

## **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: 021325

Date of Incident: 5/15/2024

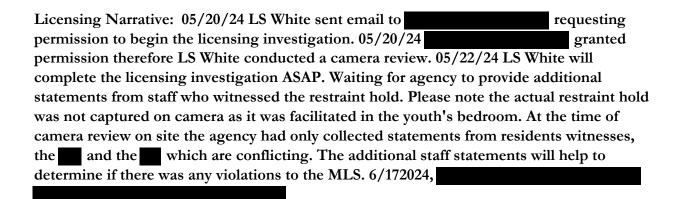
Date Received: 5/17/2024

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: Dual

| Incident Type: Duai  |
|--|
| Report Description: Resident,  |
| ? after attempting an ESI. Staff suspended .   |
| . Resident, witness, and Staff   |
| written statements collected and camera and Nursing note review conducted.               |
| came out today and interviewed Resident and  |
| witness (Resident?s roommate). was provided copies of all aforementioned                 |
| statements and documents. Outcome pending. Resident verbalizes feeling safe at this time |
| (05/17/2024).  |
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| Interim Action Narrative:  |
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## **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 Forrest City             |
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| Facility Number: 142                                       |
| Licensee Address: 603 KITTLE ROAD<br>FORREST CITY AR 72335 |
| Licensing Specialist: Eleanor White                        |
| Person In Charge:  |
| Record Visit Date: 5/20/2024                               |
| Home Visit Date: 5/30/2024                                 |
| Purpose of Visit: Complaint Visit                          |
| Regulations Out of Compliance:                             |
| Regulations Needing Technical Assistance:                  |
| Regulation Not Applicable:                                 |
| Regulations Not Correctable:                               |
| Narrative:   |
| Time 1:00 PM to 3:00 PM                                    |

#### Census: 54

Licensing Specialist Eleanor White reviewed the following incident with Immanuel Morris, Director of Quality and Risk Management which included reviewing 20 minutes camera footage of the hall before and after the incident. Camera footage verified resident coming on to the hall from the nurse's station kicking and throwing a chair several times. He then started hitting the hall exit doors and a nurse came onto the hall and was talking to him. No sound available on camera footage. 2 additional staff came onto the hall appearing to talk to him and directing the other residents in the hall to their rooms. Footage showed resident grabbing the papers out of alleged staff hands and ripping it up. Staff then gets up and resident darts around her grabbing blankets from her chair and runs into his bedroom. Staff then follows resident into his bedroom with the other 2 staff going into the room directly behind her. Restraint hold was not captured on camera however per agency's documentation during this time a restraint hold was administered. Within the next minute the nurse goes into the room and within the next minute the staff who administered the hold left the room and the hall. The other 2 staff also walking out of the bedroom. Statements from resident, other witness residents, and the nurse's body check report are conflicting. Licensing is not prepared to leave a finding at this time.

### **Provider Comments:**

CCL Staff Signature : Date: 5/31/2024

Provider Signature : Date: 5/31/2024