



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: 10/19/2023

Date Received by DCCECE: 10/23/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: Name: [REDACTED] (victim), DOB: [REDACTED], [REDACTED] (perpetrator), DOB: [REDACTED] (victim) alleged that her and [REDACTED] (perpetrator) kissed, and [REDACTED] began grabbing her breasts and made contact with her vagina without her consent. [REDACTED] states [REDACTED] ?forced her to give her hickies on her boobs.? The event was reported to have happened in their bedroom overnight on 10/19/23, but on 10/23/23, staff overheard resident on the phone describing the event to her mother. Staff then reported event to the Director of Risk and Quality and DON, a [REDACTED], and an internal investigation was initiated. Statements were then taken and cameras were reviewed, but because the event happened in a bedroom, there is no camera access to review.

Corrective Action: ? Residents were separated and placed on different units. ? [REDACTED] was placed on sexual misconduct precautions with constant line of sight. [REDACTED]

Parties notified of event: [REDACTED] ([REDACTED] Guardian) [REDACTED] ([REDACTED] DHS worker) Travis Hood, CEO Art Hickman, Regional CEO Rebecca Thomas, VP Risk Compliance/Quality/Clinical Training 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)

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 10/24/2023 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist contacted the facility and spoke to S. Kroon. Video footage for the day of the incident was discussed to ensure the footage will not be deleted before review. A visit was scheduled in order to review the incident and ensure regular bed checks are being conducted. 10/27/2023 - A follow up visit was conducted at the facility to review camera footage for the reported incident. Camera footage was reviewed for 10/19/2023 8:48PM - 11:00 PM The camera footage was reviewed for night time bed checks and supervision regarding the report incident. From 8:48 PM to 9:50 PM staff can be seen doing regular bed checks. At 9:50 PM staff can be seen on camera speaking with an up set resident at the end of the hallway. The staff resolve the incident and go back to the day room. The next bed check was not completed until 10:57 PM. Staff did not complete visual checks on each sleeping resident for one hour and seven minutes.



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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:

Home Visit Date: 10/27/2023

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 9. 907. 6

Regulation Description: Supervision during sleeping hours shall include a visual check on each child at least every thirty (30) minutes.

Findings Description: Staff did not complete visual checks on each sleeping resident for one hour and seven minutes.

Action Due Date: 10/27/2023

Action Due Description: Staff shall complete visual checks on sleeping residents every 30 minutes.

Comply Date:

Sub Regulation Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:


10/27/2023 - A follow up visit was conducted at the facility to review camera footage for the reported incident.

Camera footage was reviewed for 10/19/2023 8:48PM - 11:00 PM


The camera footage was reviewed for night time bed checks and supervision regarding the report incident. From 8:48 PM to 9:50 PM staff can be seen doing regular bed checks. At 9:50 PM staff can be seen on camera speaking with an up set resident at the end of the hallway. The staff resolve the incident and go back to the day room. The next bed check was not completed until 10:57 PM.

Staff did not complete visual checks on each sleeping resident for one hour and seven minutes.

Provider Comments:

CCL Staff Signature : 

Date: 10/27/2023

Provider Signature : 
Director risk and Quality management

Date: 10/27/2023