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Notice of Serious Incident

Case Number: 018491

Date of Incident: 1/5/2024

Date Received by DCCECE: 1/10/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] client in our PRTF program and resides in Mabee House Incident Report date/time: 01/05/24 8:02pm Location of Incident: Mabee Incident Description: Aggressive to Adults, Attempted Runaway, Threats to Safety, Property Destruction Staff Involved: [redacted] Events Leading: Client became agitated with her peers because of them saying they wanted to date client's mother. Client started walking up and down the hallway threatening to kill her peers. 8:02pm: Personal Restraint: Client became upset with her peers as one of them said they wanted to date Clients mother. Client began walking up and down the hall was threatening to kill her peers. Client was asked to come back up to the milieu but she refused. Client then started to yell at peers from the doorway of their room. Client was again asked to come up to the front but again refused. after more prompting staff attempted to escort client back up to the front. Client dropped to her knees and staffed released her. 8:06pm: Personal Restraint End: Client agreed to walk up to the front on her own, 8:24pm: Personal Restraint: Client was sitting in the hallway and again became disruptive to the other clients as they were trying to sleep. Client was prompted several times to get up and move up front but refused. Client grabbed another peer by the leg and refused to let go. staff intervened and was able to get client to release her peer. Client was then picked up and escorted to seclusion. 8:25pm: Personal Restraint End: Client was placed in into unlocked seclusion and encouraged to take a self-time out. 8:26pm: Unlocked Seclusion 8:36pm: Personal Restraint: Client left unlock seclusion and walked into her bedroom. Client picked up a plastic hair brush and began to try and break it so as to harm herself and/or staff. Staff removed the hairbrush from client. Client became upset and crawled under her bed where she found a pencil and threatened to stab herself and staff. Staff removed client from under her bed and was able to get the pencil away from client. Staff escorted client back to seclusion as it was deemed unsafe for client to be in her room. Client began to hit and fight

with staff while in unlocked seclusion. Client was able to slip out of the seclusion room door where she broke down the door to the laundry room. Client picked up a piece of metal from the door frame and began threatening staff with it. Staff removed the metal from clients hand and placed the client in a personal restraint. Client began to fight against the restraint and kick at staff. 8:49pm: Personal Restraint End: Client was able to follow instructions and returned to a calm state of mind. Client contracted to safety. Patient Debriefing date/time: 01/05/24 8:49pm: Client was able to follow instructions and return to a calm state. Client contracted to safety. Nursing Assessment date/time: 01/05/24 9:00pm: Client took PM medications without difficulty and seemed in good spirits. When it was time to return to rooms, client refused to follow staff direction. Also a peer made a comment about dating her mother. Client began to grab nearby items to destroy. Then went to the water fountain and spit on the faucet/spigot, it was at this time supportive touch was used to obtain the water bottle she was dumping in the trash and move her from destroying the water fountain. Client demanded to speak to peer, so we tried to appease her to no avail. Client sat in the middle of the hallway and would not move. Personal restraint was utilized to assist client to seclusion. Once in seclusion, client began to struggle with staff, broke free and entered her room and obtained sharps (metal). Client trying to break her brush and laundry basket. Client making homicidal threats against multiple staff including myself. Sharps were confiscated, and client dove under her bed and obtained another sharps (pencil). Client was assisted from under the bed and additional sharp was confiscated. Client was moved to seclusion. Client denies pain/injury from this incident and has no obvious injury noted. Client appears alert and oriented, gait steady, showing signs of calming down seated in the milieu. Order received to transfer to acute for treatment/evaluation of mental status. Client was asleep in the milieu at 10:15pm, transferred to acute later that evening. Guardian was notified on 01/05/24 at 10:00pm, 10:06pm, and 10:07pm with no answer and voicemail was left to call nurse back at her convenience.

Interim Action Narrative: Staff intervened, resident was placed in restraints, and order received for acute placement.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator will inquire about late reporting and documentation. 1/11/2024, Facility reported documentation had to be corrected and documentation was provided. Pictures were provided for the door being repaired. Resident will be returning to the facility once discharged from acute care.