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: 020265

Date of Incident: 3/31/2024

Date Received: 4/2/2024

Facility Name: Perimeter Behavioral of West Memphis

Facility Number: 231

Incident Type: Dual

Report Description: Residents Name: [redacted] On 3/31/24 at 18:20 Resident [redacted] was placed in a restraint for physical aggression towards staff. Resident also received chemical injection for inability to calm down and assaultive bx towards staff. No injuries to resident were noted following the restraint. On 4/1/24 Resident [redacted] alleged that [redacted] and [redacted] choked me and [redacted] threw me and made me hit my head.? Suspected abuse report was made 4/1/24 and accepted for investigation [redacted]. Camera footage was reviewed, and resident did not appear to have been choked by either [redacted] or [redacted], however both staff have been removed from working on PRTF pending investigation. [redacted] is seen on camera initiating physical restraint on resident alone and escorting her to the seclusion room hallway, upon entering the hallway the resident is seen falling to the ground. [redacted] has been placed on administrative leave pending investigation effective today 4/2/24. Actions Taken: Resident was evaluated for injuries by our Nurse Practitioner Roslyn Perry, APRN on 4/1/24 Resident complained of a headache 5/10 pain. Roslyn states no swelling or tenderness was noted on palpation. Overall normal examination but did order X-ray 3V of her skull and neuro checks x48 hours. X-ray results: ?No skull fracture. The mandible is normal. Bilateral maxillary sinuses are clear. The visualized upper cervical spine is normal. No Acute Abnormality.? Other Parties Notified: Guardian: DHS (Pulaski County)

Interim Action Narrative: Staff was placed on suspension pending the results of the maltreatment investigation.

Maltreatment Narrative: Resident [redacted] alleged that [redacted] and [redacted] choked me and [redacted] threw me and made me hit my head.?

Licensing Narrative: 04/02/24 LS White will verify that doc order is accompanying the chemical restraint while on site as well as review camera footage and inquire why this was not reported timely. Permission was granted by investigator to view camera footage and review restraint documentation. 04/03/24 LS White conducted an unannounced visit to review camera footage. Time: 3:00 PM to 5:00 PM Census: 18 Summer Berryhill assisted Licensing Specialist with review of 90 mins of camera footage of before and after the incident that occurred on 03/31/24 involving a physical then chemical restraint of a female resident. Footage shows residents going into the day room from the gym accompanied by 3 staff. Said resident starts darting towards one particular staff. 2 other staff members physically get between resident and the staff that the resident was darting towards. Said resident then runs over and pushes over the water pitcher. Staff [redacted] tries to get resident to go through the door to the seclusion rooms and when resident starts swinging on staff ?[redacted] he then initiates a restraint hold and begins escorting resident through the door into the seclusion rooms hall. As they enter the hall resident breaks free from the hold and falls forward onto the floor. Camera footage verifies she falls forward as a result of her excessive pulling forward. Staff [redacted]?s hands were at his sides showing that he did not push her as her lunging forward caused the fall. Another restraint is then executed. Both physical restraints were executed properly-no concerns. 5 staff are present during the hold in the hall. The nurse enters and is viewed to be assessing the situation and then makes a phone call. Within minutes doctor orders were received to execute a chemical restraint. Nurse then assesses that resident is physically secure and proceeds with injecting chemical restraint into resident?s hip. It is viewed that resident?s body relaxes, and she is released from the hold. Resident then sits up with her back against the wall. Resident then gets up and staff walk her to her room. She gets her hygiene bucket then rejoins the rest of the population in the day room, gets a snack and is eating it. Restraint log for the last 30 days was reviewed-complies. Doctor order regarding this chemical restraint reviewed-no concerns as it complies with verified camera footage reviewed of the execution of the chemical restraint. No regulations out of compliance. No technical assistance needed. Summer reported that 2 of the staff involved with this incident have completed restraint policy review 04/02/24. The other staff ?[redacted] who is currently suspended pending investigation will complete restraint policy review before being released back to work. This incident occurred 03/31/24. On 04/01/24 resident declared staff physically assaulted her before the restraints on 03/31/24 at that time facility made the report to the [redacted] and reported the allegations to licensing. Prior to the resident?s allegations this incident was not reportable per MLS 110.17.

