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: 10/25/2022

Date Received by DCCECE: 10/26/2022

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Facility Type: Residential

Incident Type: Licensing

Report Description: My son has now been in 7 fights and one of those being two wks ago consisted of 8, 17 year old boys jumped my son. His caseworker is punishing me indirectly by using my son as the means to punish. If you heard everything going on you would agree with me. My son's life is in serious danger by this facility the caseworker placed him at as well as this caseworker is a threat to my son's life also. I've already written the Governor Asa Hutchinson and sent that let two days ago

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative:Licensing Specialist will try to obtain more information regarding this complaint. There were no names for the complainant, resident, or staff listed in this complaint. 11/14/22- Program Coordinator was able to make contact with the reporter and discussed the concerns she had regarding the treatment and safety of her child at the facility. The Program Coordinator emailed the facility to request documents related to any restraint holds performed on the resident and any altercations involving the resident. (See

notes and attachments for further information). 11/17/22-Program Coordinator visited the facility and reviewed the incident log for November which showed three incidents with the resident, none of which were altercations with his peers. The October log is currently in a nurses office that is not at the facility so it can not be viewed at this time. However, Helena Coplin has information showing the resident was involved in eight incidents in October six of which involved the resident and peers fights then two involving the resident attacking staff members. No video footage is available for review due to the automatic deletion of footage after 14 days. The program coordinator was made aware that the incident reports and emergency safety intervention packets are now considered legal documents by the facility so the coordinator cannot obtain a copy of them. Standard 904.1.L states that all incident reports on a resident should be maintained in the child's record. The Program Coordinator will seek legal guidance. Licensing is investigating two reports of child maltreatment against this resident that were not reported to the licensing unit until 11/14/22. Licensing was notifed that the maltreatment investigations were closed as unsubstantiated. The licensing complaint is UNFOUNDED.

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City

Facility Number: 142

Licensee Address: 603 KITTLE ROAD
FORREST CITY AR 72335

Licensing Specialist: Chelsea Vardell

Person In Charge: Helena Coplin

Record Visit Date: 11/17/2022

Home Visit Date: 11/17/2022

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Licensing visit conducted from 12:00PM-2:15PM

Program Coordinator visited the facility in response to an outside complaint that alleged resident [redacted] was not being appropriately supervised by staff, the staff were allowing the resident to be beat up by other residents and not intervening, the resident has been involved in nine altercations with his peers, a staff named [redacted]

reportedly twisted his arm causing a sprain to the resident's wrist, staff [redacted] allegedly told the resident that he would "beat him so badly he wouldn't be able to walk", and that staff [redacted]r put the resident in a headlock while he was attempting to elope after staff [redacted] had hit him.

The Program Coordinator discussed these incidents with the facility and found that the resident has been involved with multiple altercations with residents and had attacked staff, but licensing was unable to review incident reports for the month of October due to the binder being kept in an office currently locked. Staff with the correct key were not present to open the door. The video footage of the incidents is no longer available due to the footage automatically deleting after 14 days. Licensing received the emergency room report of the resident's wrist sprain he sustained on 11/3/22. The licensing specialist assigned to the facility did view this incident on camera prior to its deletion on 11/8/22 and noted no licensing concerns. The specialist did mention that the resident began holding his wrist after the restraint hold. However, the resident was attacking staff and acting aggressively so it is unclear how the injury was sustained. Staff [redacted] was terminated from the facility on 11/17/22 as he had already received a final warning on 7/20/22 for "bullying and antagonizing residents". The statement from staff [redacted] and [redacted] were reviewed regarding the elopement of the resident on 10/31/22 in which the resident claims to have been hit by staff [redacted] then choked by staff [redacted]

Staff [redacted] and [redacted] are currently on suspension and the facility has requested an interim corrective action plan (ICA) for the staff.

Licensing is not prepared to leave a finding at this time.