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: 024194

Date of Incident: 9/22/2024

Date Received: 9/23/2024

Facility Name: Perimeter Behavioral of West Memphis

Facility Number: 231

Incident Type: Dual

Report Description: Residents Name: [redacted] On 9/23/24 Resident wrote a grievance stating ? [redacted] got mad at me and pushed me and I kicked the wall so he threw me on the floor and grabbed me by the back of my jacket and choked me.? I assessed the Resident for any signs of injury this morning and was not able to see any redness or bruising around her neck and no complaints of pain reported. I then reviewed footage of the alleged incident. On 9/22/24 at 19:51pm the Resident is seen on camera walking into the quiet room where she begins kicking/kneeing the wall. Staff member [redacted] is then seen entering the quiet room and trying to remove the resident. The resident holds her arms and feet against the door frame and then releases her arms and falls to the ground. The resident then stands up and begins hitting [redacted] arms. He takes hold of her hands and sits her in a seat. His hands move from her hands to the hood on the back of her jacket holding against the chair when he is intervened by another staff member coming to assist. Actions Taken: [redacted] terminated 9/23/24

Interim Action Narrative: The facility reports that the staff is on active suspension, pending certain termination as of 9/25/2024.

Maltreatment Narrative: [redacted] This morning 9/23/24 [redacted] a resident at Perimeter Behavioral of West Memphis wrote a grievance stating "[redacted] got mad at

me and pushed me and I kicked the wall so he threw me on the floor then grabbed me by the back of my jacket and choked me. " I reviewed camera footage of last night 7/22/24 at 19:51 [redacted] walks into the quiet room and begins kicking the wall. [redacted] is then seen entering the quiet room and attempts to remove resident from the quiet room. [redacted] is seen putting her hands and feet on the door frame, [redacted] arms release and she falls to the ground. [redacted] is seen standing up and attempting to hit [redacted], he holds her arms and sits her in a chair and appears to grab ahold of her hood on her jacket, briefly, then releases when corrected by another staff member. I assessed [redacted] for any signs of injury this morning and was not able to see any redness or bruising around her neck and no complaints of pain reported. [redacted] is suspended pending investigation.

Licensing Narrative: 9/24/2024- Licensing requested permission to contact from the investigator. 9/25/2024- Licensing visited the facility to review camera footage, review restraint documentation, and the personnel file of the alleged offender. 9/27/2024- The facility confirmed that the A/O has now been terminated from the facility. 9/30/2024- The facility provided retraining documentation that other staff aware of the allegation at the time of the incident have bee re-educated on their roles as mandated reporters. 10/31/2024, Licensing received notification that complaint was found unsubstantiated. Complaint founded by Licensing and facility was cited on 9/25/2024. Approved by Program Coordinator. Case complete.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 West Memphis

Facility Number: 231

Licensee Address: 600 N 7TH ST
WEST MEMPHIS AR 72301-3235

Licensing Specialist: Chelsea Vardell

Person In Charge: Summer Berryhill

Record Visit Date: 9/25/2024

Home Visit Date: 9/25/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Finding Description: Staff engaged in unprofessional conduct when he forcibly grabbed the resident by the left arm and attempted to pull her out of the empty room beside the dayroom. The staff then attempted to push the resident out of the room which resulted in her falling to the ground. The staff also was seen pulling down on the resident's jacket hood as she was seated in a chair causing it to choke her.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Program manager and licensing specialist visited the facility in response to complaint case 024194.

The facility reports that the staff named in the report has not been terminated at this time but has been placed on suspension. The facility reports they will be likely terminating this employee.

The incident occurred on 9/22/2024 at which point the resident informed other staff about what had occurred. The resident was asked to fill out a grievance from and she did on the evening of 9/22/2024. The grievance form was received by the facility director of risk management on 9/23/2024 and was reported to the child abuse hotline. Licensing discussed with the facility why the staff who were made aware of the report on 9/22/2024, did not call the child abuse hotline as they are mandated reporters. The facility reports that the staff can and are encouraged to call the hotline, but these staff did not. The facility will provide re-training to the staff who had knowledge of the incident on 9/22/2024 of their responsibilities of reporting suspected abuse and neglect to the child abuse hotline by 10/2/2024.

Nursing notes and the grievance form was reviewed by licensing during the visit.

A review of the staff's record showed that he had all his required background checks completed, he was trained and provided refresher courses in the facility's restraint hold techniques, and he had one employee corrective action in 2022 that was not related to any interaction with a resident.

Camera footage of the incident on 9/22/2024 was reviewed from 19:51-19:56. The resident was upset and walked into an empty room off the dayroom area and can be seen kicking a spot on the wall. The staff can be seen entering the room and forcibly grabbing the resident by the left arm and yanking her towards the door. The resident resists and attempts to use her hands and feet on the door frame to keep from being pushed out of the room by the staff. The staff eventually overpowers the resident, and the resident falls forward landing on the ground. The staff picks the resident off the ground and pulls her into a chair in the dayroom while standing behind her. The resident is resistant as the staff grabs the resident jacket hood and begins to pull down on it, choking the resident. Another staff identified as the lead tech immediately intervenes and tells the staff to stop as he is choking her. The staff stops and walks away. The resident continues to sit in the chair and is visibly upset about the situation as she reportedly tells the other staff entering the unit about what had just occurred.

The facility is being cited for the following violation:

109.1.g Staff engaged in unprofessional conduct that could be viewed as physically harmful to a resident

Licensing complaint is founded.

Provider Comments:

CCL Staff Signature : Chelsea Vardell Date: 9/26/2024

Provider Signature Date: 9/26/2024