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: 029427

Date of Incident: 4/30/2025

Date Received: 5/1/2025

Facility Name: Perimeter Behavioral of Forrest City

Facility Number: 142

Incident Type: Licensing

Report Description: Lead Staff brought Resident, [redacted], to Director of Nursing (DON) to show her observed markings on Resident. DON inquired of [redacted] where the markings came from and Resident alleged it was from his roommate with whom he was on unit restriction with at the time. Resident preceded to then share sexual allegations against said roommate. [redacted] An internal investigation was also simultaneously launched. Both Residents were also seen same day of allegation by their respective Therapist. Footage review of was completed by the Safety Team and Therapists included. Resident interviewed during daily Safety Meeting by Safety team and Therapist 05/01/2025. See additional information section. Resident?s rooms have been changed. Residents are also peer restricted. Unit restriction for the Sexual Rehabilitative Unit will now be conducted only in the dayrooms. Staff involved in the supervision of these Residents during the window the behaviors occurred have been terminated. Upon camera review, stick and poke tattooing from named peer was evidenced but no signs of forced interaction. Additionally, inappropriate sexual behaviors were also evidenced upon camera but appears mutual with no evidence of forced engagement. Resident admitted to behaviors and shares ?I lied on (peer)? because he ?promised me things from his pass.? Once Resident found out the peer had no pass, he presented these allegations. Resident educated on the dangers of falsely accusing peers and verbalized understanding.

Interim Action Narrative:

[redacted] **Narrative:**

Licensing Narrative: 5.1.25- uploaded the SORF from facility as well as requested video footage be retained. 5.2.25- Facility will retain footage 5.13.25- Licensing Specialist went to Facility. 5.13.25- Facility was cited for 907.2 on failure to supervise, staff involved was terminated. Details retained in inspection #087043 The case has been closed as founded by licensing.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 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: 5/13/2025

Home Visit Date: 5/13/2025

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

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 was in the hallway on their phone and did not do the 15 minute interval check ins. Staff did however mark on documentation that the checks had occurred. Staff has been terminated.

Action Due Date:

Action Due Description: Staff was terminated.

Comply Date:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Licensing Specialist arrived at 11:00 am to the facility regarding case #029427.
Current Census: 54

Video Footage reviewed was as follows:

Residents 1 and 2 were seen in their bedoom on Unit Restriction for threatening to elope.

1822:Resident 1 was seen giving Resident 2 a stick and poked tattoos using a safety pin. (Facility completed an investigation on how the safety pin was obtained and were unbale to discover this information). Resident 1 was seen pulling the door halfway closed and continuously looking out the door to ensure the staff member was not paying attention. Resident 2 was seen lifting his shirt sleeve multiple times to allow Resident 1 to apply the tattoo. This pattern continued until 1827.

Footage picked back up at 1834, Resident 1 was seen turning off the lights to the bedroom and walking around with a blanket around him like a cape. During this time, Residents 1 and 2 were engaging in a pattern of inappropriate behavior until 2004. The inappropriate behavior stopped due to other residents returning to the hall. During the video footage the staff member was never observed entering the bedroom or engaging with the residents.

Facility reported to Licensing that the staff member involved in this incident had been terminated. Licensing was informed that the staff member was documenting that she was completing the 15 minutes interval checks, per documentation. This was proven to be untrue by the video footage reviewed where the residents were left unsupervised for approximately 1 hour and 44 minutes.

According to the facility, the staff member was on her cell phone the entire time she they should have been supervising the residents while sitting in a chair in the hallway. Moving forward, the facility has changed their policy regarding Unit Restriction. The residents will be kept in the in the day rooms instead of bedrooms when placed on Unit Restriction.

The following Minimum Licensing Regulations was reviewed:

907.2- "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."

Licensing Specialist will be citing for 907.2 for staff leaving the residents unsupervised, allowing this incident to occur.

******* 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:

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CCL Staff Signature : Date: 5/13/2025

Provider Signature : Date: 5/13/2025

Charlotte Lockhart, CEO