



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: 024387

Date of Incident: 9/30/2024

Date Received: 9/30/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

Report Description: X 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 ? Other

Patient/Resident Name/DOB: [REDACTED] Date/Time of incident:

09/29/24 at 01:00 Patient Insurance: [REDACTED] Name of Perimeter Staff

Making 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 Keith

Bohannon, RN 09/30/24 01:04 Michael Walton 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, [REDACTED] self-harmed with a piece of wood, resulting in

a laceration on the right forearm. Resident was sent to the Arkansas Children?s Hospital

[REDACTED] She returned to Perimeter at approximately 04:00. Actions

Taken: ? Resident taken to the Emergency Room. ? Resident was placed on self-harm

precautions for 72 hours and is under line of sight observation. ? Provider consulted prior to

transport and for aftercare follow-up. ? Guardian notified.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 10/1/2024 - The provider reported incident was reviewed by the licensing specialist. Licensing specialist will follow up with the facility for where the wood came from, what the safety plan is, nursing notes, and any precautions the resident was put on. 10/1/2024 - Facility response received- "The wood came from the resident's bed. The mattress sits atop a piece of particle board and the resident peeled off a piece. The facility is doing a risk assessment regarding the boards and determining a course of action. The resident is on Self-Harm precautions for 72 hours and is line-of-sight while sleeping."

10/1/2024 - Nursing notes received from the facility, reviewed and uploaded to ELS.

10/8/2024 - A visit was conducted to do a walkthrough of the facility in regards to the report and inspect beds with pressed wood board. Residents rooms on blue and green unit which have pressed wood boards was inspected for damage to the beds. Upon inspection the boards appeared in good repair, and not chipped. It was not verified that the resident acquired the wood from the bed as there are no obvious signs of damage. The facility will be replacing all pressed wood board in the residents rooms as a precaution. Housekeeping staff will conduct regular inspections of the beds until the boards are replaced. Facility grounds keeping staff state the beds will be finished by 10/18/2024 and will provide photos of the beds. 10/15/2024 - the facility sent documentation that the fiberboards have been replaced in the bedrooms. Pictures have been uploaded.



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: Jarred Parnell

Person In Charge: Charriot Sales

Record Visit Date: 10/8/2024

Home Visit Date: 10/8/2024

Purpose of Visit: Subsequent Building and Grounds

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

10/8/2024 -A visit was conducted to do a walkthrough of the facility in regards to the report and inspect beds with pressed wood board. Residents rooms on blue and green unit which have pressed wood boards was inspected for damage to the beds.

Upon inspection the boards appeared in good repair, and not chipped. It was not verified that the resident acquired the wood from the bed as there are no obvious signs of damage.

The facility will be replacing all pressed wood board in the residents rooms as a precaution. Housekeeping staff will conduct regular inspections of the beds until the boards are replaced. Facility grounds keeping staff state the beds will be finished by 10/18/2024 and will provide photos of the beds.

The resident was moved to another unit as part of the safety plan for the incident.

Provider Comments:

CCL Staff Signature :

Date: 10/8/2024



Provider Signature :

Date: 10/8/2024

