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Notice of Serious Incident

Date of Incident: 11/29/2023

Date Received by DCCECE:12/1/2023

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Date/Time of Incident: 11/29/23 7:40 PM Location of Incident: Sturgis House Staff involved: Patrick Gill, Schree Eackles, Meredith Reddin (Nurse), Events Leading: Client and one of his peers began to argue in the milieu. Client and peer exchanged words and began fighting both of them landing on the floor.. Client was kicked by peer while attempting to get up off floor and was then redirected to another part of the house. Client discussed his role in this incident and how he needs to find better ways to resolve conflicts other than becoming physically aggressive. Client accepted his consequence for this incident. IR Nursing Face-to-Face Assessment: 11/29/23 8:00 PM: Pt was punched/kicked in face by peer. Upon nurses assessment, pt is sitting in milieu holding towel to bloody nose. Pt is alert and oriented to self/situation. Denies dizziness, blurry vision, h/a. Eyes PERRLA. Pt's nose bleeding stopped after several minutes of holding towel to face. No deformity, swelling, denies pain when nose is touched/pressed. Pt's bottom lip is inflamed, bleeding. Pt c/o tooth/jaw pain. Pt denies pain when jaw is touched, full ROM in jaw-area. Can chew/talk w/o discomfort. Upon nurses assessment, teeth are intact. Pt can press on teeth w/o pain/discomfort. Pt has full ROM in all extremities. C/o pain in L pointer finger. Pt has full ROM w/ pain, endorses pain in knuckle and proximal phalanx when moving or when touched. No signs of deformity, no bruising, skin intact. Denies numbness/tingling, capillary refill <2 sec. Pt told to notify staff if pt begins feeling dizzy/nauseous/lightheaded or if pain worsens or does not improve. Upon assessment, nurse noted a chip in pt's L upper lateral incisor. Pt states he is unsure if this is a new or old injury. Denies localized pain to area and tells nurse his 'face is hurting less'. Pt told to notify staff if pt begins to feel pain/discomfort in area. Doctor on call notified of finding. No further needs at this time. Doctor notified. Pt told to keep lip clean and be mindful of injury when eating/drinking. Pt given ice pack and acetaminophen per MAR. No further needs at this time. 815pm - Pt began c/o nausea. Upon nurses assessment, pt eyes are PERRLA. Pt denies dizziness/lightheadedness, denies h/a. Pt able

to walk in straight line w/ steady gait. Pt tells nurse 'I think it's just from the adrenaline'. Pt did not vomit. Nausea subsided after several minutes. Notified doctor on call. Pt asked nurse if he could go to bed. Nurse asked doctor on call. Doctor on call verified that pt can go to bed, but pt will need to notify staff if pt begins to notice worsening symptoms. Nurse reminded pt to notify staff of any other s/sx of injury. Pt verbalized understanding. No further needs at this time. Guardians Notified: 11/29/23 8:30 PM Follow-up IR 11/30/23 10:15 AM [redacted] was seen today for routine medication management and evaluation. He discussed leading events of how he and a peer got into physical altercation last night. He has a bruised and swollen hand (left)(anterior and posterior bruising to carpals 4 and 5) and an abrasion on his lower lip. Limited ROM to digits 4 and 5 of Left hand. Capillary refill less than 3 seconds and WNL. No visible deformities or protrusions. He admits that he instigated this peer after the peer walked up to him, threatening him, and stating to "keep (his) name out of (his) mouth". Admits to requesting PRN APAP 650mg earlier and reports at that time he rated his pain 7/10. This was administered at 9:39am. Endorsed some improvement in level of pain. Didn't sleep well last night following the altercation. Order to attempt to obtain or transport client to urgent care or Ortho AR to rule out fx of (L) hand received. Appointment coordinator notified of request and scheduled appointment to Ortho AR. Guaridan([redacted]) notified and plans to attend appointment by meeting staff and [redacted] at Ortho AR. Nursing Progress Note 11/29/23 7:45 PM Physical Status: Compliant w/ medications. No s/sx of acute physical/mental distress. Pt got into physical altercation w/ peer. Pt c/o pain in L pointer finger. Knuckle and finger swollen. Capillary refill <2 sec. Denies numbness/tingling. Full ROM w/ pain. Given ice pack, told to rest hand/finger. Pt had bloody nose, no s/sx of fracture. No swelling, denies pain w/ touch/pressure. Pt has split lip. Pt told to keep clean, be mindful when eating/drinking. Eyes PERRLA. Pt alert and oriented to self/situation. Denies dizziness or blurry vision, denies h/a, gait is steady/even. Pt has chip in L lateral incisor. Pt tells nurse he is unsure if that is an old or new injury. Pt denies pain localized to tooth, states that general jaw/teeth pain is 'decreasing'. No further needs at this time. Additional Information: 8:15 PM- Pt c/o nausea and sustained pain in L pointer finger. Pt denies dizziness, blurry vision. Eyes PERRLA. After several minutes nausea subsides, no vomiting. Pt is able to walk steadily. Speech is clear, pt is alert and oriented to self/situation. Pt tells nurse 'I think it was just the adrenaline, I feel ok now'. Pt then asked to go to sleep. Notified dr on call. Dr on call stated that pt can go to bed but pt will need to notify nursing of any further s/sx. Told pt to notify staff of any n/v, dizziness, pain, or further s/sx of injury. Pt verbalized understanding. Pt given acetaminophen per MAR for pain in L pointer finger at 7/10. No further needs at this time. Nursing Progress Note 11/30/23 6:15 AM: Physical Status: Bottom Left lip swollen and red. Left index finger swollen with minimal movement. Left hand has some swelling but can move fingers freely except index finger. Didn't want ice pack for hand or lip. Given Ibuprofen 400mg for soreness & pain of hand & lip with pain of 7/10 Nursing Progress Note 11/30/23 10:15 AM: Physical Status: [redacted] was seen today for routine medication management and evaluation. He discussed leading events of how he and a peer got into physical altercation last night. He has a bruised and swollen hand (left)(anterior and posterior bruising to carpals 4 and 5) and an abrasion on his lower lip. Limited ROM to digits 4 and 5 of Left hand. Capillary refill less than 3 seconds and WNL. No visible

deformities or protrusions. He admits that he instigated this peer after the peer walked up to him, threatening him, and stating to "keep (his) name out of (his) mouth". Didn't sleep well last night following the altercation. Has a family session later today and is anxious about it. He reported he spoke with his step-mother on the phone this morning although admits he does not feel their relationship is improving much at current. Admits he hasn't attempted to call his step-mother or father this week. Denies any further peer conflict. No further concerns or physical complaints voiced. Additional information: attempt to obtain urgent care appointment to rule out fx due to significant anterior and posterior bruising

Interim Action Narrative: Residents were separated. Injured resident was assessed by the nurse. 11/30/2023, resident was transported to Ortho AR for an evaluation. Both residents were placed on freeze.

Maltreatment Narrative:

Licensing Narrative: Licensing Specialist reviewed provider reported incident for licensing concerns. Licensing Specialist received documentation for this incident. Licensing Specialist will inquire about safety plan. Both residents were placed on freeze and were able to restore on 11/30/2023.