



**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: 8/1/2023

Date Received by DCCECE: 8/1/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: Name: [REDACTED] DOB: [REDACTED] Notifications: See Below

Summary: This morning around 9:30am staff reported that the resident was upset and that they were processing with her on the milieu. Resident had calmed down and was continuing to talk to therapist when another staff member went out the back exit to go outside. The therapist reported that the resident, who seemed calm, took off running out the door before it fully closed and made it outside. Once outside the patient made it outside of the locked area due to the back gate being open due to deliveries being made. Staff were able to retrieve the patient, verbally de-escalate her, and escort her back into the facility. Corrective Action: Anytime the back gate is open or unlocked, including deliveries, there will be a staff member stationed there. Anytime a staff member goes out a door leading outside they are not allowed to walk away from the door until the lock is completely re-engaged. 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 ? Clinical Director Kris Stewart, Reagan Stanford, and Ashlyn Wheelchel (Disability Rights of AR) Chelsea Vardell and Kendra Rice, and Felicia Harris (DHS) Anita Hall- guardian

Interim Action Narrative:

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Maltreatment Narrative:

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Licensing Narrative: 8/2/2023 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. 8/2/2023 - A visit was conducted at the facility to view camera footage and speak with staff about the provider reported incident. Camera footage was reviewed at the facility with CEO Travis Hood. Camera footage on date 8/1/2023 at 9:22 AM - 9:28 AM when the elopement occurred. In the video the resident [REDACTED] can be seen in the milieu with staff A. Perry. The resident and A. Perry were processing and doing some exercising. The resident can be seen smiling and dancing around with A. Perry and another staff who walks through the milieu. Staff E. Ingram comes into the milieu from the school hallway and walks outside. As the door is closing the resident ran out the door before the magnetic latch could engage. There was no video footage outside because the camera was disconnected while construction was being done on the building. Staff said the resident continued outside through the back gate which was open because a food delivery was being made. The resident ran two blocks up the road and sat down. The resident was picked up and taken back to the facility. The incident lasted a total of ten minutes. Law enforcement was called after the resident exited in the building. In response to the incident a new gate was added outside in the back which creates a barrier between the delivery gate and the recreation area. The gate is locked with a pad lock. During delivery times on Tuesday, Wednesday, and Thursday a staff person will be stationed at the back gate until the delivery is completed. Re-education will be conducted for all staff regarding entering and exiting and ensuring the doors and gates lock before moving away.



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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:** Travis Hood

**Record Visit Date:** 8/2/2023

**Home Visit Date:** 8/2/2023

**Purpose of Visit:** Special Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

8/2/2023 Licensing Specialist Jarred Parnell conducted a visit at the facility to review video footage and discuss the incident.

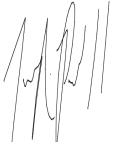
Video footage was reviewed for the incident. The resident can be seen standing with staff [REDACTED] processing and doing fitness. Another staff member [REDACTED] walks from the school hallway to the outside door. As the door is closing the resident runs out of the door before the door can latch. The resident proceeded out the gate in the back of the building because the gate was open due to a delivery truck dropping off a delivery.

CEO [REDACTED] states staff will be re-educated on exiting and entering doors and outside gates. A secondary outside gate was added in between the recreation area and the delivery area which is secured with a pad lock. A staff person will be stationed at the back of the building at the gate when deliveries are being made.

**Provider Comments:**

CCL Staff Signature :

Date: 8/18/2023



Provider Signature :

Date: 8/18/2023

