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: 023157

Date of Incident: 8/10/2024

Date Received: 8/12/2024

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: 08/10/24 at ~17:40 Patient Insurance: [redacted] Agency Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS [redacted] Director of Risk Management 12 Aug 24 16:30 [redacted] Disability Rights Center, Inc. [redacted] Director of Risk Management 12 Aug 24 16:30 incidentreporting@disabilityrightsar.org Perimeter [redacted] Director of Risk Management 12 Aug 24 16:30 [redacted] Guardian/Caseworker [redacted] Director of Risk Management 12 Aug 24 15:11 15:12 [redacted] Director of Risk Management 08/12/24 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 08/12/24, the Director of Risk received two Resident Grievance Forms dated 08/11/24, from residents [redacted]. Both forms indicated sexual misconduct occurred between residents, with [redacted] alleging [redacted] went into her bathroom and fingered her while she was showering and [redacted] stating [redacted] followed her into the bathroom and told [redacted] to touch her, which she noted she did. Actions Taken: ? [redacted] (ongoing). ? Residents moved to separate units while investigation is ongoing.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 8/15/2024, Program Coordinator spoke with Director of Risk Management and reviewed camera footage. Director of Risk Management reported that all staff have been retrained and a policy was implemented. A copy of the policy was emailed to Licensing Specialist [redacted] Due to staff members not facing the hallway where the residents were located, facility is being cited 907.2. Facility provided documentation for this incident that has been uploaded. 8/15/2024, facility reported the shower was elevated Arisa Health and building owners. A plumber was scheduled to come out within a week. Facility also reported that it looked like the shower heads needs to be replaced due to mineral buildup that is affecting the pressure.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Perimeter of the Ozarks

Facility Number: 237

Licensee Address: 2466 SOUTH 48TH STREET
SPRINGDALE AR 72766

Licensing Specialist: Kendra Rice

Person In Charge: Charriot Sales

Record Visit Date: 8/15/2024

Home Visit Date: 8/15/2024

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 members were not facing the hallway where the residents were sitting. One staff member was sitting with her back toward the residents and the other staff member was facing the dayroom area.

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: 10:00 am to 12:45 pm

Census: 27

Licensing received a provider reported incident on 8/12/2024 for ELS Case #023157.

Program Coordinator discussed the provider reported incident and reviewed camera footage with [redacted] Director or Risk Management.

The provider reported incident happened on the Orange Unit during hygiene time. The residents were observed sitting at the end of the hallway on the floor. At the beginning of the camera footage the ratio of staff and residents observed was 3:2. A staff member left off the unit and the ratio 2:2 of residents and staff was observed in camera view.

It was reported that due to resident's [redacted] shower being inoperable, she was informed to use resident's [redacted] shower. Resident [redacted] is observed walking down the hallway. Resident [redacted] is also observed popping in and out of the bedroom a few times and standing in the doorway. The longest resident [redacted] was observed in the bedroom was estimated at 1 minute and 8 seconds. There is no camera in the resident's bedroom so Program Coordinator was unable to review what took place.

Due to the camera angle and the distance of the camera and hallway, Program Coordinator could not determine what the residents were doing while sitting on the floor. It appeared that the residents were face to face a few times while sitting on the floor.

Staff members were sitting at the desk with one staff member's back toward the resident and the other staff member was facing a wall in the dayroom area. Staff were watching or could see the residents sitting on the floor at the end of the hallway. Facility will be cited for standard 907.2 due to staff not providing adequate supervision.

[redacted] reported that the residents were placed on sexual acting out precautions and placed on separate units. The facility has put a policy in place that was provided to Licensing via email. [redacted] stated that staff were retrained on Tuesday (8/13/2024) and Wednesday (8/14/2024) on hygiene/shower time.

Provider Comments:

CCL Staff Signature :

Date: 8/16/2024

Provider Signature :

Date: 8/16/2024