

## **Placement and Residential Licensing Unit**

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Notice of Serious Incident

Case Number: 021002

Date of Incident: 5/1/2024

Date Received: 5/2/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

**Incident Type: Licensing** 

Report Description: Incident Report for client in our PRTF program and resides in Mabee House Incident Report date/time: 05/01/24 5:25pm Location of Incident: Cafeteria Incident Description: Runaway Staff Involved: **Events** Leading: While leaving the cafeteria after dinner, was escalating due to peer instigation. She left the dinner line and exited the front of the administration building, heading towards a neighbor's house. Shortly after, was seen walking down the driveway to the Crestview next-door neighbor's home. Staff guess she knocked and they let her in. When Staff got to the neighbors, Staff could see the neighbor waving them to come inside. Staff opened the door and was standing in the fover tearful, stating that she could not go back there. As Staff walked towards her, she rushed to the dining area near a window and then stopped. Staff told her everything was ok and after some time, we walked out together. She states that her peer upset her and she almost beat her up, Staff encouraged her to not let others behavior make us make bad choices. Staff thanked the neighbor for his help. Nursing Assessment 1 date/time: 05/01/24 5:35pm: Client was in the cafe, then had wandered across the road from Youth Home. She apparently knocked on a neighbors door and they allowed her in. Upon my arrival, client was tearful, standing in the front foyer. I knocked and the home owner asked me to come in. Client stated that she could "not go back there". Client then entered the dining area of the house, walked around the table and stopped. I held out my hand, and I said "everything is going to be ok". She grabbed my hand and we walked out of the house together down the driveway until we were met by other Youth Home staff. Client denies pain/injury from this incident and has no obvious injury noted. Client states she was upset at peer behavior, bullying and feared being injured by peer. Encouraged client to focus on herself and not others behavior. Client walked back to Mabee House with nurse and staff. Nursing Assessment 2 date/time: 05/01/24 5:45pm: During dinner, the patient grew upset with a fellow peer and departed the

cafeteria, heading toward the neighboring house Another nurse reported that she
expressed her inability to return to the Youth Home. The nurse effectively soothed her, and
she returned to Mabee House. Upon examination, the patient stated no physical injuries,
and the nurse observed no visible injuries at the time. The patient requested to contact her
parents. Staff confirmed that she contacted her father and explained that she had gone to
the neighbor's house during dinner because she desperately wanted to speak with her
mother and leave the facility. In conversation with the nurse, the patient expressed the need
for more extensive care than what the facility could offer. The nurse informed her that the
provider would review her case the following day to determine if a transfer to acute care was
necessary. The patient took her prescribed nightly medication, including PRN medication,
to alleviate her anxiety. Additionally, due to the patient's unauthorized departure from her
designated area, she will be placed on house restriction, nurse received approval from the
on-call MD. Guardians were notified on 05/02/24 at 10:30am by Residential Clinical
Program Director. was transported Pinnacle Pointe for an acute stay on 05/02/24 and
will not be returning back to Youth Home at this time.

Interim Action Narrative: After staff talked to resident and calmed her down, staff walked
client back to facility. Resident was transported to Pinnacle Pointe for an acute stay on 5/2.

## Maltreatment Narrative:

Licensing Narrative: 5/2/24, Licensing Specialist reviewed Provider Reported Incident for licensing concerns. While Licensing Specialist was at the facility on a different matter, Licensing Specialist was informed that the facility was about to transfer this resident to Pinnacle Pointe for an acute stay. 5/3/24, emailed facility to obtain a copy of the nursing notes, to inquire about ratio and video footage of incident prior to resident going to neighbor's house. 5/6/24, uploaded nursing notes to case and reviewed. 5/13/24, emailed facility to confirm that resident would not be returning to facility after her release from acute. Facility confirmed resident would not be returning.