



**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

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**Notice of Serious Incident**

Case Number: 023406

Date of Incident: 6/22/2024

Date Received: 8/21/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

**Report Description:** We wanted to forward some concerns about an incident at Perimeter Ozarks. [REDACTED] received Serious Occurrence Report about a resident being arrested and charged with second degree battery for hitting a staff member. We reviewed video of the incident and the police report. After video review we realized the description of the events was misleading and did not match the events described in the Serious Occurrence Report. The situation could have been prevented if they had left the client in the seclusion room instead of dragging her to the unit. The staff failed to de-escalate the situation and used police as a behavior management tool. The facility is a Psychiatric Residential Facility which should be able to handle a child with behavioral issues, we are seeing too many facilities using police as behavior management, resulting in children being charged with crimes. Most parents feeling their child needs a PRTF are doing so because the child is not safe enough to be in the home and community, how horrible it is that they are being charged in a facility that should be helping them. Another issue observed in the video was the child getting a chemical restraint after she was calm for 10 Minutes. After requesting her Diagnosis, it was also found that [REDACTED] which only makes the situation worse. In summary: 1. Before the assault on the nurse occurs, resident [REDACTED] is sitting calmly in the seclusion room. She does not become dysregulated until staff pick her up and drag her out of the room and back to the unit. 2. In between the time that the resident [REDACTED] hit staff and was separated from her peers around 9:36 AM until the nurses entered at 9:52 to give [REDACTED] a shot, she sat still and didn't move. 3. The serious occurrence form says that after police left, [REDACTED] assaulted staff again. We did not see any kind of Second ?assault? when we watched the video. We did zoom call with the risk manager and she stated that the second ?assault? was [REDACTED] not cooperating when staff tried to remove her from the seclusion room back to the unit, She was sitting calmly in the seclusion room. Considering the details we have listed above; we do not feel this incident should've resulted

in a second call to the police and the arrest of [REDACTED] We have attached the video for your review.

Interim Action Narrative:

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Maltreatment Narrative:

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Licensing Narrative: 8/21/2024- Licensing reviewed the camera footage [REDACTED] [REDACTED] Licensing met with OLTC and AFMC to discuss coordinating entry to the facility. 8/26/2024- Licensing and OLTC visited the facility. A review of the facility restraint policy, video footage, restraint log, physician restraint orders, and restraint justification packets occurred. The facility could not produce the documents noted on the 521 that were missing from the resident's file.



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:** Chelsea Vardell

**Person In Charge:** Charriot Sales

**Record Visit Date:** 8/26/2024

**Home Visit Date:** 8/26/2024

**Purpose of Visit:** Complaint Visit

### Regulations Out of Compliance:

**Regulation Number:** 900.905.10

**Regulation Description:** Physical restraint shall be initiated only by staff trained by a certified instructor in a nationally recognized curriculum, and only to prevent injury to the child, other people or property, and shall not be initiated solely as a form of discipline. The agency shall maintain documentation that staff is deemed competent in physical restraint.

**Finding Description:** 905.10- Physical restraint was conducted on a resident who was in the seclusion room and not a danger to themselves, others, or property.

**Action Due Date:**

**Action Due Description:**

**Comply Date:**

**Action Due Description:**

**Regulation Number:** 900.905.12

**Regulation Description:** Seclusion, mechanical, or physical restraints shall be used only if ordered by a physician.

**Finding Description:** 905.12- Physical and Seclusion can only be used if ordered by a physician.

**Action Due Date:**

**Action Due Description:**

**Comply Date:**

**Action Due Description:**

**Regulation Number:** 900.905.17

**Regulation Description:** Documentation of all restraints shall be maintained and include child's name, date, time, reason, staff involved, and measures taken prior to restraint.

**Finding Description:** 905.17- Documentation of all restraints shall be maintained and shall include the child's name, date, time, reason, staff involved, and measures taken prior to restraint.

**Action Due Date:**

**Action Due Description:**

**Comply Date:**

**Action Due Description:**

### **Regulations Needing Technical Assistance:**

### **Regulation Not Applicable:**

### **Regulations Not Correctable:**

### **Narrative:**

Licensing visited the facility with OLTC regarding complaint case 023406. Licensing reviewed the facility restraint log, the residents file, staff [REDACTED] personnel file, and the facility restraint policy. Other information was reviewed to include video footage, police report, and 911 call.

