

## **Placement and Residential Licensing Unit**

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**Notice of Serious Incident** 

Case Number: 022859

Date of Incident: 7/26/2024

**Date Received: 7/29/2024** 

Facility Name: Youth Home, Inc.

Report Description: Incident Report for

Facility Number: 128

**Incident Type: Licensing** 

client in our PRTF program and resides in Mabee House Incident Report date/time: 07/26/24 6:25pm and 07/27/24 12:30pm Location of Incident: Mabee House Incident Description: Self-Injury(Not Suicidal), Medical Emergency(Trip to ER/Urgent Care) Staff Involved: Events Leading: 07/26/24: Client came to staff requesting a room change because she said her roommate threw a plushie at her and they had a few words with one another. Client and her roommate were asked to come up and talk to staff so we could get both stories. Client refused and sat in the corner of her room crying. Staff went back to her room to check on her because she didn't come up and because a peer across the hall reported hearing banging in her room. Client then admitted to staff that she did punch the wall a few times. 07/27/24: Client was taken to Urgent Care to have her hand assessed. Nursing Assessment 1 date/time: 07/26/24 6:30pm: Staff informed me at that sitting in a corner of her room refusing to sit on the bed and refusing to come out. Upon arrival to room facing the corner in her room, crying with pillow in hand. She will tell me why she is crying or why she is sitting in corner, she is only stating that she wants to be left alone. I informed her that she cannot be left alone in the corner, so I was going to sit down by her and gave her 3 mins to herself without bothering her so that she could feel her feelings and then we would talk. Staff member sat outside of the door during this encounter. After 3 mins, she still did not get out of the corner, she stated that staff wanted her out of the corner because they think she will self-harm, when asked why they would think that stated that she punched the wall because she was upset with her roommate. She allowed me to assess both of her hands; there was bruising noted to the right middle, fourth, and pinky finger knuckles, slight swelling noted, able to open & close hand with pain noted when closing, pain level 9/10, requesting Tylenol. I informed her that the only way that she could get Tylenol is if she gets up and comes up to the front for med pass. She stated that she did

not want to be around her peers, I offered her the option of sitting in the nurses' station
away from everyone while I did med pass, agreed and got out the corner without
incident. While in the nurses' station admitted to punching the wall 8 times with her
right hand. Nursing Assessment 2 date/time: 07/27/24 9:30am: pt reports severe pain to R
hand and limited ROM to the R hand joints. swelling noted to the knuckle area of the R
hand. cap refills < 3 sec. ice pack provided. Tylenol was administered per Night RN. Dr
notified and ordered for staff to take pt to UC for R hand injury evaluation.
making arrangements for pt transport. Nursing Assessment 3 date/time: 07/27/24 2:10pm
returned from UC. Dx with no FX. Recommendations: Tylenol for pain,
Rest/ice/compress, Ace wrap x 7 days (12 hr on/12 hr off) . pt presented with ACE wrap on
R hand with metal elements. Metal elements have sharp edges and removed for safety-tape
used to keep ACE wrap in place. pt instructed on appropriate use of ACE wrap, verbalized
understanding. pt has no s/sx of acute distress. Dr notified of the findings. Guardian
was notified 07/26/24 at 9:21pm, 07/27/27 at 11:32am, and 07/27/24 at 2:15pm Urgent Care
paperwork was emailed to on 07/29/24.
Interim Action Narrative: Resident was assessed by the nurse and sent to urgent care for an
evaluation.
Maltreatment Narrative:
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Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns. Facility provided documentation for this incident and it has been uploaded.