Placement and Residential Licensing Unit
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

Case Number: 019483

Date of Incident: 2/26/2024

Date Received: 2/28/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] Private placement client in our PRTF program and resides in Mabee House Incident Report date/time: 02/26/24 6:52pm Location of Incident: Mabee House Incident Description: Self-Injury (Not Suicidal), Aggressive to Adults, Threat to Safety Staff Involved: Tiffany Phillips-Peters, Zakira Jones, Michael Stanfield, Jonathan Dismuke, Darryel Sanders, Ebony Galmore, Shonterri Logan, Nicquira Burnett Events Leading: Pt ate dinner and was placed on a 15-minute meal check. Before the 15-minutes expired, pt ran to the open bathroom and sat on the counter. Pt was told by staff to come out of the bathroom due to the 15-minute meal check. Pt refused to come out the bathroom. Pt then laid down on the bathroom floor. Staff informed pt to come out or she would be escorted to her room. Pt still refused to exit the bathroom. With help from another staff, pt eventually exited the bathroom. Instead of going to her room as instructed, pt lingered in the hallway for some time. Pt then laid down in the middle of her peer's bedroom door way. Pt was instructed by multiple staff to leave the peer's bedroom doorway. Pt continued to disobey the directions by laying down in the peer's bedroom door way. The refusal to remove her self led to an "All Call" which was directed by the nurse. Staff informed pt to remove herself from the doorway or she will be escorted. Pt removed herself from the doorway and went to the seclusion for a self-time out. While in the seclusion room, pt hid behind the door to where staff could not see her. As a result, Staff stood in the seclusion room with her. While processing with staff, pt stated that she wanted to fall asleep in the seclusion room. Staff reminded pt that this was not allowed, but she is welcomed to her room. After several minutes of processing and pleading with pt, pt began to pull at her eyelashes. Pt was directed to stop. Pt did stop, however pt began to bite her left thumb and forearm. Pt was asked multiple times to stop yet she still refused. These actions led to a personal restraint. 6:52pm: Personal Restraint: Pt was placed in a personal restraint due to biting her left hand (left thumb area) as well as her left forearm, which staff observed was leaving pts teeth impressions in her skin as well as causing the

area to redden. Despite, multiple verbal redirections from staff asking pt to refrain from doing so as well as staff continuing their verbal support and the offering of fidgets, pt continued to engage in self-injurious behaviors. Due to unsafe behaviors, staff placed pt in a personal restraint. During the personal restraint, pt struggled against the restraint as she attempted to bite at her left knee since staff had her arms to restrict her from self-harming. 6:59pm: Personal Restraint End: Staff continued offering verbal support to pt. Pt was able to agree with refraining from struggling against the personal restraint and contracting to safety (refraining from biting herself). As a result, pt was released from the personal restraint. 7:02pm: Personal Restraint: Pt was placed in a personal restraint due to not complying with the nurse's request to let her examine the areas where the pt had caused self-inflicted bite wounds. Pt struggled against the restraint and became physically aggressive during the nurses assessment as pt began attempting to push the nurse away, so she could not photograph where the pt had been biting. 7:03pm: Personal Restraint End: Pt was released from the personal restraint as the nurse was able to obtain some photographs of the area. 7:05pm: Personal Restraint: Pt threw her Crocs (shoes) at staff when released from original restraint. After staff removed her shoes from her reach, pt began to pull at her eyelashes. Pt was informed that this is a form of self-harm and that she will be placed in a personal restraint if she continues to pull her eyelashes. Pt was placed in a personal restraint due to engaging in Trichotillomania (pulling out her eyelashes from both her left and right eye lids) despite multiple verbal redirections from staff asking her to refrain from doing so. Staff continued to offer pt verbal support. However, pt was not receptive to staff's information. Pt struggled against the restraint, which made staff transition from a seated hold to a supportive prone hold. During this time, pt was still struggling against the personal restraint as staff continued offering pt verbal support. Staff provided pt with information on how she could contract to safety and what behaviors would let them know she was ready to be released from the personal restraint. 7:16pm: Personal Restraint End: Pt was released from the personal restraint as she stopped struggling against it as well as gave staff verbal confirmation that she was going to be compliant and contract to safety. Staff first disengaged from pt at the legs and pt complied with refraining from kicking. Then, staff disengaged from the head and pt refrained from head banging. Lastly, staff disengaged from the arms and offered to help pt sit up. Pt was receptive to staff helping her sit up. 7:17pm: Unlocked Seclusion: Pt sat in seclusion with staff. At this time, pt was non-verbal. Staff tried processing with pt but she refused to engaged. Pt then stated she wanted to leave the seclusion room. 7:22pm: Unlocked Seclusion End: Pt removed herself from the seclusion room. Pt then begin to destroy property. 7:23pm: Other/None: Pt was pacing around and then began running into the laundry room door. Pt had mentioned earlier how she engaged in property destruction (broke the laundry room door off the hinge) before and would do it again. Staff attempted to verbally de-escalate the pt from this unsafe behavior as well as gave pt multiple verbal redirections to refrain from doing so. However, pt continued to do so. 7:28pm: Personal Restraint: PR Pt was placed in a personal restraint due to attempting to engage in property destruction (attempting to break the laundry room door off the hinge as the door was locked). 7:29pm: Personal Restraint End: Pt was escorted to the seclusion room and released from the personal restraint as staff placed pt in Locked Seclusion. 7:30pm: Locked Seclusion: Pt began to aggressively hit on the window of the seclusion door.

