Division of Child Care & Early Childhood Education
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

Date of Incident:8/24/2022

Date Received by DCCECE: 8/25/2022

Facility Name: Youth Home, Inc.

Facility Number: 128

Facility Type: Residential

Incident Type: Licensing

Report Description: [redacted] **of Incident: 08/24/2022 Intervention Type: Personal Restraints, Seclusions Staff Involved: Christian Spratt, Justice Taggart, Rodney Ellis, Cedric Payne, Jonathan Pulliam, Nurses-Joseph Davis, Valerie Alvarez The patient skipped his peer in line, and they made a comment towards him. The patient turned around and pushed this peer and tried to push them again as staff intervened. He then began yelling in staff's face to let him return to his room, when staff informed this was not a safe choice at the moment he began trying to make his way into the staff office. 2:56pm Personal Restraint Started The patient was restrained as a result of being aggressive to his peers, staff, and attempting to enter the staff office. Staff several times attempted to calm the patient but he continued to escalate. 2:57pm Personal Restraint Ended 2:58pm Seclusion Began The patient entered the seclusion area and immediately turned around trying to hit staff and began sticking his fingers in the door jam threatening to beat on staff. The patient began banging on the walls with his fist, in the next moment he removed his jacket from his person and began choking himself with it. Staff transitioned to unlocked seclusion and removed the jacket from the patient's neck. Once without his jacket the patient began trying to swing and hit staff again from a seated position on the floor. The patient continued trying to hit staff and in the next moment laid down on the floor. As he laid on the floor the patient began having a seizure. It was unclear the cause of this but the nurse was called immediately to aid him. Staff observed the patient during the seizure and was by his side until the nurse arrived. The nurse arrived to look the patient over and he became aggressive with them trying to fight his way out of the room. 3:07pm Seclusion Ended 3:08pm Personal Restraint The patient restrained to maintain safety of all involved. He then began yelling aloud that he wished staff would let him die. Staff offered verbal support but the patient continued yelling that he wanted to end his life. He also expressed a**

distaste for the peer he pushed, stating he had been waiting for an opportunity to get physical with them. 3:15pm Personal Restraint Ended 3:21pm Personal Restraint Began In his room the pt began trying to choke himself with a jacket again. 3:23pm Personal Restraint End 3:25pm Patient removed his pillow case and attempted to put it around his neck. Staff were able to retrieve the pillow case. Patient again contracted for safety, and had no further issues. 3:45pm Nursing Face to Face Assessment Client reportedly in personal restraint. Upon my arrival, client was on the seclusion room floor in an active restraint. Client swung and made contact with staff. Client was placed in personal restraint. Client continued to struggle with staff until client began having pseudo seizure. Client was allowed freedom of movement and safety measures in place. Client opened his eyes and asked why we would not let him die. Client was consoled and was encouraged not to make permanent decision over temporary situation. Client began to calm down and was able to process some with staff. Client got up voluntarily and walked to his room, once there, client grabbed a pillowcase and attempted to tie it around his neck. The pillowcase was confiscated. Client calmed down and was able to process with staff. Client states his left arm and left side of face has increased pain. Tylenol 650mg given for pain. No complaints of vision problems, PERRLA, denies numbness/tingling. Client placed on eyeball, Front of house, and RSPA. No other needs identified now, will continue to monitor. 3:30pm Patient Debriefing The patient had no issues or concerns about the incident and did not appear interested in talking. Staff encouraged him let them handle situations rather than reacting and being unsafe. Staff also extended the offer for him to talk if he was feeling upset later. Guardian was notified on 08/24/22 at 4:30pm 3:30pm Staff Debriefing Injury noted to client: Client states his left arm and left side of face has increased pain. Tylenol 650mg given for pain. Follow-up to Injury: Tylenol 650mg given for pain. No complaints of vision problems, PERRLA, denies numbness/tingling. Client placed on eyeball, Front of house, and RSPA. No other needs identified now, will continue to monitor. Techniques that could have prevented the incident: separating patients earlier

Interim Action Narrative:

Maltreatment Narrative: **Outcome:**

Licensing Narrative: On 8/25/22 [redacted] became dysregulated fought with staff resulting in multiple restraints. [redacted] at one point removed his jacket as to self-choke. Staff were able to prevent [redacted] from harming himself. [redacted] was eventually able to calm down without further incident. [redacted] was placed on eyeball (constant supervision).