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: 6/11/2023

Date Received by DCCECE: Perimeter of the Ozarks

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: Name: [redacted] Notifications: See Below On the evening of 6/12/23 the patient [redacted] reported to staff that she was feeling anxious and scared about sleeping in her room. Staff asked her about it and the patient pulled the staff to the side of the hall. Patient told staff that she did not want to sleep in her room because of her roommate and for safety reasons. Staff reported about 45 minutes later the same patient approached her and told her the reason she was scared was because the night before (6/11/23) her roommate had raped her. Corrective Action: Report entered in the online [redacted] portal (report, [redacted]) [redacted] and [redacted] were separated units. [redacted] was placed on a sexual misconduct precaution safety plan with constant line of sight until she is asleep for 15 mins. Therapist to further process events with both residents and develop individualized programming to tailor each need. Parties notified of event: Travis Hood, CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Jill Shrader, VP Risk Compliance/Quality Annika Perry, MSW - Therapist Edison Sullivan ? Clinical Director Kris Stewart, Reagan Stanford, and Ashlyn Whelchel (Disability Rights of AR) Chelsea Vardell and Kendra Rice, and Felicia Harris, Lidia White (DHS) [redacted] (report [redacted]) Alyssa Denny, Caseworker Caroline Torres, Guardian

Interim Action Narrative: Residents were separated. Incident was entered online with [redacted] and accepted. AO was placed on sexual misconduct precaution safety plan with constant line of sight.

Maltreatment Narrative: A resident reported that her roommate had raped her the night before on 6/11/2023

Licensing Narrative: Licensing Specialist will inquire about AO last name, DOB, and guardian. 6/14/2023- Program Coordinator and Specialist Parnell visited the facility and discussed the incident. The residents were moved to different units after the report was made and are on a safety plan. A copy of the safety plan was provided to the licensing staff. Additionally, video footage was reviewed from the unit on the night in question from 7:00PM-8:42PM. It is unknown what time the alleged incident took place during the evening. The video footage does show staff completing their checks within the minimum licensing requirements of 30 minutes, but the residents are still awake on the unit and frequently leaving their room as the two staff sit and play cards. While the staff were in ratio and completing their checks, the children were not being appropriately supervised given that they were still awake and moving around the unit. The facility staff reported that staff are supposed to continuously walk the hall back and forth until all residents are asleep then begin their 30-minute visual checks. Both staff seen on camera will be retrained on appropriate supervision and nightly visual checks. 7/12/2023 - Licensing Specialist Jarred Parnell received updated safety plan for the incident. 7/19/2023, Licensing Specialist informed that case was found unsubstantiated by Investigator Logan Waynaroski.

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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: Art Hickman

Record Visit Date: 6/14/2023

Home Visit Date: 6/14/2023

Purpose of Visit: Complaint 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: Staff on the blue unit the night of 6/11/23 were seen to be playing cards after residents were sent to their room for lights out. The residents were still visibly awake and moving about the unit periodically. The facility policy is to continuously walk the hallway until all residents are asleep after lights out then begin their nightly visual observations. The staff was not following this policy or providing adequate supervision to the residents.

Action Due Date: 6/21/2023

Action Due Description: The facility shall retrain both staff involved in appropriate supervision and notify licensing once the training is complete.

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Visit completed from 11:50AM-1:50PM by Program Coordinator and Specialist Jarred Parnell.

Licensing discussed case 014749 with the regional CEO Art Hickman and DON Sarah Kroon. The facility provided a copy of the resident's safety plan and room placement. The AO was originally placed on the blue unit but has now been moved to the orange unit in a single room. The AV has stayed on the blue unit.

Camera footage was reviewed from the night of 6/11/23 on the blue unit from 7:00PM-8:42PM. It is unknown when the alleged incident took place so no specific time frame can be reviewed. The two staff assigned to the unit can be seen sending the residents to bed for lights out. The two staff sit at a table in the dayroom and play cards and you see residents come up and down the hallway periodically exiting their rooms. The staff does complete walkthroughs of the residents on the unit in their bedrooms within the 30-minute time requirement set by the Minimum Licensing Standards, but the residents are not asleep. The facility reports their policy is for staff to take turns walking up and down the hall continuously when the residents go to their bedrooms until all the residents are asleep. Once they are asleep, the staff can begin their visual checks throughout the sleeping hours. The two staff noted on the unit will be retrained on this policy.

The licensing unit is not prepared to leave a finding for the complaint at this time, but the facility will be cited for the staff's lack of supervision on the blue unit.

Provider Comments:

CCL Staff Signature : Date: 6/15/2023

Provider Signature : Date: 6/15/2023

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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: Kendra Rice

Person In Charge: Sarah Kroon

Record Visit Date: 7/19/2023

Home Visit Date: 7/19/2023

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 1:30 pm to 2:00 pm

Census: 27

Licensing received a complaint on 6/11/2023 for ELS Case #014749.

This complaint has been founded by licensing.

The facility was cited for R907.2 on 6/14/2023.

Provider Comments:

CCL Staff Signature : Date: 7/19/2023

Provider Signature : Date: 7/19/2023