### **The following were issues and concerns identified during the review.**

- 4/5/2024- Physical Restraint for 1820-1830- No physician's order(Received by PRLU on 8/28/2024 signed by physician on 4/6/2024)
- 4/6/2024-Physical Restraint for 1652-1722- No physician's order(Received by PRLU on 8/28/2024 signed by physician on 4/7/2024)
- 4/15/2024-Physical Restraint for 1724-1747- No physician's order(Received by PRLU on 8/28/2024 signed by physician on 4/16/2024)
- 4/15/2024-Physical Restraint for 1806-1823- No physician's order(Received by PRLU on 8/28/2024 signed by physician on 4/16/2024)

- 6/12/2024-Physical Restraint for 1947-2008 noted on restraint log-No physician order or restraint justification packet.(PRLU received physician's order on 8/28/2024 signed by physician on 8/26/2024. Facility unable to locate the restraint justification packet.)
- 6/22/2024- Physical Restraint seen on camera at 940-No physician's orders or restraint justification packet.(Facility could not locate a physician's order or restraint justification packet)
- 6/22/2024- Seclusion for 1313-1330- No physician's order(Facility could not locate a physician's order or restraint justification packet)
- 6/22/2024- Seclusion ordered at 940am in chart- No restraint justification packet.(Facility reports they are not sure why a physician's order for the seclusion was ordered and in the chart as the resident walked into the room herself and the door was not locked.)
- 7/15/2024-Physical Restraint 2053-2059- No physician's order(PRLU received physician's order on 8/28/2024 signed by physician on 8/26/2024.)
- A physical restraint conducted on 4/5/2024 and a seclusion order on 6/22/2024 were not listed on the facility restraint log.
- Staff [REDACTED] was originally a contracted nurse and trained on the facility's restraint policy on 12/6/2023. [REDACTED] was then hired as a full-time staff by the facility on 7/[REDACTED]2024. The facility policy is to train every member of staff in the restraint policy at the time of hire and every six months thereafter.
- Review of camera footage showed the resident entering the seclusion room at 9:15am on her own and sits in the camera's blind spot with no movement seen. Two male staff then place the resident in a physical restraint at 9:35am and take her to the green unit as she resists. Once on the unit, the resident becomes combative with the staff escalating two other peers already on the unit. The two peers then attack the resident and must be separated by the staff. The resident is seen sitting calmly on the unit beginning at 9:36am. A peer throws a cup of water in the face of the resident at 9:40am, but the resident does not respond and continues to sit in the chair. Two nurses then enter the unit at 9:53am and proceed to administer a chemical restraint to the resident who does not resist the injection and continues to sit in the chair.
  - o When asked why the resident was placed in a physical restraint and taken to the green unit from the seclusion room, the facility reported that the resident was "out of bounds and non-compliant with staff's directive to return to the unit. Resident was on Assault Precautions, Self-Harm Precautions, and Restricted to Unit for an incident that occurred the previous night". However, there was an order for the seclusion ordered by the physician in the chart for 9:40am, but no order for a physical restraint.

**The facility will be cited for the following regulations:**

**905.12-**Physical and Seclusion can only be used if ordered by a physician.

**905.17-**Documentation of all restraints shall be maintained and shall include the child's name, date, time, reason, staff involved, and measures taken prior to restraint.

**905.10-**Physical restraint was conducted on a resident who was in the seclusion room and not a danger to themselves, others, or property.

**The facility must complete the following:**

All staff should be retrained on the facility restraint policy as restraints cannot be used unless the child is a threat to themselves, others, or property and ordered by a physician. A restraint cannot be used to obtain compliance from a resident or as a form of discipline.

Staff [REDACTED] must be retrained on Handle With Care by 9/6/2024.

**Provider Comments:**

CCL Staff Signature : *Chelsea Vardell*

Date: 8/29/2024

Provider Signature : *Charneal Sells*

Date: 8/29/2024



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**Facility Number:** 237

**Licensee Address:** 2466 SOUTH 48TH STREET  
SPRINGDALE AR 72766

**Licensing Specialist:** Chelsea Vardell

**Person In Charge:**

**Record Visit Date:** 10/15/2024

**Home Visit Date:** 10/15/2024

**Purpose of Visit:** Complaint Visit

**Regulations Out of Compliance:**

**Regulations Needing Technical Assistance:**

**Regulation Not Applicable:**

**Regulations Not Correctable:**

**Narrative:**

Licensing has investigated case 023406 and determined it to be founded.

**The facility was cited for the following on 8/26/2024**

**905.12-** Physical and Seclusion can only be used if ordered by a physician.

**905.17-** Documentation of all restraints shall be maintained and shall include the child's name, date, time, reason, staff involved, and measures taken prior to restraint.



**905.10-** Physical restraint was conducted on a resident who was in the seclusion room and not a danger to themselves, others, or property.

**The facility was required to complete the following:**

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Staff [REDACTED] must be retrained on Handle with Care by 9/6/2024

**Provider Comments:**

CCL Staff Signature :   
Provider Signature : 

Date: 10/15/2024

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