

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: 024764

Date of Incident: 10/15/2024

Date Received: 10/16/2024

Facility Name: Perimeter Behavioral of West Memphis

Facility Number: 231

Incident Type: Licensing

Report Description: Resident:

Guardianship:

On 10/15/24 at Approximately 12:10 Resident was outside in the courtyard with the other residents when she climbed over the fence and eloped from facility grounds. West Memphis PD was notified and given a description of the Resident. Sight of the resident was lost for approximately 10 minutes. Resident was then located across the street in the car wash breakroom. WMPD transported the resident back safely to Perimeter of West Memphis. Resident was assessed by RN, no injuries sustained. MD was notified and Resident was placed on elopement precautions.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 10.16.24-Licensing Specialist emailed facility inquiring on ratio and location of staff during the elopement. Facility responded with the following: "Staff to Resident ratio was 3:17 as residents entered the courtyard. One staff member stepped away to use the restroom without notifying appropriate personnel to maintain proper ratio. One staff was sitting with a group of residents at the picnic table, the other was on the sidewalk with another group. While the elopement was in progress a Lead tech was making his rounds and witnessed the resident climbing the fence, ratio 3:17 was re-established. The

resident was on top of the fence and additional staff was called, the resident leapt from the fence and code green was announced. The staff member who failed to notify appropriate personnel of needing to step away has received corrective action for not following protocol and compromising patient care and safety." 10/22/2024, police documentation requested.