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: 7/17/2023

Date Received by DCCECE: 7/20/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: Name: [redacted], DOB: 0[redacted] On 7/19/23, [redacted] reported to staff that she believes she obtained injuries on her arms from a physical hold that she was placed in on 7/17/23. Due to the allegation, a report was uploaded to the [redacted]) Corrective Action: ? Internal investigation opened, camera footage reviewed, statements provided. ? [redacted]s arms were assessed and documented. 2 superficial, 1/4-inch scratch marks were noted on her left forearm and upper arm with no actual breaks in the skin. A pea (for reference) sized circular area of mild discoloration noted on right upper arm. ? Report [redacted]) Parties notified of event: Travis Hood, CEO Margarita Burciaga, Caseworker Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Jill Shrader, VP Risk Compliance/Quality Annika Perry, MSW ? Clinical Director Kris Stewart, Reagan Stanford, and Ashlyn Whelchel (Disability Rights of AR) Chelsea Vardell, Kendra Rice, Jarred Parnell and Felicia Harris (DHS) [redacted]

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 7/21/2023-Program Coordinator emailed the facility to find out more information regarding the allegations and why there appears to be a delay in reporting [redacted] 7/24/2023- Licensing Specialist Jarred Parnell reviewed the complaint. 7/26/223- Program Coordinator and Licensing Specialist visited the facility to discuss the incident. The camera footage was reviewed. Witness statements, training verification, and regulatory check information was obtained. Licensing requested re-training of staff and a copy of the video footage. Facility cited for 905.9. Licensing received a copy of the retraining.

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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: Jarred Parnell

Person In Charge:

Record Visit Date: 7/26/2023

Home Visit Date: 7/26/2023

Purpose of Visit: Special Visit

Regulations Out of Compliance:

Regulation Number: 9. 905. 9

Regulation Description: Physical restraints shall be performed using minimal force and time necessary. Physical restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort, or holding a hand to safely escort a child from one area to another, is not considered a physical restraint.

Findings Description: Staff [redacted] did not use minimal force when attempting to escort a resident from the milieu area to the resident's unit.

Action Due Date: 8/2/2023

Action Due Description: Please ensure that staff [redacted] is retrained on how to conduct appropriate restraints/escorts with residents.

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

7/26/2023 - Licensing Specialist Jarred Parnell visited the facility to review camera footage and discuss the reported incident. Program Coordinator Chelsea Vardell was present at the visit. The video footage was reviewed with Handle with Care instructor [redacted].

Camera footage from 7/17/23 was reviewed beginning at 5: 32PM to 5:53PM.Questions during review of the video footage concerning Handle with Care practices and restraint holds used during the incident were answered by Handle with Care Trainer [redacted].Footage showed that the resident was in the milieu sitting on the floor with multiple staff surrounding her and watching. The resident had reportedly been sitting on the floor refusing to go back to her unit for over an hour. The resident was kicking and spitting on any staff that approached her. The resident was eventually placed in an attempted escort hold to go to the unit, but the hold was done incorrectly as the resident was resisting. One staff member, [redacted], does not appear to be using the minimal force required to escort the resident, nor does she attempt to correct her incorrect hold with the resident. Staff [redacted] forcefully pulls the resident by her arm onto the unit where both staff then take the resident to the floor for a proper restraint. Additional staff followed onto the unit.

Staff [redacted] appeared on the camera footage for the duration of the incident. Staff [redacted] seemed to be the primary focus of the resident's anger,according to facility staff. The resident continued to make comments and call staff [redacted] names. Staff stated that staff [redacted] was asked to leave the situation several times, but she continued to stay. When the resident was taken to the floor on the unit for a restraint hold, staff [redacted] participated in holding the resident's legs after again being told to leave the room by the Handle with Care Instructor observing the restraint.

Please ensure that staff [redacted] is retrained on how to conduct appropriate restraints/escorts with residents by **8/2/2023.**

Please ensure staff [redacted] is retrained on the facilities proper protocols when de-escalating a resident by **8/2/2023.**

Please ensure all staff present during the incident are re-educated on the facility's policy regarding proper protocols for staff response to an incident by **8/4/2023.**

Provider Comments:

CCL Staff Signature : Date: 8/18/2023

Provider Signature : Date: 8/18/2023