Division of Child Care & Early Childhood Education
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Notice of Serious Incident

Date of Incident:9/14/2022

Date Received by DCCECE: 9/14/2022

Facility Name: Youth Home, Inc.

Facility Number: 128

Facility Type: Residential

Incident Type: Dual

Report Description: Emailed complaint stating the following "My son was sent to Youth Home from Meridell, Texas (another RTC) to receive psychiatric treatment. We (myself and his out-patient psychologist) had told them that he needs testing done to figure out what his neurological dysfunction. The test he specifically needed was a Neuro-psych evaluation, full psychiatric assessment, and personality testing. They had assured me that they would take care of it during the admissions process, when I met with them and during several zoom meetings. I had also requested his medication (Zyprexa) be adjusted since he was having side effect of severe weight gain. The doctor suggested [redacted] try Thorazine so I agreed. My son started complaining of several side effects of this medication to include: lack of ability to control his impulses, running and scattered thoughts, and became increasingly depressed and suicidal. We gave it some time since it may take some time to build up to a therapeutic dosage. After some time my son became increasingly out of control and we agreed to send him to acute care at Pinnacle Pointe to be stabilized; as he was showing symptoms of psychosis. They sent him with no clothes but what he was wearing. While there the staff determined that he should be taken off of Thorazine and try Haldol. He was stabilized and no longer suicidal after roughly thirteen days there. He said he felt great and normal again. Unfortunately, the transfer back to Youth Home was a disaster and seemed to lack any planning whatsoever. It was during a weekend when Youth Home's pharmacy was closed, Pinnacle Point did not provide any medication till the pharmacy was open and without any approval from me switched him back to Thorazine for reasons unknown to me. I did not approve this, I found out through my child. I do not know why you would put a child back on a medication that made him out of control and suicidal and without any of the testing we needed to narrow down his medication decisions. After this, they decide to re-stabilize him there on the original medication (Zyprexa) with Metformin to counter the

weight gain. This option was never presented in the beginning and would make a lot more sense then having to re-stabilize him several times. During the time he was restabilizing he forced into situations that might be dangerous to himself and others. He ended up assaulting his teacher and having felony charges pressed on him. I truly believe if they would have handled this like competent professionals that my child would not be facing time in juvenile detention. He had also complained several time prior to this that several of the staff members were too rough with him when restraining him (was one). I do not know if they were or not but I had brought it up to to add to her notes. After the third complaint I had asked for some answers and had never received any follow-up regarding my concerns. And recently, during a zoom meeting, on 12 September at 8:30 am I was told by that the testing that I had initially requested had not happened because my insurance ( ) does not cover it. I followed up with that evening and they verified that they indeed due. She lied to us. She is saying that they can not keep him due to safety concerns, which I get, but when I'm telling admissions that I have these concerns and that's the reason for him being there, I expect them to be able to due what they say they are going to due and not put him in unsafe situations which ultimately lead up to him assaulting his teacher. You can not put a child with my son's psychiatric issues who isn't medicated properly in a classroom with other parents children and teachers."

Interim Action Narrative: Staff was placed on administrative leave on 9/28/2022.

Licensing Narrative: Facility visited on 9/28/22 in which the resident's file was reviewed. All restraint documentation was reviewed and at no point did the resident report rough restraint holds. Program Coordinator Chelsea Vardell discussed with the education director the education that the resident is receiving at the facility and determined that the resident is currently getting worksheets sent to his dorm and teachers are going to the dorm to educate him face to face. The face-to-face sessions did not begin until last week. The facility reports their plan is to discharge the resident, but in the meantime, they will continue to work on potentially reintegrating him back into school with other residents. The resident has received testing while at the facility for his mental health. The resident was placed back on

medication by the physician at the facility because their policy only requires guardian approval for an "initial dose" and since this medication was previously prescribed to the resident prior to his admission into an acute facility, the facility did not obtain parental consent before administering it to him. The Program Coordinator also spoke to the resident's individual therapist regarding his behaviors and noted that the resident has not had any restraint holds in the past 22 days but continues to be on dorm restriction. The resident is allowed to go on walks with staff around the campus for his exercise. The Program Coordinator and Licensing Specialist were made aware of an incident in which a staff did participate in a rough restraint with the resident on 8/24/22 [redacted] **Licensing reviewed the camera footage and determined that staff pushed the resident with unnecessary force into a seclusion room causing the resident to hit the wall and fall to the ground.** [redacted] **Complaint findings are as follows: 908.3 (Unfounded) The facility does have a medication management policy that was followed during the administration of the resident's medications. 909.1(Unfounded) The resident is receiving education services while on dorm restriction including face to face tutoring with teachers. 909.8(Unfounded) The resident is going on walks with staff around the campus 4-5 times a day to ensure appropriate exercise while on dorm restriction. 905.4.g (Founded) Staff did participate in the use of physical force as a form of behavior management at the time of a seclusion on the resident 8/24/22. 109.1.g (Founded) Staff did participate in unprofessional conduct during the course of a seclusion on the resident on 8/24/22.**