



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

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Notice of Serious Incident

Date of Incident: 10/26/2022

Date Received by DCCECE: 10/27/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: Email stating the following "Mr. [REDACTED] and Ms. [REDACTED] withheld water from the orange unit as a punishment. The water cooler was left in the classroom and asked for by the residents around 7:00pm. Mr. [REDACTED] said they were withholding it until the residents calmed down. Ms. [REDACTED] does not give bathroom breaks/makes staff wait for over an hour, indicating they are still assigning only one staff member to each dorm. Ms. [REDACTED] yells at and berates residents. Ms. [REDACTED] puts residents and staff in harm's way based on what she tells staff to do or not do. Examples: o She told one staff member to stand in a resident's room alone while they shower and do Marco Polo?, o She told two staff members to completely ignore a kid if they appear to be having a seizure, o She tells new staff that orientation kids can immediately sleep in their rooms instead of in the dayroom for the required 5-7 days of Constant LOS."

Interim Action Narrative: [REDACTED] should not have any contact with the residents pending the investigation outcome.

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Maltreatment Narrative:

Outcome:

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Licensing Narrative: 10/28/22- Licensing Specialist emailed the facility requesting more information on the last names and work schedules of the employees named in the complaint. 10/31/2022-Program Coordinator received the last names of the staff named in the report, [REDACTED] and [REDACTED]. The facility reports that [REDACTED] is no longer with the agency as of 10/24/2022 and Ms. [REDACTED] will be doing administrative duties until further notice. The Program Coordinator requested a list of all staff who worked on the Orange Unit 10/23/2022-10/26/2022. The Program Coordinator will visit the facility on Thursday 11/3/2022 as all staff will be at a required statewide meeting on 11/1/22 and 11/2/22. Licensing Specialist and Program Manager visited the facility on 11/3/2022. Licensing Specialist received a print out and list of all staff scheduled/worked from 10/23/2022 to 10/26/2022. Licensing Specialist was informed that staff member ([REDACTED]) was terminated for improper use of restraint performance. A copy of his termination letter was received. Licensing Specialist interviewed four (4) residents ([REDACTED]) from the Orange Unit. When asked how things were going and if there were any concerns regarding staff members, [REDACTED] names were mentioned. Licensing Specialist interviewed [REDACTED]. She informed Licensing Specialist that she felt like she was retaliated against for writing up a staff member. [REDACTED] informed Licensing Specialist that she would provide the documentation. 11/14/2022, Licensing Specialist emailed DON. 11/15/2022, Licensing Specialist informed that documentation of the write up that [REDACTED] completed on an employee has not been produced. No licensing concerns noted.



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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:** Chelsea Vardell

**Person In Charge:** Ana Salazar

**Record Visit Date:** 11/23/2022

**Home Visit Date:** 11/23/2022

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulations Not Correctable:**

**Narrative:**

No site visit conducted on this day.

Licensing complaint report received on 10/27/22 that reported the following has been investigated and determined to be unfounded.

“██████████” and “██████████” withheld water from the orange unit as a punishment. The water cooler was left in the classroom and asked for by the residents around 7:00pm. ██████████ said they were withholding it until the residents calmed down.

- “██████████” does not give bathroom breaks/makes staff wait for over an hour, indicating they are still assigning only one staff member to each dorm.
- “██████████” yells at and berates residents.
- “██████████” puts residents and staff in harm’s way based on what she tells staff to do or not do. Examples:
  - o She told one staff member to stand in a resident’s room alone while they shower and do “Marco Polo”,
  - o She told two staff members to completely ignore a kid if they appear to be having a seizure,
  - o She tells new staff that orientation kids can immediately sleep in their rooms instead of in the dayroom for the required 5-7 days of Constant LOS."