

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: 024389

Date of Incident: 9/29/2024

Date Received: 9/30/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Interim Action Narrative:

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? Sexual Misconduct X Other, Arrest Patient/Resident Name/DOB: Date/Time of incident: Name of Perimeter Staff Making 09/29/24 at 21:30 Patient Insurance: Notification Date Time Name of Person Notified DHS Charriot Sales, Director of Risk Management 09/30/24 18:00 Felicia Harris, Chelsea Vardell, Kendra Rice, Jarred Parnell OLTC Charriot Sales, Director of Risk Management 9/30/24 18:00 Jeff.rosenbaum@dhs.arkansas.gov Disability Rights Center, Inc. Charriot Sales, Director of Risk Management 09/30/24 18:00 incidentreporting@disabilityrightsar.org Perimeter Charriot Sales, Director of Risk Management 09/30/24 18:00 Skyler Barnes, Shawna Stover, Chris Perry, Brandy Pfeifer, Carey Ouzts, Rebecca Thomas Guardian/Caseworker Sabrina McLellen, LPN 09/29/24 23:57 Charriot R. Sales, Director of Risk Management 09/30/24 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 09/29/24, the Springdale Police Department was called on On 09/28/24, the resident assaulted multiple staff and was exhibiting the same aggression that evening. She was taken to the Juvenile Detention Center and was scheduled for court on 09/30/24 at 08:00. She returned to Perimeter on 09/30/24 at approximately 14:00. Actions Taken: ? Called the Springdale Police Department. ? Resident taken to the Juvenile Detention Center. ? Court appointment on 30 Sep 24 at 08:00. ? Guardian notified.

Maltreatment Narrative:

Licensing Narrative: 10/1/2024 - The provider reported incident was reviewed by the licensing specialist. Licensing specialist will follow up with facility if there is camera footage for review and if the resident received a citation. 10/1/2024 - Citation information received, reviewed, and uploaded to ELS. 10/3/2024 - A visit was conducted at the facility to review video footage for the reported incident. Timestamp for the video 9/29/2024 at 7:05 PM from 7:05PM to 7:13. Residents can be seen becoming dysregulated while yelling out of the door. At 7:13 PM another resident from another unit was outside of the door of the blue unit. When residents in the blue unit saw the other resident outside they became more physical. The staff can be seen utilizing body blocks and trying to verbally calm residents. Police contact at 7:19PM because the environment was becoming more unsafe. The residents continue to posture and instigate until the police arrive with no further incident. 10/7/2024 -Licensing specialist sent correspondence inquiring and requesting documentation about preventative implementations being utilized to deescalate before restraints or police intervention is needed. 10/7/2024 - 1. De-escalation Training All staff members undergo regular training in crisis prevention and intervention via Handle with Care, with a strong emphasis on verbal de-escalation techniques. This includes recognizing early signs of agitation and employing strategies such as verbal de-escalation, calming techniques, and environmental modifications to support regulation. 2. Therapeutic Interventions and Programming We have increased the availability of therapeutic programming, including group and individual therapy sessions, to address emotional regulation, conflict resolution, and coping skills. By focusing on these skills in a structured manner, we aim to reduce underlying stressors and improve residents' ability to handle challenging situations. 3. Trauma-Informed Care Approach We continue to use a trauma-informed care framework, which emphasizes understanding the root causes of behavior, considering trauma histories, and using empathy to guide our interactions with residents. This approach helps reduce triggers and build trust between staff and residents, mitigating tensions. 4. Leadership Review of Emergency Safety Interventions (ESIs) In addition to these preventative measures, all Emergency Safety Interventions (ESIs) are reviewed by leadership to ensure that best practices are being followed. This review process includes analyzing the circumstances that led to the intervention, evaluating whether preventative strategies were properly applied, and identifying areas for improvement. By conducting these thorough reviews, we aim to reduce the frequency of incidents requiring restraints or outside intervention and to further refine our de-escalation protocols. We are committed to maintaining a safe and supportive environment for all residents and staff and continue to review and refine our practices to meet these goals. If you have any additional suggestions

or would like to discuss our strategies further, we are more than happy to set up a time deeper conversation.	e for a



Division of Child Care & Early Childhood Education

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521 Visit Compliance Report

Licensee: Perimeter of the Ozarks
Facility Number: 237
Licensee Address: 2466 SOUTH 48TH STREET SPRINGDALE AR 72766
Licensing Specialist: Jarred Parnell
Person In Charge: Charriot Sales
Record Visit Date: 10/3/2024
Home Visit Date: 10/3/2024
Purpose of Visit: Self Report Visit
Regulations Out of Compliance:
Regulations Needing Technical Assistance:
Regulation Not Applicable:
Regulations Not Correctable:
Narrative:
10/3/2024 - A visit was conducted at the facility for case # 024389.

A visit was conducted at the facility to review video footage for the reported incident. Timestamp for the video 9/29/2024 at 7:05 PM from to 7:13 PM. Residents can be seen becoming dysregulated while yelling out of the door. At 7:13 PM another resident from another unit followed a nurse out of the unit and into the milieu and went to the outside of the door of the blue unit. When residents in the blue unit saw the other resident outside they became more physical. The staff can be seen utilizing body blocks and trying to verbally calm residents. Police contact at 7:19PM because the environment was becoming more unsafe. The residents continue to posture and instigate until the police arrive with no further incident.

Facility staff states they are implementing preventative measures to ensure safety. Facility states they are focusing on escalation and training staff to be aware of the actions, moods, and verbal cues of residents showing aggression or dysregulation.

Provider Comments:

CCL Staff Signature : Date: 10/8/2024

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