



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

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### Notice of Serious Incident

Date of Incident: 10/24/2023

Date Received by DCCECE: 10/25/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: Resident Name: [REDACTED], DOB: [REDACTED] Accused Staff:  
[REDACTED] (MHT); [REDACTED] (MHT) Staff involved: [REDACTED] (MHT)

Date/Time of incident: Multiple reports between 10/18/23 ? 10/24/23, [REDACTED] self-reported events to staff on 10/24/23 at approximately 2330. On 10/24/23, [REDACTED] reported to [REDACTED] (staff involved) that on different occasions, 2 male staff (Accused Staff, [REDACTED] performed sexual acts on her ranging from inappropriate touch to vaginal penetration. [REDACTED] reported the allegations to his supervisors and administration, and a hotline call was placed and accepted for investigation (pending reference number via fax from state police). An internal investigation was initiated, and the 2 staff members ([REDACTED] and [REDACTED]) were suspended without pay pending investigative results from state police. [REDACTED] was assessed at the Child Safety Center based on the details of the reported incident. According to the report, [REDACTED] stated that these incidents occurred while in the shower or bedroom. There is no camera access available in the resident bedrooms or bathrooms, but upon camera review, it was concluded that on all accounts of allegations, neither staff member was with the resident alone or off camera. Actions Taken: Staff to remain on suspension until the conclusion of the investigation with State Police. Notified: [REDACTED] (Guardian) Travis Hood, CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training, VP Risk/Quality Annika Perry, MSW ? Clinical Director Kris Stewart, Reagan Stanford, and Ashlyn Whelchel (Disability Rights of AR) Chelsea Vardell, Jarred Parnell, and Felicia Harris (DHS)

Interim Action Narrative: Both staff named as offenders were sent home on suspension pending the results of the [REDACTED].

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Maltreatment Narrative: Resident Name: [REDACTED], DOB: [REDACTED] Accused Staff: [REDACTED] (MHT); [REDACTED] (MHT) Staff involved: [REDACTED] (MHT) Date/Time of incident: Multiple reports between 10/18/23 ? 10/24/23, [REDACTED] self-reported events to staff on 10/24/23 at approximately 2330. On 10/24/23, [REDACTED] reported to [REDACTED] (staff involved) that on different occasions, 2 male staff (Accused Staff, [REDACTED]) performed sexual acts on her ranging from inappropriate touch to vaginal penetration.

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Licensing Narrative: 10/26/2023 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell 10/27/2023 - A visit was conducted at the facility to review camera footage for the incident. 10/27/2023 - A visit was conducted at the facility to review camera footage of the alleged incidents. Timeframes viewed on 10/18/2023 - 17:00 - 21:06, 10/19/2023 - 18:04 - 23:30, 10/23/2023 - 15:00 - 20:34. The resident can be seen on camera walking to her room to take a shower. There are staff members in the day room and the hallway. No staff person entered the residents room during shower times. The resident was in her room for two minutes each day to retrieve her mattress because she sleeps in the day room. Other than those times the resident can be seen sitting in the day room. Video footage from the unit also revealed the two staff persons alleged in the report are not seen working on the unit together at any point during these time frames. The only time the two staff persons are working together is when the resident is being escorted. The facility utilized the two male staff to escort the resident because of her large size and unpredictability and as a safety precaution should the resident become dysregulated, it is safer for both the facility staff and the resident.



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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:** 10/27/2023

**Home Visit Date:** 10/27/2023

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**


**Narrative:**

10/27/2023 - A visit was conducted at the facility to review camera footage of the alleged incidents.

Timeframes viewed on 10/18/2023 - 17:00 - 21:06, 10/19/2023 - 18:04 - 23:30, 10/23/2023 - 15:00 - 20:34.

The resident can be seen on camera walking to her room to take a shower. There are staff members in the day room and the hallway. No staff person entered the residents room during shower times. The resident was in her room for two minutes each day to retrieve her mattress because she sleeps in the day room. Other than those times the resident can be seen sitting in the day room.

**Provider Comments:**

CCL Staff Signature : 

Date: 11/6/2023

Provider Signature : 

Date: 11/6/2023



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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:** Jarred Parnell

**Person In Charge:** Travis Hood

**Record Visit Date:** 12/1/2023

**Home Visit Date:** 12/1/2023

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**


**Regulations Not Correctable:**

**Narrative:**

12/1/2023 - The findings of case # 017049 have been determined to be UNFOUNDED.

ICA's for staff [REDACTED] and [REDACTED] have been lifted. This was approved by Program Manager Chelsea Vardell on 11/29/2023.

**Provider Comments:**

CCL Staff Signature : 

Date: 12/1/2023

Provider Signature : *Travis Hood, MS*

Date: 12/1/2023