Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 019654

Date of Incident: 3/5/2024

Date Received by DCCECE: 3/6/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: Name: [redacted] On 3/5/24 at approximately 1430, resident [redacted] reported to staff that she had taken approximately 2 weeks? worth of medication all at once. [redacted] claimed that she had been ?cheeking? her medication at med pass for the last 2 weeks. The nursing department was promptly notified by staff, and as a preventative measure, [redacted] was transported to Arkansas Childrens Hospital for further evaluation per facility providers orders. Actions Taken: Per facility provider, [redacted] was transported to Arkansas Children?s Hospital for observation overnight. Per discharge report, there were no findings indicative of an overdose during her stay overnight, and she was released back to the facility this morning. Upon return to the facility this morning, the following orders were given per our provider; --Suicide precautions with observation level to be constant line of sight of staff at all times. -Medications will be placed in applesauce/pudding at med pass to better ensure adequate ingestion of medication - Resident [redacted] will participate in thorough mouth checks by nursing department at med pass and remain at nurses? station for 10 minutes after administration of medication for closer observation under RN supervision Parties notified of event: [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 Whorton-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: 3/7/2024 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist contacted the facility to inquire about weather the resident was "cheeking" her medications or if it was found out she was lying. Facility staff stated there was no evidence in the medical report or physical evidence showing the resident had "cheeked" her medicines. Staff believe she was lying about the incident. A copy of the residents vitals documentation completed by facility nursing staff when the resident returned to the facility will be provided. Vitals showed normal.