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: 11/7/2023

Date Received by DCCECE:11/8/2023

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report 1 for [redacted] DOB: [redacted] Private placement client in our PRTF program and resides in Mabee House. Incident Report date/time: 11/07/23 1:16pm Location of Incident: Mabee House Incident Description: Threat to Safety Staff Involved: Anthony White, Joseph Davis, Jacqueline Wheeler Events Leading: Client escalated for no apparent reason, or reasons she can't or won't express. Client observed in the seclusion area, on her on volition, slamming her head into the walls of the seclusion room with varying force. Staff present offering support. After a short time, client exited this area, and ran down the hall. There client was observed to slam her wrists and arms, and fists into the wall around her. Client ignored support given by staff. After prompting from several staff, client continued these behaviors. 1:16pm Personal Restraint: Client restrained for safety. Client physically resisted against restraint. Client observed to attempt to slam her head into the wall behind her, prompting staff to attempt to buffer with their arms. Client vehemently protested against this. Client aggressively grabbed at staff's clothing, and spit on staff's arms. Client given verbal support and remind that as she's able to relax, staff will be able to relax the hold on her as she's being safe. This cycle continued for several minutes. 1:20pm: Personal Restraint End: Client began relaxing her posture and staff was able to relax the hold on her. Restraint ended at this time. Patient Debriefing date/time: 11/07/23 1:30pm: Client given support and asked to reach out in the future and to be safe. Nursing Assessment date/time: 11/07/23 2:10pm: Client upset due to family session. Client admits that she feels as though there "is too much on my plate". Upon my arrival, client was banging on the walls of front seclusion room. Client banged head on the unlocked seclusion room door. Client required personal restraint due to threat to safety. Client was encouraged to calm down and do the next right thing multiple times. Client began to show signs of calming and was released. Client went down hallway and required personal restraint to prevent injury. Here is where client again hit hand on wall. Client complains of right hand pain, given icepack and ibuprofen x 2. Client has full/active ROM

with pain 9/10, capillary refill <3 seconds, area reddened, no other discoloration noted. Encouraged client to rest, ice, ibuprofen and elevate it. Client denies numbness/tingling, PERRLA, no swelling noted to head, no hematoma detected. No other needs identified now, will continue to monitor. Guardian was notified by nurse on 11/07/23 at 2:39pm Injuries to staff or client: Client complains of right hand pain Follow-up to injuries: given icepack and ibuprofen x 2. Actions to prevent injuries: Client refraining from punching things. Additional comments: Client is becoming a concern for this Unit Manager. She requires so much attention and resources to the extent that the other clients in the house are excluded from various things at any given time. It is this Manager's thoughts that this client is not appropriate for this setting as it stands, and other services should be considered. Incident Report 2 Date/time: 11/07/23 1:57pm Location of incident: Mabee House Incident Description: Self Injury (Not Suicidal), Threat to Safety Staff Involved: Anthony White, Joseph Davis, Anthony Mask, Melissa Rhude Events Leading: Following previous incident, client sat in seclusion area attempting to calm. Client began slamming her head into the wall of the seclusion room with varying force. Attempts to redirect client were unsuccessful. As staff attempted to place their hands between the wall and her head, client became combative. 1:57pm: Personal Restraint: Client placed in restraint. Nurse restricted her arms as she attempted to strike staff attempting to prevent client from hurting herself. 1:58pm: Personal Restraint End: Client broke free from restraint. Staff attempting de-escalation and redirection for behaviors. Attempts unsuccessful. 1:59pm: Other/None: Staff attempting to attend to client's need. Client unable to voice them; insists on harming self slamming head on door. 2:00pm: Personal Restraint: Client restrained. Client combative with staff and resisting against restraint. staff continue de-escalation and redirection. 2:01pm: Personal Restraint End: Client broke free as staff continue de-escalation and redirection. Client resumes head slamming. 2:02pm: Personal Restraint: Client restrained. Client combative with staff and resisting against restraint. staff continue de-escalation and redirection. 2:03pm: Personal Restraint End: Client broke free as staff continue de-escalation and redirection. Client resumes head slamming. 2:04pm: Other/None: Client sitting in seclusion area as staff continue verbal de-escalation. Client resumes head banging and ignores redirection from staff. 2:05pm: Personal Restraint: Client restrained. She physically resisted and attempted to thrash and slam her body about. Staff offered verbal support. Client offered medication by mouth to help her calm. Client declined. Client continued to thrash about and become tearful as staff offered verbal support. 2:12pm: Personal Restraint End: Client began to calm and was no long combative. She sat quietly as staff talked with her. Restraint ended at this time. Client slapped the walls of the seclusion room door and began slamming her head into the wall again. Client ignored prompting and redirection to stop. 2:13pm: Personal Restraint: Client restrained. Client thrashed her body and screamed throughout. Client offered verbal support. Nursing approached with IM medication. 2:15pm Chemical Restraint: Nursing administered shot to client at this time. 2:16pm: Personal Restraint End: Client tearful and no longer resisting against restraint. Restraint ended at this time. Patient Debriefing date/time: 11/07/23 2:25pm: Time spent talking with client about how she could have handled the situation differently. Nursing Assessment date/time: 11/07/23 2:25pm: Client upset due to family session. Client admits that she feels as though there "is too much on my plate". Upon my arrival, client was banging on the walls of front

seclusion room. Client banged head on the unlocked seclusion room door. Client required personal restraint due to threat to safety. Client was encouraged to calm down and do the next right thing multiple times. Client began to show signs of calming and was released. Client went down hallway and required personal restraint to prevent injury. Here is where client again hit hand on wall. Client complains of right hand pain, given icepack and ibuprofen x 2. Client has full/active ROM with pain 9/10, capillary refill <3 seconds, area reddened, no other discoloration noted. Encouraged client to rest, ice, ibuprofen and elevate it. Client denies numbness/tingling, PERRLA, no swelling noted to head, no hematoma detected. No other needs identified now, will continue to monitor. Chemical restraint administered per nursing. Client showing signs of calming. Client in good spirits around 6pm, client had positive sounding telephone conversation with guardian. Awaiting transport to acute placement. Guardian notified on 11/07/23 at 2:39pm [redacted] was transported to Rivendell for an acute stay on 11/07/23 during the evening shift. She remains at Rivendell at this time.

Interim Action Narrative: Resident was restrained for safety, assessed by the nurse, and place in acute care.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist reviewed provider reported incident for licensing concerns. Licensing Specialist will inquire if resident will be returning to the facility and documentation for chemical restraint. Licensing Specialist informed that it is unknown at this time if resident will be returning to the facility.