ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 11/20/2023

Date Received by DCCECE:11/21/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: On 11/20/23 at 15:19 was escalated and trying to fight another resident. When staff tried to remove other resident tried to follow and run off unit. The accused staff grabbed the resident and pushed her back on the unit knocking her to the floor. This was discovered upon review of footage of the second incident. The second incident was reported by staff to myself, DON, and CEO. Another staff member reported that during an incident that happened about 20 minutes later that the accused staff had hit resident in the back. The accused staff reported that the resident had bit her while she was trying to help separate the resident from another resident she was fighting. Both incidents were reported to the child abuse hotline. . for the pushing was documented. Corrective Action: ? Accused staff suspended immediately during investigation. ? and other resident who where fighting have been separated. Parties notified of event: Travis Hood, CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Chris Perry, VP Risk Compliance/Quality John Sneed, VP Human Resources Annika Perry, MSW ? Clinical Director Sarah Kroon-Director of Nursing Kris Stewart, Reagan Stanford, and Ashlyn Whelchel (Disability Rights of AR) Chelsea Vardell, Kendra Rice, Jarred Parnell and Felicia Harris (DHS)

Interim Action Narrative: Staff was placed on suspension pending the results of the investigation.

Maltreatment Narrative: On 11/20/23 at 15:19 [redacted] was escalated and trying to fight another resident. When staff tried to remove other resident [redacted] tried to follow and run off unit. The accused staff grabbed the resident and pushed her back on the unit knocking her to the floor. Th

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Licensing Narrative: 11/21/2023- Program Manager emailed the facility for the resident's DOB and guardianship status. DOB is [redacted] and the resident is a private placement. 11/21/2023 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist reached out to the DCFS investigator Corbyn White to obtain permission to contact the facility. Licensing Specialist will contact the facility as soon as permission is obtained to inquire further about the incident and review the safety plan. Licensing Specialist reached out to the facility to discuss the incident and safety plan with C.E.O Travis Hood. Staff member [redacted] was on the orange unit with two other staff [redacted] and [redacted]. [redacted] did not see the incident. [redacted] did see the incident and reported to Travis Hood and provided a statement. Video footage was reviewed of the incident by Travis Hood, Sarah Whorton and Sarah Kroon. Two incidents were viewed. Time stamps for the incidents are 11/20/2023 at 16:19 - 16:20 and 16:42 - 16:44. Explanation of the incidents, the staff member used improper Handle with Care practices. The staff member used a hip throw on the resident. The staff member punched the resident in the back after she was bitten by the resident. T. Hood states if she had used proper handle with care practices, she would not have been in a position to be bitten by the resident, also punching the victim was not proper handle with care practices. Licensing Specialist requested to save the camera footage for review on Monday 11/27/2023 The safety plan enacted by the facility is to place staff member [redacted] on suspension and terminate her employment 11/22/2023. This is not only due to the content seen in the reported incident but also other complaints voiced by residents and other staff members. The resident also had altercation with another resident which lead to the resident being dysregulated to begin with. These residents have been placed on separate units and are on line of sight precautions. 11/27/2023 - Licensing Specialist conducted a visit to the facility to review camera footage for the provider reported incident. Video footage was reviewed for the date 11/20/2023 at time stamp 16:19 - 16:25 and 16:42 - 16:50. Video footage for the first incident starting at 16:19 shows the staff person [redacted] in the day room assisting the other two staff. The staff are separating [redacted] from another reason she was having an altercation with. Staff step in between [redacted] and remove the other resident from the unit. [redacted] can be seen near the door. [redacted] bumps the resident with her shoulder and then throws the resident to the floor. The resident walks away from the staff and walks to her room bedroom. Video footage for the second timestamp started at 16:42. [redacted] can be seen leaving her bedroom. Another resident walks behind [redacted] and pulls her to the ground with her hair. Staff [redacted], [redacted] and [redacted] begin to restrain the residents. [redacted] grabs the aggressor by the arms and lifts her off [redacted]. [redacted] can be seen on [redacted] with her right arm around her face. The resident bites [redacted] [redacted] hit [redacted] in the center of her back with a fist because she

was not releasing the bite. The residents are separated. Licensing specialist spoke to CEO T. Hood about the incident. [redacted] was put on suspension and terminated 11/22/2023 as part of the safety plan. T. Hood stated the staff person did not use the proper Handle with Care practices which is why she was bitten by the resident. Hitting a resident is not the handle with care practices. Throwing the resident to the ground is not handle with care practices either. Staff have been retrained in resident/staff interactions.

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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: 11/27/2023

Home Visit Date: 11/27/2023

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Finding Description: A staff person used unprofessional conduct for engaging in behavior that could be dangerous, and physically harmful to children.

Action Due Date: 2023-11-27

Action Due Description: The staff person shall be placed on leave pending the results of the investigation.

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

Action Due Description: The staff person shall be placed on leave pending the results of the investigation.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

11/27/2023 - A visit was conducted to review camera footage for a complaint received for an incident that occurred on 11/20/2023. Video footage was reviewed for two incidents at16:19 - 16:25 and 16:42 - 16:50.

Video footage for the first incident starting at 16:19 shows the staff person [redacted] in the day room assisting the other two staff. The staff are separating the alleged victim from another resident she was having an altercation with. Staff step in between them and remove the other resident from the unit. The alleged victim can be seen near the door, [redacted] bumps her with her shoulder and then pushes the her to the floor. The alleged victim walks away from the staff and walks to her room bedroom, she returns to the day room a few moments later. Staff are still de-escalating the resident.

Video footage for the second timestamp started at 16:42. The alleged victim can be seen leaving her bedroom. Another resident walks behind the alleged victim and pulls her to the ground with her hair. Staff [redacted], [redacted] and [redacted] begin to restrain the residents. [redacted] grabs the aggressor by the arms and lifts her off the alleged victim. [redacted] can be seen on [redacted] with her right arm around her face. The resident bites [redacted]. [redacted] hit the allege victim in the center of her back with a fist because she was not releasing the bite. The residents are separated from each other.

The facility is being cited for unprofessional conduct for engaging in behavior that could be dangerous, and physically harmful to children.

The facility has terminated [redacted]. Residents have been moved to different units, and staff have been retrained on resident/staff interaction.

Provider Comments:

CCL Staff Signature : Date: 11/27/2023

Provider Signature : Travis Hood, MS Date: 11/27/2023

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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:

Record Visit Date: 3/28/2024

Home Visit Date: 3/28/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

No in-person licensing visit completed on 3/28/2024.

Licensing Specialist received a complaint on 11/21/2023 for ELS Case #017654.

This complaint has been**FOUNDED**by licensing.

The facility was cited for regulation standard 100.109.1.g

Provider Comments:

CCL Staff Signature : Date: 3/28/2024

Provider Signature : Date: 3/28/2024