DHS Placement and Residential Licensing Unit
Office of the Secretary
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Notice of Serious Incident

Case Number: 019011

Date of Incident: 2/5/2024

Date Received by PRLU: 2/6/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: SERIOUS OCCURRENCE REPORTING FORM ? Serious injury requiring outside medical attention ? *X* Resident?s attempted suicide ?Allegation of abuse/neglect ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse Resident: [redacted] DOB: [redacted] Date/Time of incident: 2/5/24 at 08:11 and 13:26 Name of Perimeter Staff Making Notification Date Time Name of Person Notified Agency Rep Sarah Whorton, RN, Director of Risk and Quality 2/06/24 11:30 am See Below Sarah Whorton, RN, Director of Risk and Quality 02/06/2024 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 2/5/24 resident [redacted] was self-harming around 7:40 am. She was removed from the unit and sat with the nurse. While with the nurse she had her self-harm scratches cleaned. She was given medication and returned to the unit. Once resident was returned to the unit she grabbed a sweater and walked into the room that stays open for bathroom usage. Two minutes later the staff on the unit went to check on resident and called for support due to finding resident with material wrapped around her neck. Material was removed. Nurse assessed resident and there was no injury. Resident placed on precautions and redirected to dayroom. Resident changed into scrubs (part of suicide precautions) around 11:05 am. Resident was moved to green unit at 13:10. At 13:26 staff support was called and resident was found wrapping material around her neck again. Material was removed and nurse assessed and found no injury. When asked why staff did not enter the room with resident he stated he did not want to be put in the position of having allegations due to their being no cameras in the room. Staff arrived in less than one minute after support was called. Resident was removed from

unit and taken to the sensory room to process with staff. Resident continued to have behavior issues for several more hours but was able to be redirected and no other attempts were made. Corrective Action: ? Coaching of leads and supervisor on shift. Initiating 1:1 supervision with DON to discuss job descriptions and responsibilities of this position. ? Facility leadership will follow-up on safety precautions and will review suicide precautions. ? Facility is developing a corrective action plan including re-organization and re-structuring of milieu leadership and responsibilities. Parties notified of event: [redacted], Guardian [redacted], CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Chris Perry, VP Risk Compliance/Quality Annika Perry, MSW ? Clinical Director Heather Harper, VP Nursing 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:

Maltreatment Narrative:

Licensing Narrative: 2/6/2024 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist inquired with the facility as to how they will handle line-of-sight residents going forward, and suggested use of the sensory room bathroom which is more open and situated near the milieu. 2/7/2024 - Licensing Specialist received correspondence from the facility stating they are in the process of coming up with a plan regarding this. We are going to re-do our SI precautions and look at adding that with the bathroom as well.