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: 021406

Date of Incident: 5/21/2024

Date Received: 5/21/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: X Serious injury requiring outside medical attention X Resident?s attempted suicide ? Allegation of abuse/neglect related to a restraint ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse Resident Name/DOB: [redacted] Date/Time of incident: 05/21/2024 at 0752 Name of Perimeter Staff Making Notification Date Time Name of Person Notified Agency Rep Charriot Sales, Director of Risk Management 05/21/24 14:00 See Below Charriot Sales, Director of Risk Management 05/21/2024 Name and title of staff completing this form Date: Name of Facility: Perimeter Behavioral of the Ozarks Phone Number: 479-957-9857 ext. 108 Street Address, City, State, Zip: 2466 S. 48th Street Suite B. Springdale, AR 72762? Please give a description of the incident: During medication pass on the Milieu, [redacted] hid in an open laundry room. During the next Q15 rounds, it was determined he was missing. A brief search identified his location. During discussion with the Nurse and Mental Health Technician, [redacted] admitted to ingesting some block laundry detergent that contained bleach. A call to Poison Control advised he should be taken to the ER. [redacted] Corrective Action: [redacted] placed on self-harm precautions. Parties notified of event: [redacted], Guardian [redacted] Caseworker [redacted] CEO Art Hickman, Regional CEO Rebecca Thomas, VP Clinical Training Chris Perry, VP Risk Compliance/Quality Sarah Whorton, Director of Nursing Shawna Stover, Director of Clinical Services 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: 5/21/2024 - The provider reported incident and facility implement was reviewed by the Licensing Specialist. Licensing Specialist will visit the facility to review camera footage of the incident and review supervision. 5/22/2024 - A visit was conducted at the facility to review video footage for the incident on 5/21/2024 - 7:49 am - 8:12 am. video footage observed during visit showed a resident was left unsupervised in the milieu and was able to access the laundry room where she was able to hide and remain unsupervised for 14 minutes. Resident may have ingested laundry detergent. It is not clear whether she did as the toxicology report did not show abnormalities. Medical report uploaded to ELS. Incident was staffed with program coordinator K. Rice The facility was cited for 907.2 for not supervising the resident and ensuring she returned to the unit. 521 inspection report sent to facility for signature. 5/23/2024 - 521 inspection report signed and returned. Staff will be retrained for supervision, follow up with facility 5/29/2024 for proof of training. 6/13/2024 - Proof of training request from facility

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: Charriot Sales

Record Visit Date: 5/22/2024

Home Visit Date: 5/22/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Number: 900.907.2

Regulation Description: Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

Finding Description: Staff did not ensure the resident returned to the unit after receiving medication. The resident was able to access the laundry room and hide from staff where she remained unsupervised for 14 minutes.

Action Due Date: 2024-05-22

Action Due Description: Staff will be trained on supervision and transition times to ensure residents return to their units after medication pass and any other time they leave the units.

Comply Date:

Action Due Description: Staff will be trained on supervision and transition times to ensure residents return to their units after medication pass and any other time they leave the units.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

5/22/2024 - A visit was conducted at the facility to review video footage for 5/21/2024 at 7:49am - 8:12 am. Video footage shows the resident enter the milieu to receive medication from nurse [redacted] The resident can be seen walking to get water and coming back to the milieu counter. The residents speaks with the nurse briefly and then takes the medication. The nurse turns checks the cup for the medication and then turns to throw it in the trash, The resident begins walking back to her unit. Staff person [redacted] can be seen walking from another unit past the resident. The resident walks towards the unit and then stops and goes into the laundry room. Both staff in the milieu were not supervising the resident. The resident goes into the laundry room at 7:52 am. Staff lead [redacted] can be seen walking across the milieu just before the resident enters the room, but also does not see the resident. Several staff pass by the laundry room door during this time and then the resident closes the door a few moments later. Staff do not discover the resident is missing until a supervisory check was conducted and the resident was not in her room. Staff begin to search the building and find the resident in the laundry room at 8:06 AM. While the resident was in the laundry room she was able to access a block laundry detergent which she states she ingested. Poison control was contacted and the resident was taken to the hospital for a toxicology report, which did not reveal the resident had ingested the detergent.

The resident was left was unsupervised in the milieu unsupervised. Staff did not ensure she returned to her unit after receiving her medication. The resident was able to access a laundry room where she remained unsupervised for 14 minutes. The resident reportedly ingested laundry detergent while in the laundry room. The toxicology report conducted after did not show any abnormalities and it is unclear if the resident did ingest laundry detergent. The facility was cited for Licensing Standard 907.2.

Provider Comments:

CCL Staff Signature : [signature] Date: 5/23/2024

Provider Signature : [signature] Date: 5/23/2024