Staff asked pt multiple times to refrain from doing so and told pt that if she did not that staff would have to come in the seclusion room. Pt struggled to accept staff's information and continued hitting on the window and then began limit-testing as she also started to hit on the door. 7:31pm: Locked Seclusion End: Locked Seclusion Ended due to client continuing to hit aggressively on the Seclusion Room window and door. As staff unlocked the door, pt tried to deny staff entry by attempting to block the door using her body. However, staff was able to gain entrance. 7:32pm: Personal Restraint: Once staff gained entrance to seclusion room, pt was placed in a restraint. While in restraint, pt was purposefully stomping on staff's feet. Pt was told to stop or she would be placed in a supine restraint if continued to be aggressive with staff. Pt then started to stomp her feet on the ground aggressively. Staff informed pt to stop. Staff began to talk client about coping skills she could use to be released from restraint. Pt stated that she enjoyed music. Staff was able to play music to help pt calm down. 7:36pm: Personal Restraint End: Pt was released from restraint when she calmed down with her choice of coping skill. Staff stayed with client to help her calm down completely. Patient Debriefing date/time: 02/26/24 8:00pm: During debriefing, staff tried to lighten pt's mood by dancing and singing songs with pt. Pt did receive a phone call with guardian. Pt at first refused to speak with mother. After convincing pt to speak with mother, pt told mother that she felt like this place was not helping her. She felt as if her mother was not listening to her needs and wants. Pt did end the call with mother and was in a very tearful mood. Pt later called mother when calmed down to start another phone call with guardian. Nursing Assessment 1 date/time: 02/26/24 8:03pm: Staff contacted a nurse to speak with the patient because she refused to leave her peer's doorway. The nurse made many attempts to motivate the patient out the door, but she refused. Staff ultimately took the patient out of the doorway and led her into seclusion. While in seclusion, the patient began biting herself and banging her head against the wall. She was placed in a personal restraint due to her dangerous behavior. She managed to settle down for a few minutes. When the nurse requested if she could look at the self-inflicted bite wounds, the patient refused, so staff placed her in another personal restraint so the nurse could examine her. Shortly later, the on-call therapist arrived to try to speak with the patient. However, the patient was not willing to talk. Patient exited the isolation room and began roaming the home. Staff told her multiple times that she wasn't authorized to do that. The patient attempted to run into the laundry area, but was restrained briefly before being placed in lock isolation. While in lock seclusion, she began hitting on the window and became unsafe, prompting staff to unlock the door and place the patient in a personal restraint. The patient eventually calmed down and was freed. The nurse spoke with the patient face to face, and she denied any injuries or pain. All events were reported to the on-call physician and therapist. The on-call MD gave the PR, UL, and LS orders. The nurse also notified the patient's mother about the issue. Due to the patient's unstable behavior, the on-call therapist was able to get her admitted to an acute institution. The transfer order was received by the on-call MD. The patient was transported by facility staff. A few belongings were sent with the patient. There are no other issues at this time. Nursing Assessment 2 date/time: 02/26/24 8:06pm: Patient was transferred to Rivendell behavior health facility due to unstable behaviors. On call MD give order for transfer. On call therapist notified of

transfer. Patient mother notified of transfer. Guardian was notified on 02/26/24 at 8:06pm [redacted] remains at Rivendell for an acute stay.

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: Facility contacted and informed Program Coordinator of provider reported incident. Facility provided documentation. 2/29/2024, Program Coordinator reviewed provider reported incident for licensing concerns. Program Coordinator will inquire about property damage. 3/4/2024, Program Coordinator followed up with facility on property damage and if resident returned. Facility reported that resident tried to tear the laundry room door off the hinges. Facility also reported resident returned to the facility.