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: 027164

Date of Incident: 1/21/2025

Date Received: 1/29/2025

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: [redacted]

Report Description: Director of Quality and Risk Management received communication (phone call) that Resident, [redacted] **, accused Staff member,** [redacted] **or scratching his right arm and saying ?I will f*ck your mom.? AR DHS visited and interviewed** [redacted] **and** [redacted] **01/29/2025. Status of** [redacted] **is pending, referral number** [redacted]**. Statements from Resident, Staff, and witness have been collected. Camera review has been conducted. An ICA request has been submitted.**

Interim Action Narrative: Staff placed on administrative leave pending the results of the investigation.

[redacted] **Narrative: av is** [redacted] **his PRFCs name is unknown and the AO is a staff member at Perimeter Behavioral Group Home for Children. on Jan 23, A staff member at the Arkansas group home , told the AV , " i fucked your mother". Av then went after the staff member . Av was restrained he has scratches on his right forearm avs arms were held behind his back and causing his arms to go numb**

Licensing Narrative: Program Coordinator looked in [redacted]**. 1/30/2025, licensing requested** [redacted] **and for the facility to save camera footage. Witness statements were also requested. Facility reported incident was not accepted by** [redacted]**. Facility inquired about the**

status of the ICA and was informed that the request was sent to management. Facility reported that camera footage has been saved. ICA request denied by licensing due to staff member being named in multiple previous incidents. 3.20.25- Email received from Director of Quality and Risk Management stating the following: [redacted] has been on suspension since January 30th. We will offer conditional return to [redacted] under the following requirements: mandated retraining around therapeutic engagement with Residents, thirty-day performance improvement plan (PIP), and a temporary shift change (second shift to first shift)to work side by side with precepting supervisor to ensure quality of care. A conversation with his Director explaining this was held today. Employee will sign an attestation of policies. [redacted] will return to work tomorrow, 1st shift.

Division of Child Care & Early Childhood Education
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521 Visit Compliance Report

Licensee: Perimeter Behavioral of Forrest City

Facility Number: 142

Licensee Address: 603 KITTLE ROAD
FORREST CITY AR 72335

Licensing Specialist: Andrea Adamson

Person In Charge: Immanuel Morris

Record Visit Date: 2/4/2025

Home Visit Date: 2/4/2025

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 900.905.16

Regulation Description: Staff shall continually monitor each child in seclusion or restraints and shall document.

Finding Description: A female staff left a one-person restraint between the AV and AO three times resulting in the restraint being left unmonitored by any other staff.

Action Due Date: 2025-02-19

Action Due Description: The facility shall retrain staff on appropriate supervision and how to aid staff during the course of a restraint hold.

Comply Date:

Regulation Number: 900.907.2

Regulation Description: Child caring staff shall be responsible for providing the level of supervision, care, and treatment necessary to ensure the safety and well-being of each child at the facility, taking into account the child's age, individual differences and abilities, surrounding circumstances, hazards and risks.

Finding Description: Staff failed to provide adequate supervision to the resident during a restraint hold when leaving the AV and AO alone three times during the course of the restraint hold.

Action Due Date: 2025-02-19

Action Due Description: The facility shall retrain both staff in appropriate supervision of the residents to ensure their safety and well-being.

Comply Date:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

The Licensing Specialist visited the agency in regard to complaint case # 027164.

AMENDED AFTER APPEAL

Camera footage was reviewed of the alleged incident, and the following was noted:

Footage beginning at approximately1842 the AV is seen standing outside of his room with the AO and a female staff member.

AV is seen going back into his room and shortly after AO is seen moving quickly into the bedroom after the AV. Nothing can be seen happening inside the bedroom, however, there is another female staff member that is seen leaning on the doorframe of the bedroom during the initiation of the restraint. The female staff member does not move from the doorway to assist the staff with the restraint hold. At 18:53 the female staff member can be seen walking away from the doorway of the bedroom where restraint is occurring on the AV by the AO. The female staff member is seen talking to another staff member on the hallway then goes to other bedrooms to look in on other residents but does not have a view of the physical restraint occurring in the AV bedroom. The female staff member does return to the doorway of the AV's room briefly before leaving again at 18:55 as she walks to other staff on the hallway, returning to the doorway of the AV's room at 18:56. The female staff leaves the doorway of the AVs room again and leaves the hallway to the nurse's station at 18:58 returning at 18:59. The nurse enters the unit at 19:00 and looks in on the physical restraint occurring in the bedroom. Both the AV and the AO are then seen walking out of the bedroom at 19:02.

Licensing interviewed the AV with the OLTC and reviewed the witness statements. The AV presented with a fresh red mark that he reported was from earlier in the morning when he was involved in a restraint, but it was not causing him any pain or discomfort.

A review of the AO personnel file showed previous corrective actions have been taken on the staff by the facility for issues concerning the following:

- Code of Conduct; Unprofessionalism by "allowing outside relationships to spill into workplace, impacting residents and caused several altercations amongst residents"-***2.9.23***
- Left Resident unattended-***10.23.23***
- Improper Containment-***1.7.24***
- Conduct pertaining to "refraining from any verbal abusive language in front of residents; will not engage in any verbal or physical altercations in front of residents; adhere to all program rules and guidelines."-***10.30.24***
  This also resulted in a suspension from 10.30.24 to 11.6.24

Licensing is unable to determine what occurred during the restraint hold of the resident in the bedroom as it is off camera, and the witness statements are contradictory. However, camera footage did reveal concerns related to the supervision of the resident while in a restraint hold. One staff member who was in the doorway while the one-person restraint was taking place in the resident's room between the AV and AO was not assisting the AO. Additionally, the female staff in the doorway does not consistently monitor the physical restraint occurring in the bedroom off camera between the AV and AO as she steps away several times before returning to the doorway.

The facility will be cited for:

907.2failing to ensure adequate supervision to ensure the safety and well-being of a resident.

905.16failing to continually monitor each child in a restraint.

The AO is currently suspended pending the results of the investigation. Please ensure that the two other staff present during the restraint on the hall are retrained on appropriate supervision and aiding staff during a restraint by 2/19/2025.

Licensing is unable to determine if there were any violations to standards 905.4.g using lewd or obscene language as a form of disciplinary actions or 905.9 using the minimal force necessary during the course of a restraint hold at this time.

Complaint case is founded for violations of standards 907.2 and 905.16.

******* Pursuant to A.C.A. § 9-24-406(e)(3-4): If you believe that the Department's notice of noncompliance is in error, you may ask for reconsideration. The request for reconsideration must be in writing and delivered to the Department by certified mail within twenty (20) business days of receipt of the notice of noncompliance. The request must specify the parts of the notice that are alleged to be in error, explain why you believe those parts are in error, and include documentation to support the allegation of error. Once received the Department shall issue a decision on your request within twenty (20) days after receipt of the request.**

Provider Comments:

CCL Staff Signature : Date: 2/4/2025

Provider Signature : Date: 2/4/2025