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: 12/21/2022

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Facility Type: Residential

Incident Type: Licensing

Report Description: "Around 1825, [redacted] damaged the fire sprinkler on her unit resulting in the fire alarm being triggered. A rapid release of water occurred from the sprinkler that resulted in widespread flooding throughout the units/milieu. All residents were taken to the back courtyard unil it was verified by the fire department that there was no fire. Once deemed safe by the fire department, all head counts were verified by staff, and residents were taken back into the building. While back inside, [redacted] verbalized to staff that she had plans to break the sprinkler so she could elope but was unable to do so. She sustained no injuries during this incident. Because of these events, she has been placed on an attempted elopement precaution safety plan with constant line of sight while she remains in the mindset of continuing to want to elope from the facility. She has also been placed on a property destruction safety plan due to the widespread flooding that occurred after she damaged the sprinkler, and the overall damage left from that."

Interim Action Narrative:

Maltreatment Narrative: **Outcome:**

Licensing Narrative: 12/21/2022- This incident was reviewed in the incident log at the facility by the Program Coordinator on 12/21/22. The facility did not report this incident to licensing, and it is not required that they report it to licensing by the next business day according to the Minimum Licensing Standards. However, due to several issues regarding residents setting off the fire alarm in the past, the licensing unit will be reviewing this incident for any potential supervision concerns. 12/29/22- Program Coordinator and Licensing Specialist Michele Sutton visited the facility. The licensing team discussed the incident with DON Ana Salazar and reviewed the camera footage from 12/17/22. The incident occurred on the Orange Unit. Video reviewed from 18:02 to approximately 18:45. The residents can be seen on the unit with staff in ratio. One resident, [redacted] starts to escalate at 1813 and can be seen pacing, knocking things over, ripping things off the walls, and throwing papers. Staff Mr. Tony appears to be attempting to de-escalate the resident. Other staff remove several other residents from the unit at 18:19, but both [redacted]. and [redacted] remain on the unit with Mr. Tony. Resident [redacted] can be seen throwing things at the wall/door including a chair. Resident [redacted] then finds a Lysol bottle that was left out by staff and begins to carry it around. At 1834 [redacted] climbs on a chair and begins hitting the sprinkler with the Lysol bottle as Mr. Tony continues to attempt to de-escalate the resident. The resident gets down but goes back on the chair at 18:35 and begins hitting it again. [redacted] then stops, but again gets on the chair at 18:39 and begins hitting the sprinkler. The last attempt was successful, and the fire alarm begins to go off as the sprinklers discharge flooding the unit. Staff immediately remove [redacted] and [redacted] off the unit. Licensing asked about the Lysol bottle and the DON reported that the unit had active cases of COVID so they had been cleaning on the unit prior to the incident. However, the Lysol was not removed and taken back to its storage area and instead remained on the unit. This was an oversight by staff and the bottle has since been removed. Licensing also discussed the staff's response to not intervene with the resident as she attempted to damage the fire sprinkler multiple times before she was successful. The DON stated that staff have been made aware that if a resident is attempting to damage a fire sprinkler which causes widespread facility water damage and possible threats to the safety of residents, it would be advised they remove the resident from the area or physically restrain them to ensure the safety of all the residents.

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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: 12/29/2022

Home Visit Date: 12/29/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Description: The grounds of the facility shall be kept clean and free of safety hazards.

Sub Regulation Description:

Regulation Number: 9.910.1

Regulations Needing Technical Assistance:

Regulation Description: Physical restraint shall be initiated only by staff trained by a certified instructor in a nationally recognized curriculum, and only to prevent injury to the child, other people or property, and shall not be initiated solely as a form of discipline. The agency shall maintain documentation that staff is deemed competent in physical restraint.

Sub Regulation Description:

Regulation Number: 9.905.10

Regulations Not Correctable:

Narrative:

Program Coordinator and Licensing Specialist Michele Sutton visited the facility to follow up on an incident involving resident [redacted] setting off the fire alarm/sprinkler system on the Green Unit the day of 12/17/22.

The licensing team discussed the incident with DON Ana Salazar and reviewed the camera footage from 12/17/22. The incident occurred on the Orange Unit. Video reviewed from 18:02 to approximately 18:45. The residents can be seen on the unit with staff in ratio. One resident, [redacted] starts to escalate at 18:13 and can be seen pacing, knocking things over, ripping things off the walls, and throwing papers. Staff Mr. Tony appears to be attempting to de-escalate the resident. Other staff remove several other residents from the unit at 18:19, but both [redacted] remain on the unit with Mr. Tony. Resident [redacted] can be seen throwing things at the wall/door including a chair. Resident [redacted] then finds a Lysol bottle that was left out by staff and begins to carry it around. At 18:34 [redacted] climbs on a chair and begins hitting the sprinkler with the Lysol bottle as Mr. Tony continues to attempt to de-escalate the resident. The resident gets down but goes back on the chair at 18:35 and begins hitting it again [redacted] then stops, but again gets on the chair at 18:39 and begins hitting the sprinkler. The last attempt was successful, and the fire alarm begins to go off as the sprinklers discharge flooding the unit. Staff immediately remove [redacted] and [redacted] off the unit.

Licensing asked about the Lysol bottle and the DON reported that the unit had active cases of COVID so they had been cleaning on the unit prior to the incident. However, the Lysol was not removed and taken back to its storage area and instead remained on the unit. This was an oversight by staff and the bottle has since been removed. Licensing also discussed the staff's response to not intervene with the resident as she attempted to damage the fire sprinkler multiple times before she was successful. The DON stated that staff have been made aware that if a resident is attempting to damage a fire sprinkler which causes widespread facility water damage and possible threats to the safety of residents, it would be advised they remove the resident from the area or physically restrain them to ensure the safety of all the residents.

The facility will be cited for 910.1 due to the Lysol being left unattended on the unit allowing a resident to obtain it.

The facility was provided T/A on standard 905.10 regarding the initiation of physical restraints in an effort to prevent injury or damage to property.