



Placement and Residential Licensing Unit

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

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Notice of Serious Incident

Case Number: 020815

Date of Incident: 4/23/2024

Date Received: 4/24/2024

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: 04/23/24 8:00pm Location of Incident: Mabee House Incident Description: Suicidal, Aggressive to Peers, Threat to Safety, Property Destruction Staff Involved: Kelton Johnson, Michael Tucker, Kierra Taylor, Marilyn Howell Events Leading: Client had a bad phone with her parents. Client was upset because of her conversations with peers. She asked her parents to come get her. Her parents told her that she will not be coming home until she finishes her treatment. Client was upset. Client started to pace back, and forth. Client started to kick door down to plan an escape. Client was redirected to stop kicking the door. Client then charged as though to strike another client. Staff stepped between clients to avoid this conflict. Client then became more angry. Client started to grab electronic cords, and wrap them around her neck. Staff grabbed the cords and prevented client from wrapping them around her neck. Client redirected to sit in the milieu and offered to have a talk away from others in the recreation room. Client sat in a chair in the milieu and became tearful with staff offering verbal support that they were here for her and offered another area to de-escalate. Client grabbed for her own neck, and staff provided supportive touch, placing their hands on hers and prompting to not do this. Client continued crying and lowered her hands. Staff continued supportive touch, encouraging client to walk with them to the rec room. Client walked with staff with no resistance, sat in the rec room and continued crying, processing with staff about the phone call. Nursing Assessment date/time: 04/23/24 8:10pm: She walked into the nurses' station but would not speak or answer my questions. Redness was noted to her face & neck but no marks apparent. Pt appears to be very upset, slight body shaking noted, tight posture. I did ask her multiple questions to see what was going on but she still would not answer. I noticed that there was a male staff member standing outside of the door pacing/watching and not saying anything. So out of curiosity I asked him if she was put in a restraint and he stated that she was not. After sitting in nurses'

station for a few minutes [REDACTED] ended up walking out and went to sit at a table. No acute distress noted. Guardian was contacted on 04/23/24 at 8:22pm: Spoke with father to inform him of the events that took place this evening after their phone call. Informed him that pt. is requesting to go to acute but that is not in the plan at this time. Informed him that she has orders for front of house, eyeball, and run risk. He stated that he was aware that she was very upset about them not coming to check her out due to her behavior.

Interim Action Narrative: Staff redirected resident and nurse assessed resident after she became aggressive and wrapped cords around her neck out of anger. Staff removed cords from resident's possession to prevent her from wrapping them around her neck.

Maltreatment Narrative:

Licensing Narrative: 4/25/24 - Licensing Specialist reviewed Provider Reported Incident for licensing concerns. Will check with facility to see if acute placement is currently needed or if there have been any other issues. 5/1/24, Licensing Specialist sent email to facility to review video footage of incident on 5/2/24 at 1:30 p.m. 5/1/24, Visit scheduled for 5/2 at 1:30 p.m. to review video footage of incident. 5/2/24, Facility visited in response to incident. Camera footage reviewed. Facility cited for 911.15.d.



Division of Child Care & Early Childhood Education
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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: Tara Norton

Person In Charge: BEVERLY FOTI

Record Visit Date: 5/2/2024

Home Visit Date: 5/2/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulation Number: 900.911.15.d

Regulation Description: Areas used by children shall be designed, constructed, and furnished to reduce risk of suicide and assault including, but not limited to:

Finding Description: Resident was observed attempting to place loose wires from a computer around her neck before staff were able to remove the wires from her possession.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: No loose wires, cords, chains, or ropes;

Action Due Description:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 1:30 pm to 2:30 pm

Census: 44

Licensing received a provider reported incident on 4/24/2024 for ELS Case #020815

Licensing Specialist Norton visited the facility to review video footage related to the above-referenced ELS case. Video footage was reviewed with Mr. Anthony White, UM for Mabee House. Licensing Specialist observed resident on the phone talking to her parents. Resident appeared upset while talking on the phone and continued to escalate. Staff were observed redirecting the resident and telling her that she is out of time on her phone call, while a peer waits on the couch for her turn to make a call. (Ratio 3:2)

Resident's phone call was ended at the direction of staff and resident was observed walking over to a door. Resident was observed kicking the door while staff continued to use verbal de-escalation techniques with the resident. Staff was observed sending the other peer to her bedroom. (Ratio 3:1) Resident began kicking the door while a male staff member was observed blocking the door.

A different peer was observed entering the room to get a drink and began looking at the resident. Resident was observed saying something to the peer and walking toward her, trying to attack her. Staff were observed stepping in between resident and peer. Staff directed the peer to go to her bedroom and was observed leaving the room. (Ratio 3:1)

Resident was then observed making her way over to a displaced computer, grabbing some loose wires, and attempting to place the wires around her neck. (Ratio 3:1) Staff were observed removing the wires from resident's hands and was observed using verbal de-escalation techniques with the resident. Resident was observed placing her hands around her neck as staff was observed pulling the resident's hands away from her neck. Staff were then observed escorting the resident to the seclusion room where she was able to calm down without incident.

Facility will be cited for 911.15.d, Resident was observed attempting to place loose wires from a computer around her neck before staff were able to remove the wires from her possession.

Provider Comments:

CCL Staff Signature :

Date: 5/2/2024



Provider Signature :

Date: 5/2/2024

