the hallway and stepping into each room with a flashlight to complete q 15-minute checks. [redacted], who was on 1:1 safety precaution during the day at time of incident was sleeping in the dayroom on a mattress out of view of the camera. At around 2200 staff member Bill B. was observed going down hallway completing checks. The shadow of [redacted] could be seen in the dayroom grabbing his chair while he was completing these checks. Another staff member, Ms. Joy, was observed to immediately stand up and follow her. Mr. Bill was observed to quickly return to dayroom after completing his last check. The rest of the incident could not be observed because it was out of camera view. Per facility ADON, additional staff were called, and a physical restraint was initiated to ensure the safety of the resident. The facility was in ratio at time of incident, and no supervision failures were observed during footage review. Facility is working on a discharge to acute care for resident, pending locating a facility who will accept her.

Buildings and grounds: Viewed all units. Facility continues to be very clean. The bedrooms are consistently orderly and tidy. No contraband or dangerous materials observed. Several children were restricted to the units and working calmly with staff on schoolwork or resting in their rooms. No children in their rooms were on 1:1 or self-harm precautions. Resident [redacted]., who has had multiple self-harm reports, was observed within LOS of staff wearing paper scrubs. Plywood has been placed around the toilet boxes in all of the bathrooms to prevent trash and contraband from collecting. No citations in areas viewed.

[redacted] was observed to be 1:1 with staff in the comfort room at time of visit.

Ratio: Classroom 2:9, Orange unit 2:6, comfort room 1:1, Blue unit 2:10

Provider Comments:

CCL Staff Signature : Date: 3/15/2023

Provider Signature : Date: 3/15/2023