ARKANSAS DEPARTMENT OF HUMAN SERVICES

Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 029247

Date of Incident: 4/23/2025

Date Received: 4/24/2025

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Licensing

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, [redacted] Time of incident: 4/23/2025 at ~ 17:52 Patient Insurance: [redacted] Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS Charriot Sales, Director of Risk Management 4/24/25 14:00 Felicia Harris, Chelsea Vardell, Kendra Slade, Jarred Parnell OLTC Charriot Sales, Director of Risk Management 4/24/25 14:00 Jeff Rosenbaum, Angela Smith Disability Rights Center, Inc. Charriot Sales, Director of Risk Management 4/24/25 14:00 incidentreporting@disabilityrightsar.org Perimeter Charriot Sales, Director of Risk Management 4/24/25 11:00 Skyler Barnes, Chris Perry, Brandy Pfeifer, Carey Ouzts, Rebecca Thomas Caseworker Sabrina Mclellan, LPN 4/23/25 17:13 10:08 Savannah Chenault, Caseworker Charriot R. Sales, Director of Quality and Risk Management 4/24/25 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: At approximately 17:14 on April 23, 2025, resident [redacted] removed two batteries from a remote control and placed one in her mouth. Staff support was immediately notified, and a physical restraint was implemented to prevent additional self-harm. During the intervention, the assigned nurse successfully prompted [redacted] to expel the battery, and both batteries were secured by staff. During post-incident processing, [redacted] alleged she had previously concealed another battery on her person and had swallowed it. Due to the potential risk of ingestion, the medical provider was consulted. Out of precaution, [redacted] was referred to [redacted] for further evaluation. At 17:52, [redacted] transported [redacted] with one staff traveling with her and another meeting them at the [redacted] Upon evaluation at the [redacted], an X-ray confirmed that there was no foreign

object present in [redacted] body. However, given the escalation in suicidal gestures over the past 48 hours, the clinical team determined that an emergency discharge was necessary to facilitate admission to a higher level of psychiatric care. [redacted] was accepted for [redacted]. She was transferred into their care at approximately 04:00 on [redacted], 2025. Actions Taken: Resident transported to the [redacted] Staff remedial training for securing objects Updated guardian as needed

Interim Action Narrative:

[redacted] Narrative:

Licensing Narrative: 4/25/2025 - Licensing specialist Jarred Parnell reviewed the report. Licensing specialist requested nursing notes for the reported incident. and training documentation. Licensing specialist received a statement from the facility that they will provide the documentation for the training early next week as the training has not fully been completed by staff. Nursing notes received, reviewed and uploaded to ELS. 4/20/2025- Licensing specialist received facility training sign in sheet regarding contraband. The sign in sheet was reviewed and uploaded to ELS.