Arkansas Department of Human Services

Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Perimeter Behavioral of West Memphis	**Person In Charge: Summer Berryhill**
Address: 600 North 7th St., West Memphis, AR 72301	**Phone: (870)394-7113**
Licensing Specialist: Eleanor White	
Date of Visit: 04/03/24	**Purpose of Visit: incident of 03/31/24**
	ELS Case: 020265

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
	Time: 3:00 PM to 5:00 PM Census: 18 Summer Berryhill assisted Licensing Specialist with review of 90 mins of camera footage of before and after the incident that occurred on 03/31/24 involving a physical then chemical restraint of a female resident. Footage shows residents going into the day room from the gym accompanied by 3 staff. Said resident starts darting towards one particular staff. 2 other staff members physically get between resident and the staff that the resident was darting towards. Said resident then runs over and pushes over the water pitcher. Staff [redacted] tries to get resident to go through the door to the seclusion rooms and when resident starts swinging on staff [redacted] he then initiates a restraint hold and begins escorting resident through the door into the seclusion rooms hall. As they enter the hall resident breaks free from the hold and falls forward onto the floor. Camera footage verifies she falls forward as a result of her excessive pulling forward. Staff [redacted]s hands were at his sides showing that he did not push her as her lunging forward caused the fall. Another restraint is then executed. Both physical restraints were executed properly-no concerns. 5 staff are present during the hold in the hall. The nurse enters and is viewed to be assessing the situation and then makes a phone call. Within minutes doctor orders were received to execute a chemical restraint. Nurse then assesses that resident is physically secure and proceeds with injecting chemical restraint into resident's hip. It is viewed that resident's body relaxes, and she is released from the hold. Resident then sits up with her back against the wall. Resident then gets up and staff walk her to her room. She gets her hygiene bucket then rejoins the rest of the population in the day room, gets a snack and is eating it. Restraint log for the last 30 days was reviewed-complies. Doctor order regarding this chemical restraint reviewed-no concerns as it complies with verified camera footage reviewed of the execution of the chemical restraint. No regulations out of compliance. No technical assistance needed. Summer reported that 2 of the staff involved with this incident have completed restraint policy review 04/02/24. The other staff [redacted] who is currently suspended pending investigation will complete restraint policy review before being released back to work. This incident occurred 03/31/24. On 04/01/24 resident declared staff physically assaulted her before the restraints on 03/31/24 at that time facility made the report to the [redacted] and reported the allegations to licensing. Prior to the resident's allegations this incident was not reportable per MLS 110.17.		

COMMENTS of Person receiving form

[redacted] 4/3/24		Eleanor White	04/03/24
PERSON SIGNING AS RECEIVING	**DATE**	**LICENSING SPECIALIST**	**DATE**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Perimeter Behavioral of West Memphis

Facility Number: 231

Licensee Address: 600 N 7TH ST
WEST MEMPHIS AR 72301-3235

Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 4/30/2024

Home Visit Date: 4/30/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing has investigated complaint 020065 and determined it to be unfounded.

The facility sent the corrective action documentation to licensing dated for 4/8/2024. The corrective action included the following: Patient's Rights, identify strategies to improve performance, incident reporting, video surveillance of incident, restraint or seclusion use policy 1311, discussed work arrangement such as not working on unit four, set clear objectives for moving forward, and required to attend an 8-hour handle with care re-certification class.

The ICA for the staff may be lifted and he can return to regular work duties.

Provider Comments:

CCL Staff Signature : Chelsea Vardell Date: 4/30/2024

Provider Signature : Date: 4/30/2024