Placement and Residential Licensing Unit
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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Notice of Serious Incident

Case Number: 019742

Date of Incident: 3/7/2024

Date Received: 3/8/2024

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: Dual

Report Description: Resident, [redacted], alleged to Nurse that a staff member punched and choked him. Nurses called the allegation into the AR [redacted]. Written staff statements have been submitted. Interval investigations formally commenced 03.08.2024 during daily morning Safety meeting. Camera review conducted and multiple Residents, including alleged victim, were interviewed. Written statements were collected 03.07.2024. No bruising, injury, or discoloration noted on nursing evaluation. Internal findings do not lead to abuse/maltreatment at this time. Alleged staff will remain on suspension pending [redacted] is conducted. While internal findings do not lead to abuse/maltreatment at this time, protocol of going into Resident room without immediate supervision at the door was not followed. Policy will be reviewed with Staff by Program Director.

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

Maltreatment Narrative: AV is [redacted] residing in Perimeter Behavioral where AO [redacted] works. It was reported that [redacted] disclosed that he and [redacted] were playing earlier until they got upset with each other, [redacted] punched him in the face and choked him, its unknown if his breathing was restricted and no injuries were seen. [redacted] was questioned about this later but when questioned he refused to talk about this or give a statement.

Licensing Narrative: LS is gathering information re [redacted] then will be conducting an onsite camera (footage) review visit. 03/11/24 [redacted] gave permission for licensing to conduct their investigation. 03/12/24 camera review completed by Licensing Specialist White. 03/18/24 LS White viewed staff's SAMA certification. Staff is certified until 06/15/24. Also received a copy of restraint hold on flash drive for upper management to review. 03/26/24 Agency is cited, inspection created, and compliance record is completed.

Arkansas Department of Human Services

Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Perimeter Behavioral of Forrest City	**Person In Charge: Charlotte Lockhart**
Address: 603 Kittle Rd., Forrest City, AR 72335	**Phone: (870) 633-3200**
Licensing Specialist: Eleanor White	
Date of Visit: 03/12/24	**Purpose of Visit: complaint ELS case 019742**
	Incident Date: 03/07/24

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
	Time 1:00 PM to 3:30 PM Census: 52 Immanuel Morris, Director of Quality/Risk Management assisted Licensing Specialist with the camera footage review of incident on 03/07/24 for ELS case 0197742 which verified resident was walked out of his room in a restraint hold by staff member following a pencil and staff's badge being thrown into the hall from resident's room. Once resident and staff (while in the restraint hold) were in the hallway staff used unnecessary force in taking the child to the floor. It did not appear that resident was resisting the restraint hold by staff before being taken to the floor. Facility staff explained that the staff member may have been escalated from being poked in the back by a pencil by the resident prior to the restraint. The facility SAMA instructor also viewed the camera footage with licensing and expressed concerns about the staff's conduct during the restraint. This staff member is SAMA certified. His certification expires 06/13/24. <u>Facility will be cited as follows:</u> 905.9. Physical restraints shall be performed using minimal force and time necessary. Physical restraint means the application of physical force without the use of any device for the purposes of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort or holding a hand to safely escort a child from one area to another, is not considered a physical restraint. Complaint case regarding the punching and choking of a resident is undetermined at this time due to no camera in the resident's bedroom. However, video review did show the staff member failing to use the minimal force necessary during the restraint hold.	N/C	

COMMENTS of Person receiving form:

Charlotte Lockhart 3-26-24 Eleanor White 03/26/24

PERSON SIGNING AS RECEIVING **DATE** **LICENSING SPECIALIST** **DATE**