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: 12/5/2022

Date Received by DCCECE: 12/6/2022

Facility Name: Youth Home, Inc.

Facility Number: 128

Facility Type: Residential

Incident Type: Licensing

Report Description: Chestnut House [redacted] Private Placement Resident refused his evening medication and informed staff that he was not taking his medication and they could not make him. It was reported that resident stated he'd kill himself first before taking his medication. Shift Nurse was informed of resident's refusal and he refused with the nurse also. Resident started running across his room and jumping on his bed. Staff attempted to get resident to calm down. Resident was non-complaint with staff's efforts to calm down and use his coping skills. He was verbally aggressive with staff. Resident banged his head on his bedroom door and kicked his bedroom walls. When resident closed his door without permission and was informed that was a threat to safety. On resident's second attempt, staff opened his door. Resident was verbally aggressive and continue to bang his head on his bedroom door. Resident was placed in locked seclusion due to his continued threats of aggression towards staff despites staff efforts of encouragement. When resident attempted to use his hoodie to hide while choking himself, his hoodie was removed. Resident kicked the seclusion door, cursed staff, and made threats to self-harm by placing his hands toward his neck and making gagging sounds. Resident was assessed by the nurse and no concerns noted. Resident also had to have his shoes and pants removed for safety. The doctor was contacted and chemical restraint ordered due to resident being defiant. Resident had to be placed in a physical restraint due to his unpredictable behavior for the nurse to administer a chemical restraint. Resident eventually calmed down and was able to return to his bedroom to prepare for bed. He was placed on eyeball precaution due to his suicidal remarks and actions.

Interim Action Narrative: Resident was placed on eyeball precautions.

Maltreatment Narrative: **Outcome:**

Licensing Narrative: Licensing Specialist entered incident on 12/7/2022 due to facility being unable to enter the incident into ELS on 12/6/2022. Record Compliance Coordinator reported receiving an error message. Licensing Specialist will inquire about restraint documentation and camera footage. Licensing Specialist received a provider reported incident on 12/6/2022. Facility reported a resident made suicidal threats, went to seclusion, placed in physical and chemical restraints due to his non-compliant behaviors. Licensing Specialist was informed by staff (Anthony and Peggy) that 12/6/2022 was resident?s first day at the facility. Licensing Specialist reviewed camera footage. Licensing Specialist observed resident being taken to the seclusion room by two staff members. While in the seclusion room, Licensing Specialist observed resident pull the hood of his shirt over his head and put his arms inside the shirt. Staff attempted to process with resident who in returned used foul language and threats. Resident was placed in a physical restraint and his shirt was taken for safety reasons. He started kicking the door and hitting the window of the door. Licensing Specialist observed resident with his hands resting on his shoulders making gagging noises. He did not appear to be choking himself. Resident was also observed pressing his thumbs against his voice box making gagging noises. Once staff entered the room, the resident stopped. Staff attempted to process with resident, he tried to close the door while staff was talking. Resident continued to display suicidal behaviors and his clothes were taken for safety reasons. Resident was placed in a physical restraint so that his clothes could be removed. Licensing Specialist observed each time staff including the nurse tried to process with the resident, he did not comply. Resident continued displaying verbal and physical aggression toward staff and facility property and attempted to choke himself. He made threats toward himself and staff. Resident was placed in a physical restraint so that he could receive a chemical restraint due to his continued behaviors. The chemical restraint was ordered by the doctor and administered by the nurse. Licensing Specialist observed both restraints. Once the chemical restraint was administered the physical restraint was released, resident started back kicking the door. Few minutes after the chemical restraint, the nurse assessed the resident. He processed with the nurse and staff. Resident was given back his clothes and he return to his bedroom. Resident was taken off eyeball precautions today and remains on close observation precautions. No licensing concerns noted.

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521 Visit Compliance Report

Licensee: Youth Home, Inc.

Facility Number: 128

Licensee Address: 20400 COLONEL GLENN ROAD
LITTLE ROCK AR 72210

Licensing Specialist: Kendra Rice

Person In Charge: Robbie Lagrone

Record Visit Date: 12/7/2022

Home Visit Date: 12/7/2022

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulations Not Correctable:

Narrative:

Time of Visit: 2:00 pm to 3:45 pm
Census: 35

Licensing Specialist received a provider reported incident on 12/6/2022. Facility reported a resident made suicidal threats, went to seclusion, placed in physical and chemical restraints due to his non-compliant

behaviors. Licensing Specialist was informed by staff (Anthony and Peggy) that 12/6/2022 was resident's first day at the facility.

Licensing Specialist reviewed camera footage. Licensing Specialist observed resident being taken to the seclusion room by two staff members. While in the seclusion room, Licensing Specialist observed resident pull the hood of his shirt over his head and put his arms inside the shirt. Staff attempted to process with resident who in returned used foul language and threats. Resident was placed in a physical restraint and his shirt was taken for safety reasons. He started kicking the door and hitting the window of the door.

Licensing Specialist observed resident with his hands resting on his shoulders making gagging noises. He did not appear to be choking himself. Resident was also observed pressing his thumbs against his voice box making gagging noises. Once staff entered the room, the resident stopped. Staff attempted to process with resident, he tried to close the door while staff was talking. Resident continued to display suicidal behaviors and his clothes were taken for safety reasons. Resident was placed in a physical restraint so that his clothes could be removed.

Licensing Specialist observed each time staff including the nurse tried to process with the resident, he did not comply. Resident continued displaying verbal and physical aggression toward staff and facility property and attempted to choke himself. He made threats toward himself and staff. Resident was placed in a physical restraint so that he could receive a chemical restraint due to his continued behaviors. The chemical restraint was ordered by the doctor and administered by the nurse. Licensing Specialist observed both restraints. Once the chemical restraint was administered the physical restraint was released, resident started back kicking the door.

Few minutes after the chemical restraint, the nurse assessed the resident. He processed with the nurse and staff. Resident was given back his clothes and he return to his bedroom. Resident was taken off eyeball precautions. He remains on close observation precautions.

No licensing concerns noted.