



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: 022099

Date of Incident: 6/18/2024

Date Received:6/19/2024

Facility Name: Perimeter of the Ozarks

Facility Number:237

Incident Type: Licensing

Report Description: ? Serious injury requiring outside medical attention ? Resident?s attempted suicide ? Allegation of abuse/neglect related to a restraint ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse X Sexual Misconduct ? Other Patient/Resident Name/DOB: [REDACTED] and [REDACTED]

[REDACTED] Date/Time of incident: Unknown Patient Insurance: [REDACTED]

[REDACTED] Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS [REDACTED], Director of Risk Management 19 Jun 24 12:00 [REDACTED]

[REDACTED] Disability Rights Center, Inc. [REDACTED]

[REDACTED] Director of Risk Management 19 Jun 24 12:00

incidentreporting@disabilityrightsar.org Perimeter [REDACTED], Director of Risk

Management 19 Jun 24 12:00 [REDACTED]

[REDACTED] Guardian/Caseworker [REDACTED], Director of Risk Management 19 Jun 24 11:30 [REDACTED], Director of Risk

Management 19 Jun 24 Signature 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 describe

the incident: On 06/18/24, the Director of Risk received a resident report that alleged sexual misconduct occurred between [REDACTED] and [REDACTED]. The allegation stated

[REDACTED] and [REDACTED] were fingering each other in [REDACTED] bedroom while another resident watched for staff. Both [REDACTED] and [REDACTED] were interviewed on 06/18/24 and each denied

the incident occurred. Residents have been separated with each sleeping on another unit while the investigation is ongoing. Actions Taken: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Opened

investigation (ongoing). ? Residents moved to separate units while investigation is ongoing.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 6/19/2024 - The provider reported incident and facility implement was reviewed by the Licensing specialist. Licensing specialist will follow up with the facility in regards to the report and inquire what date the alleged incident occurred. A visit was conducted at the facility to follow up with the facility for the provider reported incident. Q-15 bed check logs were requested and provided by the facility. There were no dates of the incident mentioned in the report for video footage review. The report was made from a verbal resident grievance which was given same day the report was made. 6/21/2024- Licensing specialist followed up with the facility in regards to the reported incident and received the following correspondence: "Both residents denied the incident occurred, so they did not provide a date. The two peers who stated it did occur supplied dates that were drastically different (2 weeks apart) and neither were confident in their answer. However, apparently during her interview with the PD Investigator yesterday, AC said the incident occurred. I plan on interviewing her today to see if she'll provide additional information. " Licensing specialist requested facility to follow up if the resident specifies a timeframe for the incident in order to review video footage. Licensing specialist received correspondence from the facility after speaking with the alleged victim in order to confirm a specified date and time: "last week I think." was the response of the resident.



Division of Child Care & Early Childhood Education
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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: 6/19/2024

Home Visit Date: 6/19/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:



Regulations Not Correctable:

Narrative:

6/19/2024 - A visit was conducted at the facility to follow up for case # 022099. Video footage for the incident was not reviewed because both residents denied the incident happened and a time and location was

not specified. Q15 bed check information was requested at the visit for 6/16/2024 and video footage was reviewed for supervision and bed check compliance. Video time stamp reviewedTimestamp reviewed 6/16/2024 - 9:00 PM - 6/17/2024 5:00AM.

Provider Comments:

CCL Staff Signature : 
Provider Signature : 

Date: 6/21/2024

Date: 6/21/2024