ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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Notice of Serious Incident

Date of Incident: 3/25/2023

Date Received by DCCECE: 3/27/2023

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Facility Type: Residential

Incident Type: Licensing

Report Description: Residents Name/DOB: [REDACTED], [REDACTED] Date/Time of incident: 3/25/2023/ 8:28am Please describe the incident: Per staff report the resident?s eloped from the facility grounds after tampering with a smoke detector in his room causing all the facility doors to unlock. Actions Taken: Camera review was conducted on 3/27/2023 at 11:00am. Two residents are observed going into room 104. The resident exited the room and a peer entered. As the peer entered about 30 seconds later the fire alarm was triggered. Staff are observed lining the resident up and exiting the building to the courtyard. While waiting in the courtyard for the building the be cleared. Two residents ([REDACTED] and [REDACTED] are observed getting out of line and walking towards the building. A third resident ([REDACTED] is also observed getting out of line from the far right and running towards his two peers. All three residents ran inside of the building down 100-Hall to the exit. Staff are observed following the residents from the courtyard to the building and to 100-hall out of the exit. FCPD was called and gave the residents description. The residents were found by the FCPD on 3/276/2023 around 9:30am. At the first point of contact all three residents had knives on them, the residents procured the knives after eloping from the facility. 2 of them ([REDACTED] and [REDACTED] dropped their knives and the police were able to obtain them. The third resident, who is [REDACTED] took off running in the middle of an open field. The resident then held the knife to his throat threatening to kill himself. The police were able to subdue the resident and retrieve the weapon. [REDACTED] was taken to Forrest City ED for further evaluation. The resident has now been transferred to Perimeter West Memphis Acute for homicidal ideation and suicide gesture. [REDACTED] and [REDACTED] were both sent out to the FCMC on 3/26/2023 for further evaluation. Both residents returned with no new orders. Both residents have been placed on a safety plan and elopement precautions. The residents will remain on precautions until

they are deemed safe. Precautions will be evaluated every 72 hours (about 3 days). and are currently presenting safe and stable. The facility is conducting fire evacuation re-education and a root/cause analysis to help prevent this incident from reoccurring. Guardianship: Foster Care Foster Care Private Placement

Interim Action Narrative: FCPD was contacted. Residents were evaluated at FCMC. One resident ( ) was admitted to Perimeter of West Memphis Acute. Residents (were placed on a safety plan and elopement precautions.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist reviewed provider reported incident. Licensing Specialist spoke with Mr. Hickman regarding placing small clear plastic cages of the smoke detectors to prevent the residents from tampering them. Licensing Specialist will follow-up with the facility regarding camera footage. 3/29/2023, Licensing Specialist reviewed camera footage and received a copy of the Root Cause Analysis. Licensing Specialist informed that the nurse were included in the count during the incident, per Charlotte Lockhart, CEO. Licensing Specialist observed four (4) nurses on the courtyard.

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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: 3/29/2023

Home Visit Date: 3/29/2023

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: Residents were able to bypass staff and exit the building.

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: 12:15 pm to 1:45 pm

Census: 55

Licensing Specialist reviewed camera footage for a provider reported incident on 3/25/2023.

Licensing Specialist inquired about the knives that the residents had. Licensing Specialist was informed that the knives were obtained while the residents were away from the facility. The knives were NOT obtained from the facility.

Licensing Specialist reviewed camera footage. Licensing Specialist observed the residents and staff coming out of their designated areas in single file lines to the courtyard. They came out in the following order: SRU, 100 Hall (residents ███ and ███), 300 Hall (resident ███), and 400 Hall. Once outside, Licensing Specialist observed the residents form lines according to what hall they were on. Licensing Specialist observed staff and nurses on the courtyard, facility was out of ratio during the timeframe of this incident.

Licensing Specialist observed maintenance walking through the building entering each room. It appeared that maintenance was making sure that all areas were clear. Licensing Specialist observed residents (███ and ███) walking toward and passed a staff member into building on the 100 Hall. Licensing Specialist also observed resident ███ running toward the residents toward the building. A staff member was observed walking behind the residents and once in the building the residents ran down the hall with the staff member following closely behind. Once out the door, the staff member was observed running out the door and returning inside the building.

Mrs. Coplin-Smith (Director of Quality and Risk Management) informed Licensing Specialist that the facility spoke with Forrest City Fire Department's Fire Marshall. They will be working with the fire department looking for alternatives regarding the smoke detectors. Licensing Specialist was provided with a copy of the Root Cause Analysis with their action plan.

907.2, staff shall be responsible for providing the level of supervision to ensure the safety and well-being of each child at the facility. 907.3, staff to child ratio be at least one to six (1:6) during waking hours.

Moving forward the following CAA will be implemented: (1) Meet with the Director of Nursing to review the Evacuation Plan and Fire Drill Policy to ensure nursing staff are aware of their responsibilities. (2) Increase scheduled staff for the weekend shifts. Increase staffing by at least two (2) staff members.

Ms. Charlotte Lockhart, CEO, informed Licensing Specialist that the nurses were included in the count during the time of the incident. Licensing Specialist updated regulation 907.3.

Provider Comments:

CCL Staff Signature : Date: 3/29/2023

Provider Signature : Date: 3/29/2023