ARKANSAS DEPARTMENT OF HUMAN SERVICES

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:10/24/2022

Date Received by DCCECE: 10/25/2022

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Facility Type: Residential

Incident Type: Dual

Report Description: Residents Name/DOB: [redacted] Date/Time of incident: 10.24.2022 8:35pm Please give a description of the incident: Per staff report the resident was involved in an altercation with a peer. Resident stated he was horse playing with a peer and it went too far. The peer reported the resident put his peer in a head lock, pinned his throat with his knee, and repeatedly punched him. The peer reported he asked him to stop but did not, the peer then stated this resident shoved a comb up his rectum. Actions Taken: The resident was assessed by nursing and sent out to FCMC for further evaluation. The resident will be moved to a different classroom and program hall from the alleged peer. Residents will be peer restricted as well. Camera review was conducted at 11:35 am on 10/25/2022; staff members will receive appropriate disciplinary actions and supervision training leading up to termination. [redacted] Please give a description of the incident: Per staff report the resident was involved in an altercation with a peer. Resident stated he was horse playing with a peer and it went too far. The resident reported his peer put him in a head lock, pinned his throat with his knee, and repeatedly punched him. The resident reported he asked him to stop but did not, the resident then stated his peer shoved a comb up his rectum. Actions Taken: The resident was assessed by nursing and sent out to FCMC for further evaluation. The resident will be moved to a different classroom and program hall from the alleged peer. Residents will be peer restricted as well. Camera review was conducted at 11:35 am on 10/25/2022; staff members will receive appropriate disciplinary actions and supervision training leading up to termination. [redacted]. Residents will be assigned a single room placement and put on staff shadow precautions. Guardianship: TX, Foster Care Residents Name/DOB: [redacted] Date/Time of incident:

10.24.2022 8:35pm Please give a description of the incident: Per staff report the resident was involved in an altercation with a peer. Resident stated he was horse playing with a peer and it went too far. The resident reported his peer put him in a head lock and repeatedly punched him. The resident reported he asked him to stop but did not, the resident then stated his peer held him down while another peer stuck a comb up his rectum. Actions Taken: The resident was assessed by nursing and sent out to FCMC for further evaluation. The resident will be moved to a different classroom and program hall from the alleged peer. Residents will be peer restricted as well. Camera review was conducted at 11:35 am on 10/25/2022; staff members will receive appropriate disciplinary actions and supervision training leading up to termination. [redacted] Residents' room will be reassigned to single room placement Guardianship: Private Placement

Interim Action Narrative: Resident was assessed and referred to FCMC for further evaluation. He was moved to a different classroom and program hall from alleged peer. Residents were peer restricted. Staff members will received appropriate disciplinary actions and supervision train

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[redacted] [redacted] **Outcome: Founded**

Licensing Narrative: Licensing Specialist will follow-up with facility to review camera footage. Specialist informed that[redacted] is the alleged victim. [redacted] are the alleged offenders. [redacted] allegedly shove the comb and [redacted] allegedly held[redacted] down. Licensing Specialist reviewed camera footage on 10/27/2022 for 10/24/2022 from 20:20 to 20:37. Licensing Specialist observed different residents walking up and down the hall and entering into different bedrooms from 20:20 to 20:32. Two (2) staff members were sitting in the middle of the hallway facing each other. Staff members did not prevent the residents from going into unassigned bedrooms. At 20:33, staff entered into the bedroom where the alleged incident took place. At 20:35, everyone (residents and other staff member) were observed looking and going into the bedroom. At 20:37[redacted] was observed coming out of the bedroom with staff following behind. Due to no cameras in the bedroom, Licensing Specialist is unable to determine what took place. Licensing Specialist reviewed witness statements of the alleged incident. Facility will be cited for R907.2. Staff failed to provide level of supervision to ensure the safety and well-being of each resident.

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521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City

Facility Number: 142

Licensee Address: 603 KITTLE ROAD
FORREST CITY AR 72335

Licensing Specialist: Kendra Rice

Person In Charge:

Record Visit Date: 10/27/2022

Home Visit Date: 10/27/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Number: 9. 907. 2

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.

Findings Description:

Action Due Date:

Action Due Description:

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 4:00 pm to 4:45 pm

Census: 50

Licensing Specialist reviewed camera footage on 10/27/2022 for 10/24/2022 from 20:20 to 20:37. Licensing Specialist observed different residents walking up and down the hall and entering into different bedrooms from 20:20 to 20:32. Two (2) staff members were sitting in the middle of the hallway facing each other. Staff members did not prevent the residents from going into unassigned bedrooms. At 20:33, staff entered into the bedroom where the alleged incident took place. At 20:35, everyone (residents and other staff member) were observed looking and going into the bedroom. At 20:37 [redacted] was observed coming out of the bedroom with staff following behind. Due to no cameras in the bedroom, Licensing Specialist is unable to determine what took place. Licensing Specialist reviewed witness statements of the alleged incident.

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

Provider Comments:

CCL Staff Signature : Date: 10/27/2022

Provider Signature : Date: 10/27/2022

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521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City

Facility Number: 142

Licensee Address: 603 KITTLE ROAD
FORREST CITY AR 72335

Licensing Specialist: Kendra Rice

Person In Charge: Helena Coplin

Record Visit Date: 12/1/2022

Home Visit Date: 12/1/2022

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

No in-person licensing visit on 12/1/2022.

Licensing Specialist received a complaint on 10/24/2022 reporting that residents were horse playing and things went too far. Allegedly resident reported that a peer put him in a head lock, pinned his throat with his knee, and repeatedly punches him. Then allegedly a peer shoved a comb up his rectum. [redacted], [redacted]

Licensing Specialist reviewed camera footage on 10/27/2022 for the reported incident on 10/24/2022. Licensing Specialist was not able to observe the actual incident due to no cameras in the bedrooms. Facility was cited on 10/27/2022 for R907.2, due to staff failure to provide level of supervision to ensure safety and well-being of each resident.

Licensing Specialist was informed by the Program Manager that the case was screened out.

No licensing concerns noted.