



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: 11/23/2023

Date Received by DCCECE: 11/27/2023

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: SERIOUS OCCURRENCE REPORTING FORM ? Serious injury requiring outside medical attention ? Resident?s attempted suicide ? Allegation of abuse/neglect ? Resident?s death ? AWOL/Elopement ?*X* Allegation of sexual/physical abuse Victim: [REDACTED] DOB: [REDACTED] Alleged Abuser: [REDACTED] DOB: [REDACTED] Date/Time of incident: 11/23/23 at 1802 Name of Perimeter Staff Making Notification Date Time Name of Person Notified Agency Rep Sarah Whorton, RN, Director of Risk and Quality 11/24/23 10:30 am See Below Sarah Whorton, RN, Director of Risk and Quality 11/24/2023 Name and title of staff completing this form Date: Name of Facility: Perimeter Behavioral of the Ozarks Phone Number: 479-957-9857 Street Address, City, State, Zip: 2466 S. 48th Street Suite B. Springdale, AR 72762 Please give a description of the incident: On 11/24/23 resident [REDACTED] reported to staff that on 11/23/23 [REDACTED] had touched her inappropriately without consent. [REDACTED] stated that [REDACTED] told her to put her hand on [REDACTED]'s thigh and that when she did [REDACTED] in return put her hand on [REDACTED]'s thigh and then moved up to her vagina against her wishes. Residents report that it was over clothes and [REDACTED] stated that the actives were consensual. This took place in the dayroom while the residents were sitting next to each other under separate blankets that were overlapping. There was no sign of distress or fighting/arguing. Residents were sitting in the back of the dayroom with all of the peers from that unit and staff in front of them. Both residents can be seen watching staff and stopping movement under blankets when they think he is going to see them. Corrective Action: ? Residents separated. ? Residents placed on sexual misconduct precautions. ? Staff will be re-educated on blankets not being allowed in the dayroom unless therapeutically approved and meeting the criteria to be allowed (can not cover half of the body) Parties notified of event: [REDACTED], Guardian ([REDACTED]), Guardian ([REDACTED]) Travis Hood, CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Chris Perry, VP Risk Compliance/Quality Annika Perry, MSW ? Clinical Director Sarah Kroon-Director of

Nursing Kris Stewart, Reagan Stanford, and Ashlyn Welchel (Disability Rights of AR)
Chelsea Vardell, Kendra Rice, Jarred Parnell and Felicia Harris (DHS)

Interim Action Narrative: ? Residents separated. ? Residents placed on sexual misconduct precautions. ? Staff will be re-educated on blankets not being allowed in the dayroom unless therapeutically approved and meeting the criteria to be allowed (can not cover half of the body)

Maltreatment Narrative: On 11/24/23 resident [REDACTED] reported to staff that on 11/23/23 [REDACTED] had touched her inappropriately without consent. [REDACTED] stated that [REDACTED] told her to put her hand on [REDACTED]'s thigh and that when she did [REDACTED] in return put her hand on [REDACTED]'s thigh and then moved up to her

Licensing Narrative: 11/27/2023 - The provider reported complaint was reviewed by Licensing Specialist Jarred Parnell. Video footage for the incident was reviewed at the facility. Times reviewed for date 11/23/23 at 18:00 - 18:30. The two residents can be seen in the day room sitting in chairs with separate blankets. The blankets are overlapping and movement can be seen near the residents pelvic areas. Staff are present in the room and supervising the residents, and at one point appear to be engaging in conversation with the residents from across the day room. The two residents can be seen watching staff while seated in their chairs. After approximately two minutes, the residents stand and walk towards the door for meal time. It is unclear if the alleged victim is distressed or upset after she stands from her chair and walks to the door.



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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: 11/28/2023

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:



Narrative:

11/27/2023 - The provider reported complaint was reviewed by Licensing Specialist Jarred Parnell. Video footage for the incident was reviewed at the facility. Times reviewed for date 11/23/23 at 18:00 - 18:30. The

two residents can be seen in the day room sitting in chairs with separate blankets. The blankets are overlapping and movement can be seen near the residents pelvic areas. Staff are present in the room and supervising the residents, and at one point appear to be engaging in conversation with the residents from across the day room. The two residents can be seen watching staff while seated in their chairs. After approximately two minutes, the residents stand and walk towards the door for meal time. It is unclear if the alleged victim is distressed or upset after she stands from her chair and walks to the door.

The residents have been placed on separate units and are on line of sight as part of the safety plan.

Provider Comments:

CCL Staff Signature : 
Provider Signature : 

Date: 11/28/2023

Date: 11/28/2023



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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 3/28/2023.

Licensing Specialist received a complaint on 11/27/2023 for ELS Case #017720.
This complaint has been **UNFOUNDED** by licensing.

Provider Comments:

CCL Staff Signature : 

Date: 3/28/2024

Provider Signature : 

Date: 3/28/2024