Notice of Serious Incident

Date of Incident: 7/26/2023

Date Received by DCCECE: 7/27/2023

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: Licensing

Report Description: Please describe the incident: On 7-26-23 Resident [redacted] eloped from the facility at @17:44 from Station One after a peer pulled a fire alarm that disabled the doors for safety. Resident returned with staff after he responded to staff?s verbal de-escalation and processing on his own. Actions Taken: Police were notified, and the resident was returned to the facility at @17:52 When he was returned to the facility there were no injuries that were apparent. The psychiatrist and AOC were notified as well. The resident was placed on Elopement Precautions.

Interim Action Narrative: Staff provided verbal de-escalation and the police were called. Resident was assessed and placed on elopement precautions. Psychiatrist and AOC were notified.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist was informed of provider reported incident via email. 7/28/2023, Licensing Specialist reviewed provider reported incident for licensing concerns. Licensing Specialist will inquire about camera footage. 7/31/2023, Licensing Specialist followed-up on camera footage. 8/2/2023, Licensing Specialist unable to review camera footage due to Clinical Director conducting a training. 8/9/2023, Licensing Specialist reviewed camera footage.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
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Facility Number: 142

Incident Type: Licensing

Report Description: Please describe the incident: On 7-26-23 Resident [redacted] eloped from the facility at @17:44 from Station One by pulling a fire alarm that disabled the doors for safety. Resident returned without struggle per police escort. Actions Taken: Police were notified, and the resident was returned to the facility at @18:10. When he was returned to the facility there were no injuries that were apparent. The psychiatrist and AOC were notified as well. The resident was placed on Elopement Precautions.

Interim Action Narrative: The police called. Resident was assessed and placed on elopement precautions. Psychiatrist and AOC were notified.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist was informed of provider reported incident via email. 7/28/2023, Licensing Specialist reviewed provider reported incident for licensing concerns. Licensing Specialist will inquire about camera footage. 7/31/2023, Licensing Specialist followed-up on camera footage. 8/2/2023, Licensing Specialist unable to review camera footage due to Clinical Director conducting a training. 8/9/2023, Licensing Specialist reviewed camera footage.

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Report Description: Please describe the incident: On 7-26-23 Resident [redacted] eloped from the facility @17:44. Resident returned on his own after verbal escalation with staff and processing with staff at @17:52 body check and cheek check were performed it did not appear that resident had any injury. The resident then ran out of the building again as staff were working with the door company to get the doors back online at @18:10. Police had to escort the resident back to the facility @ 18:15. Actions Taken: Staff were able to convince [redacted] to return to the facility on his own after the first elopement through processing and verbal de-escalation. Per the second elopement, police escorted [redacted] back to the facility, and the resident was returned to the facility at @18:15. When he was returned to the facility there were no injuries that were apparent. The psychiatrist and AOC were notified as well. [redacted] was administered per doctor?s order for agitation, a 2nd body check was performed and there were no injuries noted or observed.

Interim Action Narrative: The police were called. Staff provided verbal de-escalation. Resident was assessed. Psychiatrist and AOC were notified.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist was notified of provider reported incident on 7/27/2023. 7/28/2023, Licensing Specialist reviewed provider reported incident for

licensing concerns. Licensing Specialist will inquire about camera footage and safety precautions. 7/31/2023, Licensing Specialist followed-up on camera footage. 8/2/2023, Licensing Specialist unable to review camera footage due to Clinical Director conducting a training. 8/9/2023, Licensing Specialist reviewed camera footage.

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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: Charlotte Lockhart

Record Visit Date: 8/9/2023

Home Visit Date: 8/10/2023

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 10:30 am to 1:30 pm

Census: 57

Licensing Specialist spoke with Ms. Charlotte Lockert, CEO, Antione Jackson, Clinical Director, and Clifton Williams, Program Director, regarding ELS Cases #015267, #015268, and #015269.

Licensing Specialist reviewed camera footage of provider reported incidents on Station 1 Hall. Licensing Specialist observed staff and residents in the hallway, ratio 3:3. One resident ███ was standing at the by the hallway exit door. Residents were observed walking up and down the hallway, in and out of the dayroom, and moving the drink (water) dispenser. Licensing Specialist did not observe residents in the dayroom or shower.

Resident ███ was observed jumping up by the exit door with his hand in the air by the exit sign. He then pushed the door open and ran off the hallway. Licensing Specialist observed a nurse run after the resident. Two residents ███ and ███ were observed bypassing staff, come out of the dayroom, and running off the hall. The other residents remained in the dayroom.

Licensing Specialist observed a staff member on a walkie come down the hallway and return to her location. Staff member was unable to go after the residents due to having residents in the shower. Staff member that was by the dayroom was unable to go after the residents due to having a resident on line of sight. Nurse was observed returning to the hall.

Residents ███ and ███ returned with staff. It was reported that staff was able to process (verbal de-escalate) and convince the residents to return to the facility.

Provider Comments:

CCL Staff Signature : Date: 8/18/2023

Provider Signature : Date: 8/18/2023