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: 12/11/2022

Date Received by DCCECE: 12/21/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: "Resident was taken off the unit earlier in the day after her and another resident got into a verbal disagreement. After being on the milieu with staff for over 10 minutes, she returned to the unit where she got into several more verbal altercations with peers, began tearing down Christmas decorations off the walls, and kicked her door several times after being told she could not use her personal bathroom and would have to use the open bathroom on the unit. She dysregulated several residents by her actions, and the rest of her unit was taken to the classroom as a result of her behavior. She stood up in the chair and began reaching for something on the ceiling (lights/fire alarm), staff escorted her down off chair where she began getting physically aggressive with staff. She was placed in a physical restraint for a short time to ensure safety of herself and staff while she was dysregulated. She was able to calm herself down but began getting frustrated again after being told she would be unable to join her peers in the cafeteria for dinner. She stated she was going to continue to show unsafe behaviors as a result of being told "no". She walked over to the hygiene closet on the unit, closed the doors, and locked it from the inside. Staff remained around door and attempted to make entry several times until resident decided to open the door. Once the door was opened, resident refused to exit hygiene closet. She was escorted out of the closet by staff where she began being physically aggressive again. She was placed in a second physical restraint to maintain the safety of herself and staff and while in second restraint, she began head banging on the floor and bit RN in the ankle. Dr. Froman called due to escalation of behaviors in second restraint and gave orders for an [redacted] injection. After [redacted] medication was given, resident sat at the end of the hallway and calmed herself down. She was taken off the unit to the bathroom/comfort room per her request. Resident remained in comfort room with staff where she regulated without further incident. Resident assessed after event and is noted to have sustained zero injuries. Bite mark was examined

on RN, no further medical assessment required. Resident will be placed on assault precaution safety plan as a result of these events."

Interim Action Narrative:

Maltreatment Narrative: **Outcome:**

Licensing Narrative: 12/21/22- 12/21/22-Program Coordinator reviewed the incident log at the facility during an intent training on 12/21/22. The Program Coordinator requested a copy of the incident as it was not reported to licensing as required in their current Corrective Action Agreement. The facility was made aware that this incident will be reviewed, and further discussion would occur in the near future as this was a failure to comply with the current Corrective Action Agreement. 12/29/22- Program Coordinator and Licensing Specialist visited the facility and discussed the incident. Licensing also viewed the hygiene closet on the green unit where the incident took place. The staff explained that it was during hygiene time so the door to the closet was unlocked as residents were completing hygiene. The resident became dysregulated and locked herself inside the closet. Licensing viewed the inside of the closet and seen that there is a twisting lock on the interior of the door. The Program Coordinator spoke to the corporate representative with the facility on site and discussed how the lock can be disabled from the inside easily by maintenance so no resident can lock themselves inside the closet again.

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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: 12/27/2022

Home Visit Date: 12/27/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Sub Regulation Description:

Regulation Number: 1.109.1.f

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

No site visit conducted on this day.

The Program Coordinator reviewed an incident from 12/11/22 in the incident log at the facility. The report showed that resident [redacted] self-harmed on 12/11/22 by banging her head on the floor. The Program Coordinator discussed how all self-harm reports are to be reported to the licensing unit per the corrective action agreement. This report was not sent to the licensing unit by the next business day; therefore, the facility is in violation of their corrective action agreement.

The facility will be cited for 109.1.f.

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Licensee Address: 2466 SOUTH 48TH STREET
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Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 12/29/2022

Home Visit Date: 12/29/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Program Coordinator and Specialist Michele Sutton visited the facility to follow up on an incident involving resident [redacted] on 12/11/22 in which the resident became dysregulated on the Green Unit and locked herself in a hygiene closet. Reports indicated that the resident was still highly aggressive when she was taken out of the closet, injuring staff, biting a nurse on the ankle, and banging her own head on the floor. The resident was placed on assault precautions and a safety plan.

Licensing viewed the hygiene closet on the Green Unit and seen that the door does have a twisting lock on the interior side. Licensing discussed with DON Ana Salazar and the corporate representative Shane Moody any alternative ways to ensure this door cannot lock from the inside. Mr. Moody explained that a mechanism on the inside of the lock can be disabled ensuring no one would be able to lock the door from the inside moving forward. The lock will be disabled as discussed by 12/30/2022.