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: 11/21/2022

Date Received by DCCECE: 11/22/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: [redacted]) DOB: [redacted]. Guardian notified. (DHS - Texas). [redacted] ON 11/22/22 It was reported by residents and staff that 2 residents were allowed to use vape by another staff member while on transportation to an outside medical facility. Incident occurred on 11/21/2022 at approximately 05:45pm. Guardians were notified.

Interim Action Narrative: Staff [redacted] was terminated from the facility and escorted from the facility grounds on 11/22/22. Residents and their belongings were searched. Staff, [redacted] received a verbal and final written warning.

Maltreatment Narrative: **Outcome:**

Licensing Narrative: 11/23/22- Program Coordinator spoke to CEO Michael Hinton and Ana Salazar on the phone and discussed the incident. Mr. Hinton reported that the two residents were being taken to the emergency room for treatment of a stomachache and strep throat. The two staff transporting them were [redacted] and a new female staff that was in training with [redacted]. The female staff reported to her supervisor the following day that she

witnessed [redacted] give a vape pen to both the residents and allow them to use it in the vehicle and while at the hospital. [redacted] was asked about this by management, and he reported "something like that may have happened" and then refused to discuss the incident any further. The staff was immediately terminated and walked off the facility grounds. The female staff was given a written warning as she did not provide the vape pen to the residents and she did report it to her supervisor. The vape pen had an unknown content and is believed to be nicotine. A sweep of the facility was conducted and no vape pen has been recovered. The [redacted] made by the facility [redacted]) was screened out. Licensing Specialist inquired about the 11/21/2022 provider reported incident. Licensing Specialist was provided with the discharge papers for the residents going to the emergency room, witness statement from a staff member of the incident, phone numbers of the staff members, and corrective action plan. CEO, Michael Hinton, informed Licensing Specialist that staff ([redacted]) was suspended on 11/22/2022 pending investigation and the facility keys and key fob was taken from his possession. DON informed Licensing Specialist that the residents ([redacted] and [redacted]) were searched including their bedrooms and nothing was found. Resident ([redacted]) denied allegations and resident ([redacted]) didn?t want staff to get into trouble. Facility will be cited for R907.2. Staff failed to provide level of supervision to ensure the safety and well-being of the residents. 12/22/2022, Licensing Specialist informed referral #[redacted] was screened out.

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Facility Number: 237

Facility Type: Residential

Incident Type: Dual

Report Description: [redacted] DOB: [redacted]. Guardian notified. (DHS/AR). [redacted] ON 11/22/22 It was reported by residents and staff that 2 residents were allowed to use vape by another staff member while on transportation to an outside medical facility. Incident occurred on 11/21/2022 at approximately 05:45pm. Guardians were notified.

Interim Action Narrative: Staff [redacted] was terminated from the facility and escorted from the facility grounds on 11/22/22. His keys and key fob were taken. Staff, [redacted], received a written and final written warning. The residents were searched along with their be

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[redacted] Narrative: [redacted] SCREENED OUT
Outcome:

Licensing Narrative: 11/23/22- Program Coordinator spoke to CEO Michael Hinton and Ana Salazar on the phone and discussed the incident. Mr. Hinton reported that the two residents were being taken to the emergency room for treatment of a stomachache and strep

throat. The two staff transporting them were [redacted] and a new female staff that was in training with [redacted]. The female staff reported to her supervisor the following day that she witnessed [redacted] give a vape pen to both the residents and allow them to use it in the vehicle and while at the hospital. [redacted] was asked about this by management, and he reported "something like that may have happened" and then refused to discuss the incident any further. The staff was immediately terminated and walked off the facility grounds. The female staff was given a written warning as she did not provide the vape pen to the residents and she did report it to her supervisor. The vape pen had an unknown content and is believed to be nicotine. A sweep of the facility was conducted and no vape pen has been recovered. The [redacted] by the facility ([redacted]) was screened out. Licensing Specialist inquired about the 11/21/2022 provider reported incident. Licensing Specialist was provided with the discharge papers for the residents going to the emergency room, witness statement from a staff member of the incident, phone numbers of the staff members, and corrective action plan. CEO, Michael Hinton, informed Licensing Specialist that staff ([redacted]) was suspended on 11/22/2022 pending investigation and the facility keys and key fob was taken from his possession. Staff member [redacted] received a verbal and final written warning. DON informed Licensing Specialist that the residents ([redacted] and [redacted]) were searched including their bedrooms and nothing was found. Resident ([redacted]) denied allegations and resident ([redacted]) didn?t want staff to get into trouble. Facility will be cited for R907.2 Staff failed to provide level of supervision to ensure the safety and well-being of the residents. 12/22/2022, Licensing Specialist informed referral #[redacted] was screened out.

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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: Self Report Visit

Regulations Out of Compliance:

Regulation Description: Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

Sub Regulation Description:

Regulation Number: 9.907.2

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

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

Census: 24

Licensing Specialist inquired about the 11/21/2022 provider reported incident. Licensing Specialist was provided with the discharge papers for the residents going to the emergency room, witness statement from a staff member of the incident, phone numbers of the staff members, and corrective action plan. CEO, Michael Hinton, informed Licensing Specialist that staff [redacted] was suspended on 11/22/2022 pending investigation and the facility keys and key fob was taken from his possession. Staff member [redacted] received a verbal and final written warning. DON informed Licensing Specialist that the residents [redacted] were searched including their bedrooms and nothing was found. Resident [redacted] denied allegations and resident [redacted] didn't want staff to get into trouble.

Facility will be cited for R907.2. Staff failed to provide level of supervision to ensure the safety and well-being of the residents.