



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: 11/17/2022

Date Received by DCCECE: 11/17/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: During a buildings and ground walkthrough of the facility, multiple residents expressed concerns about the facility.

Interim Action Narrative: Facility reports the wall plate was corrected on site. Pick proof caulking has been ordered to secure the wall plates. Shower drain was repaired by routing the drains. The black substance on the ceiling was cleaned and ceiling was painted.

Maltreatment Narrative:

Outcome:

Licensing Narrative: 11/17/22- Licensing Specialist interviewed [REDACTED] and [REDACTED]. The specialist attempted to interview residents [REDACTED] and [REDACTED] as well, but they refused to be interviewed. Specialist reviewed camera footage of an alleged incident. Specialist interviewed facility management. Specialist completed a buildings and grounds walkthrough. See inspection 056053 for further information. 11/22/2022 Licensing Specialist informed: The wall plate was removed by the residents and corrected. Pick proof caulking was ordered to secure the wall plates by sealing them. The showers that drained slowly was due to the epoxy used to fix the tile citations had been

repaired by routing the drains. The drains did not flood but drained slowly. The small amount of black substance on the ceiling was due to the fire system being set off and the cleaners missing the spot. The black substance was cleaned and the ceiling has been painted. Licensing Specialist will observe the repairs during next visit. On 11/23/2022, Licensing Specialist received a complaint on 11/17/2022 regarding complaints from the residents. Licensing Specialist completed a buildings and grounds of the Blue and Orange Units. Blue Unit ratio 3:9, residents and staff were participating in self-care (hair and make-up). Licensing Specialist checked Bedroom 105 and the drain had been fixed. The water did not drain slow. Mr. Ron informed Licensing Specialist that Bedroom 101 was still in the process of being repaired. In the dayroom on the Orange Unit the wall plate was replaced. Ratio was 2:8. DON informed Licensing Specialist that the residents are only allowed a hairbrush and hair conditioner only during hygiene. DON also informed Licensing Specialist upon request, residents are provided with a small cup of liquid soap to wash their hands. Licensing Specialist did not observe a black substance on the ceiling, it was reported that the black substance was cleaned off and painted.



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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: Michael Hinton

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:

Regulation Description: There shall be an adequate supply of soap, towels, and tissue.

Sub Regulation Description:

Regulation Number: 9.912.6

Regulation Description: Severe weather drills shall be practiced with children quarterly.

Sub Regulation Description:

Regulation Number: 9.914.8

Regulations Not Correctable:

Narrative:

Resident [REDACTED] reported that she does not feel safe in facility. She stated she called the police last night and filed a report about a staff member ([REDACTED]) who she alleges antagonized her by calling her and her (resident) mother nasty. She alleges that staff member stated, "get the girl away from me because is she comes over here, she'll have to fight me." She reports this incident was witnessed by staff member [REDACTED] and "the entire blue unit."

Licensing specialist interviewed resident [REDACTED]. She reported that [REDACTED] was angry and disruptive which is "normal behavior" for her. She stated that resident [REDACTED] was restrained yesterday along with 12-year-old resident [REDACTED], and she had no concerns about it. She stated staff member [REDACTED] is "always" telling one resident what another resident is saying about them, and she states staff member [REDACTED] can corroborate this. She reported that her primary concerns are that there is a socket with screws and exposed wires behind a chair in the orange unit (FOUNDED and corrected on site), the showers do not drain (FOUNDED and cited), and there is "black mold" in the blue unit (unknown black substance on ceiling--cited). She reported that two residents [REDACTED] are self-harming with staples and recommended licensing specialist interview them. She complained about not having a hairbrush or hair conditioner. She had no other comments regarding the incident with [REDACTED].

Attempted to interview resident [REDACTED], who was allegedly restrained yesterday. She refused to be interviewed or provide information.

Attempted to interview resident [REDACTED] who allegedly is self-harming. She refused to be interviewed or provide information but was observed to be wearing self-harm precaution paper scrubs during interview.

Interviewed resident [REDACTED] who stated the issues last night could be summarized in one word--and gave name of the resident who made initial complaint. She stated that resident [REDACTED] and [REDACTED] were playing around when resident [REDACTED] became escalated and threw Kool Aid on the floor. [REDACTED] was trying to calm her down. She stated this is not the first incident with resident [REDACTED]. She stated that later in the day [REDACTED] jumped over nurses' station and was yelling at [REDACTED] who was "yelling back." She stated the police were called.

Interviewed resident [REDACTED] she stated the "cops were called, stuff was thrown, and there was yelling and fighting." She said staff responded to [REDACTED] outburst by removing her from the unit. She stated she was mostly concerned about "black mold" on the unit, lack of hand soap, and that a report she made this summer about sexual assault was not followed up on. (Licensing specialist verified that report was investigated by state police).

Licensing specialist reviewed camera footage for incident. No footage during time period review of resident [REDACTED] being restrained and there is no documentation that either of them were. No evidence in footage that [REDACTED] was yelling at the resident or being aggressive toward her--footage showed she maintained appropriate distance. It appears she is speaking but licensing could not determine what was being said. (905.4.d unfounded)

Interviewed administration who stated that the police cited resident [REDACTED] for spitting in [REDACTED] face and [REDACTED]. [REDACTED] is pressing charges. Resident [REDACTED] previously assaulted a staff nurse and charges were pressed.

911.6 (founded) Please ensure all of the showers are properly draining to ensure no flooding in bathroom/bedrooms by 12/17/22.

There is an unknown black substance around the skylight feature in the blue unit. Please address this issue by 11/25/22.

There was an exposed outlet with exposed wires and a screw in it behind a chair in the orange unit dayroom. Licensing specialist was made aware of this by a resident. Please regularly check the units for serious safety hazards. (Outlet repaired on site).

912.6 Technical assistance: please ensure the residents have access to hand soap each time they go to the bathroom. No soap was found in any bathroom on the unit or in any of the day areas. Several residents reported they do not get soap when they use the restroom--only at hygiene time. Staff reported that they do get soap for use in the bathroom. If facility does not feel like it is safe to have soap in the bathrooms, then a verifiable system needs to be implemented to ensure the residents have access to soap when they need it.

914.8 Technical assistance: please ensure severe weather drills are being completed quarterly as per the regulations. Facility reports that they believed they were required to do them every 6 months. Licensing specialist provided clarification. and facility acknowledged understanding.

Ratio: 26 residents/6 staff



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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: Kendra Rice

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:

Time of Visit: 10:15 am to 12:30 pm

Census: 24

Licensing Specialist received a complaint on 11/17/2022 regarding complaints from the residents. Licensing Specialist completed a buildings and grounds of the Blue and Orange Units. Blue Unit ratio 3:9, residents and

staff were participating in self-care (hair and make-up). Licensing Specialist checked Bedroom 105 and the drain had been fixed. The water did not drain slow. Mr. Ron informed Licensing Specialist that Bedroom 101 was still in the process of being repaired. In the dayroom on the Orange Unit the wall plate was replaced. Ratio was 2:8. DON informed Licensing Specialist that the residents are only allowed a hairbrush and hair conditioner only during hygiene. DON also informed Licensing Specialist upon request, residents are provided with a small cup of liquid soap to wash their hands. Licensing Specialist did not observe a black substance on the ceiling, it was reported that the black substance was cleaned off and painted.

Licensing Specialist reviewed MARs for the following residents:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

All initialed and up to date.

No licensing concerns noted.