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: 020922

Date of Incident: 4/25/2024

Date Received: 4/29/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: SERIOUS OCCURRENCE REPORTING FORM ? Serious injury requiring outside medical attention ? Resident?s attempted suicide ?Allegation of abuse/neglect ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse Resident: [redacted] Date/Time of incident: 04/25/24 @21:00 Name of Perimeter Staff Making Notification Date Time Name of Person Notified Agency Rep Sarah Whorton, RN, Director of Nursing 04/29/24 2:30 pm See Below Sarah Whorton, RN, Director of Nursing 04/29/2024 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 04/26/24, [redacted] reported to the lead Mental Health Technician, Tyrell Wall, that on 04/25/24 at 21:00 pm while in a resident room with two others, she was held down by [redacted] and kissed against her will. Corrective Action: ? Residents were separated ? Residents were placed Sexual Misconduct Precautions, which includes increased observation ? [redacted] Parties notified of event: [redacted], Guardian [redacted], Guardian [redacted] Skyler Barnes, 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: 4/29/2024 - The provider reported incident and facility response was reviewed by the Licensing Specialist. Licensing Specialist spoke to facility staff who stated the alleged incident occurred in a bedroom where there is no video footage available. The report was not accepted by the hotline. Licensing specialist will follow up with facility and request bed check logs for the date of the alleged incident.