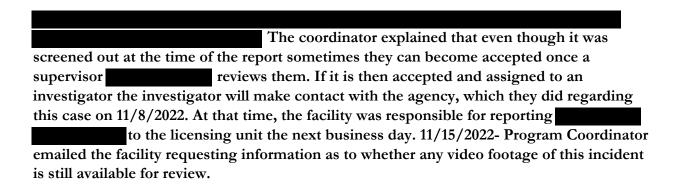


Division of Child Care & Early Childhood Education

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:10/31/2022
Date Received by DCCECE: 11/14/2022
Facility Name: Perimeter Behavioral of Forrest City
Facility Number: 142
Facility Type: Residential
Incident Type: Dual
Report Description: The resident eloped from the campus after a fire alarm was activated unlocking all doors at the facility. The resident disclosed that staff and choked him by placing his hands around his neck, restricting his
oreathing, and hitting him.
Interim Action Narrative: Staff was placed on suspension
Maltreatment Narrative:
Outcome:
Licensing Narrative: 11/14/2022-
and went to the facility to make contact on
the same day 11/8/2022. The coordinator called the facility and spoke to Helena Coplin who





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:

Regulation Description: 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.

Sub Regulation Description: Regulation Number: 1.110.12

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

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

Program Coordinator visited the facility in response to the complaint received on 11/14/22 regarding an incident that occurred on 10/31/22. The incident involved the elopement of resident who stated that he eloped from the facility because staff hit him. The resident states that while he was eloping from the facility staff chased him down and placed his hands around his throat, restricting his airway. The report was called into the child abuse hotline but was screened out per the facility staff. An investigator then came to the facility on 11/8/22 to discuss the report. The facility failed to report that the report had been accepted for investigation after they were notified on 11/8/22. The facility will be cited for R110.12 The Program Coordinator provided education to the facility that if an investigator comes to the facility and states that a report is now under investigation, they must report that to the licensing unit by the next business day. The personnel records of both staff, and and ., were reviewed for regulatory checks, pre-service training, and any corrective actions. It was noted that staff received disciplinary action for "bullying and antagonizing residents" on 7/19/22. The staff received retraining on SAMA and returned to work with the is also involved in an open maltreatment report from 9/7/22, but it is not mentioned or addressed in his personnel file. is currently being terminated from employment on 11/17/22. Staff ... is suspended pending the review of an interim corrective action requested by the facility. No video footage is available of this incident due to the time lapse between when it occurred and when licensing received notification. The Program Coordinator discussed how the serious occurrence description put into ELS on 11/1/22 did not match the serious occurrence reporting form given to the CACD investigator on 11/8/22. Furthermore, the serious occurrence reporting form sent to the Office of Long-Term Care is identical to the one input into ELS for licensing, but also differs from the form provided to the investigator. The form provided to the investigator states that the resident made allegations of abuse against staff and that the was called, but the reports to Licensing and the Office of Long-Term Care, do not report that information. The facility staff is unsure how this occurred. The Program Coordinator provided education that the serious occurrence forms submitted must contain all relevant information regarding an incident.

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



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521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City	
Facility Number: 142	
Licensee Address: 603 KITTLE ROAD FORREST CITY AR 72335	
Licensing Specialist: Kendra Rice	
Person In Charge: Helena Coplin	
Record Visit Date: 12/2/2022	
Home Visit Date: 12/2/2022	
Purpose of Visit: Complaint Visit	
Regulations Out of Compliance:	
Regulations Needing Technical Assistance:	
Regulations Not Correctable:	
Narrative:	
Time of Visit: 12:45 pm to 2:00 pm	
Census: 57	

Licensing Specialist received a complaint on 10/31/2022, resident eloped from the facility's grounds after a fire alarm was activated and unlocked all doors at the facility. The resident disclosed that staff members allegedly choked him by placing his hands around his neck, restricting his breathing, and hitting him.

Licensing Specialist was informed by the Program Coordinator that Investigator Lorra Wicker reported the case being unfounded and unsubstantiated.

No licensing concerns noted.