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: 12/17/2022

Date Received by DCCECE: 12/22/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: Patient was given incorrect dose of medication which lead to increased aggression and the harm of others. Patient was then discharged and parents were notified via email and given 72 hours to pick the the patient 15 hours away. No aftercare plans were made

Interim Action Narrative:

Maltreatment Narrative: **Outcome:**

Licensing Narrative: Licensing specialist reviewed patient chart including intake information, case management notes, parent/family contacts, and medication logs. Patient admitted on 11/28/22 from a psychiatric facility in [redacted]. She arrived after regular business hours with limited paperwork and bottles of pills. The admitting nurse was not aware of a diagnosis [redacted], and it was not listed in the paperwork that was received. The first episode of staff assault/physical violence resulting in restraint happened upon admission when resident became violent during an initial admit search of her belongings and property. After this incident, medication was reviewed. The patient had two bottles of [redacted]--one

was a 60 mg bottle, and one was an 80 mg bottle. The admitting nurse assumed that the 80 mg was the current dosage and had been increased from 60 mg. The actual dosage prior to placement at Perimeter was 140mg daily. The nurse listed resident's [redacted] dosage as 80mg on the medication sheet. The psychiatric APRN visited the following morning and reviewed all medications and signed off on them. She made medication adjustments based on resident irritability and aggressive behaviors the day before and family was notified of medications that were increased. They were not provided a full list of current meds and dosages, however, which would have reflected the lower dose of [redacted]. Resident continued to exhibit violent behaviors throughout her stay: 11-29-22 assaulted nurse, 12/5/22-assaulted therapist, 12/12/22-involved in a fight on the unit. On 12/17/22 the family was notified via email that medications had been adjusted due to behaviors. On 12/20/22 at 1430 the facility sent an email to guardians informing of decision to initiate an emergency 72-hour discharge due to resident acuity and behaviors. Licensing specialist viewed communication between therapist Madelyn Spence and patient's father. Therapist contacted several physicians for follow up at guardian's request. A follow up appointment was made with primary care physician Dr. Raice for 12/22/22 at 4 PM. Attempt was made to schedule an appointment with an autism specialist Dr. Karem--specialist was booking 6 months out--family was provided with information about how to complete paperwork to request an appointment. Urgent emails were sent to Dr. Gilcrest, and Emily Ronkin for mental health follow up per family's request--no response prior to discharge, but family was provided with contact information. Therapist also attempted to schedule an appointment with Dr. Prosak, psychiatry, who stated that the guardians would need to call to request an appointment. Guardians were provided a list of medications upon discharge by facility APRN. This is when they discovered the reduced dose of [redacted] and insisted that she needed to be on the 140 mg. APRN stated and documented that this was not recommended and could not be done without reducing the other meds that had been increased during her stay. Family stated they wished to go back to previous medication regime--a 30-day supply of meds of the medications she was on prior to being placed in facility was called in for resident. Facility CEO Art Hickman advised that facility learned after patient admitted that she had several aggressive/violent behaviors at previous facility require multiple restraints weekly, therefore, facility does not believe change in medication dosages caused behavior prompting emergency discharge. Licensing has investigated this complaint and provided technical assistance on 1/4/2023 regarding standard 902.10 . Licensing complaint is UNFOUNDED

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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: Deborah Bailey

Record Visit Date: 1/4/2023

Home Visit Date: 1/4/2023

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Description: At the time of admission, the following information shall be documented in the child's record:

Sub Regulation Description:

Regulation Number: 9.902.10.f

Regulations Not Correctable:

Narrative:

Licensing specialist reviewed patient chart including intake information, case management notes, parent/family contacts, and medication logs. Patient admitted on [redacted] from a psychiatric facility in Ohio. She arrived after regular business hours with limited paperwork and bottles of pills. The admitting nurse was not aware of a [redacted], and it was not listed in the paperwork that was received. The first episode of staff assault/physical violence resulting in restraint happened upon admission when resident became violent during an initial admit search of her belongings and property. After this incident, medication was reviewed. The patient had two bottles of [redacted]--one was a 60 mg bottle, and one was an 80 mg bottle. The admitting nurse assumed that the 80 mg was the current dosage and had been increased from 60 mg. The actual dosage prior to placement at Perimeter was 140mg daily. The nurse listed resident's [redacted] dosage as 80mg on the medication sheet. The psychiatric APRN visited the following morning and reviewed all medications and signed off on them. She made medication adjustments based on resident irritability and aggressive behaviors the day before and family was notified of medications that were increased. They were not provided a full list of current meds and dosages, however, which would have reflected the lower dose of [redacted]. Resident continued to exhibit violent behaviors throughout her stay: 11-29-22 assaulted nurse, 12/5/22-assaulted therapist, 12/12/22-involved in a fight on the unit. On 12/17/22 the family was notified via email that medications had been adjusted due to behaviors. On 12/20/22 at 1430 the facility sent an email to guardians informing of decision to initiate an emergency 72-hour discharge due to resident acuity and behaviors. Licensing specialist viewed communication between therapist Madelyn Spence and patient's father. Therapist contacted several physicians for follow up at guardian's request. A follow up appointment was made with primary care physician Dr. Raice for 12/22/22 at 4 PM. Attempt was made to schedule an appointment with an [redacted]specialist Dr. Karem--specialist was booking 6 months out--family was provided with information about how to complete paperwork to request an appointment. Urgent emails were sent to Dr. Gilcrest, and Emily Ronkin for mental health follow up per family's request--no response prior to discharge, but family was provided with contact information. Therapist also attempted to schedule an appointment with Dr. Prosak, psychiatry, who stated that the guardians would need to call to request an appointment. Guardians were provided a list of medications upon discharge by facility APRN. This is when they discovered the reduced dose of [redacted] and insisted that she needed to be on the 140 mg. APRN stated and documented that this was not recommended and could not be done without reducing the other meds that had been increased during her stay. Family stated they wished to go back to previous medication regime, and a 30-day supply of meds of the medications she was on prior to being placed in facility was called in for resident. Facility CEO Art Hickman advised that facility learned after patient admitted that she had several aggressive/violent behaviors at previous facility require multiple restraints weekly, therefore, facility does not believe change in medication dosages caused behavior prompting emergency discharge.

Technical Assistance: 902.10f which requires facility to have documentation at time of admission of all medications currently prescribed for the child (if known and available) --please seek clarification from psychiatrist if unclear regarding dosages of medications upon admission. Please ensure that an attempt to get a full medication list from receiving facility/guardian is made at time of admission. Facility DON stated that moving forward, the facility plans to complete a nurse review and medication reconciliation for each new resident to ensure meds/dosages are correct and will follow up with a phone call to guardian to ensure accuracy. Licensing strongly recommends this protocol is used with all new admits.

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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:

Record Visit Date: 1/12/2023

Home Visit Date: 1/12/2023

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 received a complaint that on 12/14/22 a patientwas given the incorrect dose of medication which led to increased aggression and the harm of others. Patient was then discharged, and parents were notified via email and given 72 hours to pick the patient up 15 hours away. No aftercare plans were made for the resident.

Licensing has investigated this complaint and provided technical assistance on 1/4/2023 regarding standard 902.10 .

Licensing complaint is UNFOUNDED.