ARKANSAS DEPARTMENT OF HUMAN SERVICES

Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 022918

Date of Incident: 7/31/2024

Date Received: 8/1/2024

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] Date/Time of incident: Unknown, approximately three weeks ago. Patient Insurance: [redacted] Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS [redacted], Director of Risk Management 01 Aug 24 09:00 [redacted] Disability Rights Center, Inc. [redacted] Director of Risk Management 01 Aug 24 09:00 incidentreporting@disabilityrightsar.org Perimeter [redacted] Director of Risk Management 01 Aug 24 09:00 [redacted] Guardian/Caseworker [redacted] Director of Risk Management 31 Jul 24 15:30 [redacted] Director of Risk Management 31 Jul 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 7/31/24, Resident [redacted] reported to staff that while he and resident [redacted] were sitting on the floor in the Dayroom with a chair flipped to its side to use as a table to color on, [redacted] asked [redacted] if she could finger him. [redacted] reported he didn?t say anything when [redacted] pulled down his pants and fingered him; he reported feeling very uncomfortable. When asked when this occurred, [redacted] reported, ?I don?t really know.? He did identify what staff was working. Actions Taken: ? [redacted] and Serious Incident

Report; [redacted] **Residents moved to separate units. ? Opened investigation. (Investigation ongoing)**

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 8/1/2024- The provider reported incident was reviewed by the licensing specialist. Licensing specialist will follow up with the facility to review supervision concerns, 8/1/2024 - Licensing specialist received a response from the facility " No, I spoke to [redacted] and he stated it was between break-ups, anytime between one to three weeks ago. The staff members are [redacted] and [redacted] "