



Placement and Residential Licensing Unit

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

Case Number: 019739

Date of Incident: 3/7/2024

Date Received by DCCECE: 3/8/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: Patient/Resident Name/DOB: [REDACTED]

[REDACTED]
[REDACTED] Date/Time of incident: 3/7/24 @ 1957 On 3/7/24 at 1957,
[REDACTED] physically assaulted [REDACTED] by punching her in the face after a verbal altercation.
Within a few seconds, [REDACTED] became involved and began physically assaulting [REDACTED]
During the altercation, [REDACTED] ran up and kicked [REDACTED] The altercation was ceased in
under a minute by staff intervention. Upon separation, [REDACTED] exited the unit with staff
while [REDACTED] [REDACTED] and [REDACTED] remained on the unit. Due to the nature of the attack, the age
difference between [REDACTED] (initial perpetrator) and [REDACTED] (victim), and the recent
increase in assaultive behavior with [REDACTED] Springdale Police Department was contacted.
Upon arrival at the facility, law enforcement reviewed camera footage and conducted staff
interviews. At the conclusion of the investigation with law enforcement, [REDACTED] [REDACTED] and
[REDACTED] were detained and transported to Washington County Juvenile Detention Center by
Springdale Police Department. Actions Taken: [REDACTED] [REDACTED] and [REDACTED] were transported to
Washington County JDC where they were booked overnight. All 3 perpetrators were seen by
the judge this morning at JDC and were charged with Battery ? 2nd degree. [REDACTED] and [REDACTED]
were transferred back to the facility after their hearing. [REDACTED] remained in custody at
Washington County JDC after her hearing. Facility provider was notified of the incident and
will be seeing [REDACTED] for a medical assessment today to ensure there was no significant
injury. Parties notified of event: Perpetrator 1 [REDACTED]
Perpetrator 2 [REDACTED] Perpetrator 3 [REDACTED]
[REDACTED] Victim [REDACTED] Sara Loftis, CEO Art Hickman,
Regional CEO Rebecca Thomas, VP Clinical Training Chris Perry, VP Risk
Compliance/Quality Shyanne Anthony ? 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: 3/8/2024 - The provider reported incident was reviewed by Licensing Specialist Jarred Parnell. Licensing Specialist will reach out to the facility for the police report. A visit was conducted on 3/12/2024 Video footage was reviewed for 6:55 - 6:59 - 3/7/2024 in regards to the provider reported incident. An altercation started when [REDACTED] kicked a spiral from [REDACTED] [REDACTED] became upset and started to move around the halls of the unit. Three residents surrounded the Tech area in the dayroom. [REDACTED] was put behind tech Arland [REDACTED] then moved around Arland and was hit in the face and knocked to the ground by [REDACTED] 3 techs came into the room and stopped the altercation and separated the residents. Arland put [REDACTED] was placed in an appropriate handle with care hold on the ground. The three aggressors [REDACTED] were taken to JDC and [REDACTED] is still in custody. Police responded to the scene. A copy report has been requested from the police department and will be sent to Licensing as soon as possible. 3/14/2024 - Licensing specialist staffed the provider reported incident with Licensing Supervisor. Licensing specialist reached out to the facility in regards to safety plans in place prior to the incident, and TA was provided for altercations between residents. The following TA was provided to the facility; Technical assistance was provided regarding escalation and altercations in the future. When residents are exhibiting assaultive behavior and deregulation as a group, the facility will remove the target of the aggression and assaultive behavior to the milieu to process and diffuse the situation as a preventative measure. If there is only one deregulated resident exhibiting assaultive behavior, that resident will be removed to the milieu for processing to diffuse the situation.



Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
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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: 3/12/2024

Home Visit Date: 3/12/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

3/12/2024 A visit was conducted to review video footage for 6:55 - 6:59 - 3/7/2024 in regards to the provider reported incident. An altercation started when [REDACTED] kicked a spiral from [REDACTED] became upset and started to move around the halls of the unit. Three residents surrounded the Tech area in the dayroom.

[REDACTED] was put behind tech [REDACTED] then moved around [REDACTED] and was hit in the face and knocked to the ground by [REDACTED] 3 techs came into the room and stopped the altercation and separated the residents. [REDACTED] put [REDACTED] was placed in an appropriate handle with care hold on the ground. The three aggressors [REDACTED] were taken to JDC and [REDACTED] is still in custody. Police responded to the scene.


A copy report has been requested from the police department and will be sent to Licensing as soon as possible.

Information regarding events leading up to the incident was discussed with facility staff and inquiries were made regarding safety plans in place as a preventative measure for the assaultive behavior of the resident [REDACTED]. Safety plans had been previously initiated while the resident was on different units because of the assaultive behavior described in the report. Leading up to this incident the resident did not have any assaultive history with the victims in the report in particular, however during this incident she was the target. [REDACTED] had been displaying assaultive behavior in the past on different units and was placed in this unit as part of a previous safety plan. Due to the residents history of assaultive behavior in each unit she was discharged from the facility. The other two aggressors in the incident were not previously assaultive until they had been influenced to do so by resident [REDACTED].

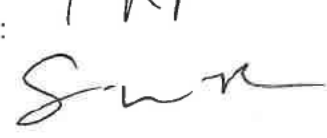
Technical assistance was provided regarding escalation and altercations in the future. When residents are exhibiting assaultive behavior and deregulation as a group, the facility will remove the target of the aggression and assaultive behavior to the milieu to process and diffuse the situation as a preventative measure. If there is only one deregulated resident exhibiting assaultive behavior, that resident will be removed to the milieu for processing to diffuse the situation.

This 521 inspection report was amended on 3/14/2024

Provider Comments:

CCL Staff Signature : 

Date: 3/14/2024

Provider Signature : 

Date: 3/14/2024