



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: 023606

Date of Incident: 8/7/2024

Date Received: 8/29/2024

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: Dual

Report Description: Resident [REDACTED] alleged Staff member [REDACTED] hit him. Staff was suspended 08/20/2024 pending investigation. [REDACTED]

Interim Action Narrative: Staff placed on suspension pending investigation.

Maltreatment Narrative: AV is [REDACTED] AO is Perimeter Behavioral staff member (Unknown Unknown). During a phone call with [REDACTED], he said he was being restrained by a staff member. That staff member put his arm on his throat while restraining him. [REDACTED] told him he couldn't breathe, and he pushed harder. [REDACTED] said he did report the Incident to the staff member superior. [REDACTED] did not give the name of the person, but it should be on the report he filed with his superior

Licensing Narrative: Program Coordinator was contacted and received an email from the facility regarding if staff could return to work. 8/29/2024, facility informed that Licensing did not have any information regarding this incident. 8/30/2024, Program Coordinator inquired if camera footage was still available and requested documentation. Facility provided documentation for this incident and it has been uploaded. 8/31/2024, Program Manager approved for staff member to return to work. 9/3/2024, Director of Risk Management informed Licensing that resident did not complete a grievance statement.

Resident submitted a communication form on 8/28/2024 about a missing folder and 8/7/2024 about a snack. 9/4/2024, Program Coordinator discussed complaint and reviewed camera footage with [REDACTED], Director of Quality Risk Management. Facility was cited for 110.12. Case closed.



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 Behavioral of Forrest City

Facility Number: 142

Licensee Address: 603 KITTLE ROAD
FORREST CITY AR 72335

Licensing Specialist: Kendra Slade

Person In Charge: Charlotte Lockhart

Record Visit Date: 9/4/2024

Home Visit Date: 9/4/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.110.12

Regulation Description: The agency shall notify the Licensing Unit by the next business day when a report of child maltreatment is accepted by the child abuse hotline against the owner/operator, employee, foster parent, volunteer, child, or other person in a child welfare agency.

Finding Description: Facility did not notify licensing by the next business day when a report of child maltreatment is accepted by the child abuse hotline against an employee.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulation Number: 100.110.12

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Finding Description: Facility did not notify licensing by the next business day when a report of child maltreatment is accepted by the child abuse hotline against an employee.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 10:15 am to 12:15 pm

Census: 49

Licensing received a complaint on 8/29/2024 for ELS Case #023606.

Program Coordinator spoke with Director of Risk Management about this complaint and reviewed camera footage. The reported incident happened on 7/30/2024 near the 100 Hall. Resident was upset at a peer over a remote control.

Program Coordinator observed the resident standing at the end of the hallway near the entrance/exit doors. Resident was observed jumping up and knocking down the ceiling tiles. A staff member was observed picking up the ceiling tiles, ratio 2:1. Staff members appeared to be talking with the resident.

Resident continued to jump up and knock down ceiling tiles. Program Coordinator observed wires coming out of the ceiling and resident continued jumping up in the air attempting to knock down more ceiling tiles. The male staff member was observed attempting to place the resident in a restraint. The resident was observed resisting the restraint, ratio 2:1.

The male staff member was observed struggling to place the resident in a restraint. Program Coordinator observed the resident attempting to pin the staff member against the wall. Another male staff member was observed entering the area to assist, ratio 3:1.

The female staff member was observed attempting to control the resident's legs. The resident continued to resist the restraint. Once the resident was placed on the floor, he continued to struggle with staff by kicking and moving his body attempting to get out of the restraint. A nurse was observed entering the area and appeared to be communicating to the resident who continued to resist the restraint, ratio 4:1.

Facility will be cited for standard 110.12 for not notifying licensing by the next business day when a report of child maltreatment is accepted by the child abuse hotline against an employee.

Provider Comments:

CCL Staff Signature :

Date: 9/4/2024



Provider Signature :

Date: 9/4/2024

