ARKANSAS DEPARTMENT OF HUMAN SERVICES

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: 023525

Date of Incident: 8/12/2024

Date Received: 8/27/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: ? Serious injury requiring outside medical attention ? Resident?s attempted suicide X Allegation of abuse/neglect related to a restraint ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse ? Sexual Misconduct ? Other Patient/Resident Name/DOB: [redacted] Date/Time of incident: 08/12/24 at 21:26 Patient Insurance: [redacted] Agency Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS [redacted] Director of Risk Management 27 Aug 24 07:00 [redacted] Disability Rights Center, Inc. [redacted] Director of Risk Management 27 Aug 24 07:00 incidentreporting@disabilityrightsar.org Perimeter [redacted] Director of Risk Management 27 Aug 24 07:00 [redacted] Guardian/Caseworker [redacted] Director of Risk Management 12 Aug 24 23:00 [redacted] Director of Risk Management 08/26/24 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 08/26/24, the Director of Risk received notice from [redacted] that [redacted] regarding an inquiry received from: [redacted] which stated [redacted] reports that a staff member named [redacted] became upset with her when she left the common room to sit in her bedroom. Per [redacted] when she refused to leave her room said staff member picked her up and slammed her into the wall. [redacted] reported that she was scratched on her neck/shoulder area as a result of this.? Actions Taken: ? Resident was medically assessed on 08/12/24 and treated with topical medication. ? DOR and DON reviewed camera on 08/13/24 and determined excessive force was not used. [redacted] received Handle with Care refresher training on 08/16/24.

Interim Action Narrative: Staff will work in medical records filing documents with no direct or unsupervised contact with any resident during the course of the investigation.

[redacted]

Licensing Narrative: 8/26/2024-During an unrelated visit, licensing was made aware of this complaint as licensing was exiting the building. Licensing informed the agency they would return the following morning for follow up on this case. 8/27/2024- Licensing visited the facility and asked to review camera footage. Camera footage was reviewed. Nursing notes were obtained. The licensing specialist requested copies of the restraint order and justification packet and the staff retraining the facility provided to the A/O on 8/16/2024. ICA for the A/O was obtained and approved by licensing.

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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: Chelsea Vardell

Person In Charge: Charriot Sales

Record Visit Date: 8/27/2024

Home Visit Date: 8/27/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.110.9.a

Regulation Description: Any owner, operator, employee, foster parent, or volunteer in a child welfare agency shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has

Finding Description: The facility was made aware of an allegation of abuse on 8/13/2024, but never reported it to the child abuse hotline.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: Been subjected to child maltreatment

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing visited the facility in response to complaint case 023525. Licensing reviewed camera footage of the alleged incident beginning at 9:10pm-10:05pm. The review showed residents in their bedrooms with two residents on precautions sleeping on the unit dayroom floor. The facility reports that at this time the resident named in this report is in her bedroom yelling/making noise that is disrupting the unit. Several staff can be seen going to her door and standing in the doorway. The facility reports staff were attempting to verbally de-escalate her. The A/O and a nurse enter the resident's room and the camera does not capture what occurs inside the room. At 9:26pm the resident is seen being restrained by the A/O and walked to the seclusion room outside of the unit. The resident is attempting to resist as the A/O gets the resident into the seclusion room and locked seclusion begins. Video from inside the seclusion room shows the resident escalated as she kicks the door and appears to be dancing. The resident then sits against the wall with her knees at her chest. Approximately five minutes later the nurse enters the room and can be seen talking to the resident. The facility reports that the nurse is attempting to contract for safety, but the resident refuses and continues to sit on the floor. The nurse leaves then returns to the room at 9:35pm offering the resident a chemical restraint. The resident refuses. Additional staff then place the resident in a physical restraint and the resident becomes combative. Once the resident is laying in a prone position on the floor with three staff holding her, the nurse administers a chemical restraint. The resident is then kept in that physical restraint until 10:03pm when she is released. The resident stands up and returns to her unit willingly and goes to bed.

The facility reports that the resident made a grievance report regarding the restraint on 8/13/2024 at which time it was reviewed by the DOR and DON. The DOR and DON then reviewed camera footage and determined that the restraint was done correctly therefore they did not report the allegation to the child abuse hotline.

Licensing asked why the facility did not report the allegation to the child abuse hotline as the video camera footage does not show what occurred inside the resident's bedroom. The facility reports that the nurse who was in the room at the time of the alleged incident reported to the DOR that she did not witness any maltreatment. Licensing requested a copy of the witness statement from that nurse, or any other staff present during the time. The facility reported that the nurse has not yet written a witness statement.

Licensing received the physician orders for the chemical, seclusion, and physical restraints that occurred on 8/12/2024, but signed by the physician on 8/26/2024. Licensing received nursing notes documenting scratches on the resident's neck that were treated with topical ointment. Licensing received nursing shift notes dictated by the RN and LPN. A witness statement from the RN was also received. Licensing requested a witness statement from the LPN.

Licensing discussed with the facility why the resident was forcibly given a chemical restraint. The facility reported that the resident was verbally threatening staff and had attempted to punch the staff while in the

bedroom before the physical restraint was initiated. Licensing discussed how the resident had appeared to be calming down in the seclusion room before staff entered. Additionally, the resident was only in the seclusion room for eight minutes when the staff entered to forcibly administer the chemical restraint after the resident refused it.

The facility will be cited for the following:

110.9.a Any owner, operator, employee, foster parent, or volunteer in a child welfare agency shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has: (a) Been subjected to child maltreatment.

Licensing will meet with the facility management team to discuss compliance concerns on 9/5/2024.

Licensing is not prepared to leave a finding for this complaint at this time as there is no video footage of the alleged incident that occurred inside the resident's bedroom.

Provider Comments: Chelsea Vardell

CCL Staff Signature : Date: 8/29/2024

Provider Signature : Charrad Sally Date: 8/29/2024

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Licensing Specialist: Chelsea Vardell

Person In Charge:

Record Visit Date: 9/27/2024

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Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing has investigated complaint 023525. The case has been determined to be unfounded by licensing.

The current ICA for the staff named in the complaint may be lifted and the staff may return to normal job duties.

Provider Comments:

CCL Staff Signature : Date: 9/27/2024

Provider Signature :  Date: 9/27/2024