ARKANSAS DEPARTMENT OF HUMAN SERVICES

Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 023083

Date of Incident: 8/7/2024

Date Received: 8/8/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] t client in our PRTF program and resides in Sturgis House Incident Report date/time: 08/07/24 1:45pm Location of Incident: Sturgis House Incident Description: Self Injury (Not Suicidal), Medical Emergency(Trip to ER/Urgent Care) Staff Involved: [redacted] Events Leading: This nurse responded to a nurse call to Sturgis. [redacted] reported that he was attempting to clean out the trash beside his bed with his comb, yawned, and swallowed a screw. Nursing Assessment 1 date/time: 08/07/24 1:45pm: This nurse responded to a nurse call to Sturgis. [redacted] reported that he was attempting to clean out the trash beside his bed with his comb, yawned, and swallowed a screw. He then would alter his story as more questions were asked. AAOx4. [redacted] general appearance is healthy. Dressed fairly appropriate in his Pjs. Poor hygiene as he presents with a mild odor. Speech fairly clear(mumbling) and coherent, WNL for this client. No signs of hoarseness, coughing, gagging, retching, drooling, nausea, or vomiting. RR 18/min, unlabored. No retractions, accessory muscle use, or nasal flaring. Skin is pink, warm, and dry. Clear lung sounds in all lobes. No adventitious sounds, wheezing, or stridor. SpO2 99%. No signs of oropharynx obstructions, abrasions, ulcers, or lacerations. Denies pain in mouth, neck, throat, or chest. Airway patent. No signs of respiratory distress. Abd is fairly soft, symmetric, and non-tender without distention. No palpable masses. No signs of rigidity or guarding. Bowel sounds are present and normoactive in all four quadrants. He reports last BM this morning, rating "4 or 6" on the Bristol stool scale. He admits to recent straining and difficulty passing stool the past few days. After this nurse completed the abd assessment, client then started guarding his upper abd quad reporting a "stabbing sensation". Able to swallow without difficulty. Patient continues to alter story and presents with unreliable history. He was challenged on conflicting parts of his history and report. BP: 152/90, HR 109. Avoidant of eye contact and

use of excessive hand gestures to plead his case with mumbling (WNL for this client). He attempted to show this nurse as he crawled under his bed, explaining. He was challenged again in which he admitted to lying about how the screw initially fell into his mouth. He denies intentionally ingesting. Denies any current thoughts of self-harm or SI. He reports last incident of self-harm was approx. last Friday. He endorsed some feelings of hopelessness and sadness. He discussed wanting to come off TRS. He reported he had a session with his CT earlier today and feels it went well. He discussed he was provided more assignments. The size of the reported screw varied as well as how the screw went down the esophagus. Patient also disclosed locations in his room where screws were missing. He was challenged into how the screw from his door was under his bed. [redacted] voiced uncertainty and feelings of anxiety. He voiced frustration and displeasure that his CT has been notified. The metal detector wand did not signal any signs of metal object. Attending MD and CT notified. He is NPO (nothing by mouth) while he remains under close observation. Nursing Assessment 2 date/time: 08/07/24 7:28Pm: Pt told nursing staff earlier in shift that pt 'accidentally swallowed screw'. See previous Nursing page. Upon this nurses assessment, pt states that he 'swallowed a mechanical screw while under the bed reading what people wrote'. Pt states that he believes that 'someone put a screw under the bed to hide it and when it fell it went down his throat and he couldn't stop it'. Pt states that screw was about '3-4 inches'. Pt affect is calm, pt is alert and oriented to self and situation. Speech clear/coherent. VS as follows: BP 122/69, HR 84, RR 18, temp 97.9. Resp even, unlabored. Airway patent. Breathing clear to auscultation. Pt states that he had one BM this AM that was a 5-6 on the Bristol chart. States that he has been constipated lately. Bowel sounds normoactive in all four quadrants when auscultated. Pt endorses pain in middle upper abd area. Denies pain when swallowing, denies pain when abd is pressed on, no guarding/rigidity. Pt denies n/v. No drooling, gagging. Provider notified of findings. Due to pt's c/o pain and statement that he swallowed a screw, pt taken to ACH ER. Pt taken to ACH ER at 1935 by staff. Staff reported that [redacted] No further updates were rec'd this shift. Nursing Assessment 3 date/time: 08/07/24 11:53pm: Resting in bed but was easily awakened by staff who gave directs to take night time meds. Alert and oriented. No visible signs or symptoms of distress. No complaints of pain or discomfort. Vital signs: 118/71 80 Pulse ox 96% 18. Took night time meds without any difficulty. Requested crackers afterwards. Seemed to be in good spirits as evidenced by talking with this nurse about future plans to join army and how what's learned @ Youth Home will be beneficial in the years to come. Remains on Eyeball and Front Of House. Will continue to monitor. Guardian was notified on 08/07/24 at 2:30pm and 7:20pm. Guardian was also notified on 08/08/24 at 12:04am ER paperwork has been emailed to [redacted]

Interim Action Narrative: Resident was assessed by the nurse and sent to ACH ER for an evaluation.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator reviewed provider reported incident for licensing concerns and uploaded documenation from the facility. 8/9/2024, Prorgam Coordinator inquired about timeframe of resident being seen at ACH. Faciltiy reported the direct care staff and medical team were collecting information to determine if there was any merit to the resident's claim about the object. The information that the resident gave to staff changed multiple times during the interview. When nursing called the residentt's father, he insisted on speaking to his son to determine if he was telling the truth about the situation. The resident showed no signs of acute distress, he did not choke, no trauma to the throat, no hoarseness, his airway was patent, breathing not labored, respiration were normal rate and rhythm. Resident was eating and drinking without difficulty as well. There were no signs that would deem this a medical emergency. The decision was made to send him out for evaluation and then staff had to be arranged to take him to ACH. Facility also reported that maintenance is removing the wooden furniture from the resident?s bedroom to hopefully making it more difficult to acquire screws.