Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 023632

Date of Incident: 8/28/2024

Date Received: 8/29/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Clients were told to return to their bedrooms in preparation for the next structured activity. The client was asked not to as this client would be transferred to an acute facility. Upon hearing this information, the client became aggressive and tried to rush past staff to open the door to the hallway which was being blocked by a staff member. Staff tried to reassure the client that they would be safe in this new placement and attempted to verbally de-escalate the situation however the client was not receptive to verbal de-escalation. The client was irate with receiving this information. Client continued to escalate, and attempted to continue to force her way through staff down the hallway. Client placed in personal restraint to remove computer components from her hands. Client physically resisted against the restraint and became tearful with the news of being transferred to acute. Client feelings were validated by staff. Client dropped to the floor in a seated position and staff followed the momentum and continued restraint for safety. Client attempted to strike out towards staff with her hands, and clawed at client hands, contorting her body. Client made several demands to talk with a peer she identifies as her boyfriend and was denied. Client then made demands to call her father, and agreed to willingly go with MEMs for transport. Staff facilitated this call. Nursing Assessment The nurse informed staff that all patients needed to return to their rooms due to the arrival of MEMs to transport a patient to an acute facility. The patient in question was instructed not to return to her room because of her upcoming transfer. Upon receiving this information, the patient became aggressive and attempted to push past staff to access the hallway. Staff reassured her that she would be safe in the new placement and tried verbal de-escalation techniques, but the patient did not respond positively. The patient became increasingly agitated and continued to force her way through staff down the hallway. At this point, the patient was placed in a personal restraint to remove computer components from her hands as she made several attempts to strike staff and clawed at their hands. The patient repeatedly requested to speak with a peer she

identified as her boyfriend, which was denied. She then demanded to call her father and eventually agreed to cooperate with MEMs for transport. After contracting for safety, she was released from the hold, and staff facilitated the call with her father. The phone call did not go well; the patient became upset and began wrapping the phone cord around her hand, necessitating another personal restraint to retrieve the cord. Patient contracted to safety and was released from the personal restraint. The nurse did not complete a full face-to-face assessment as MEMs was already on the scene to transport the patient. The nurse observed that the patient showed no signs of pain and did not express any concerns, other than her reluctance to leave as she got onto the cot. The patient sat calmly with a comfort pillow as she was placed into the MEMs vehicle. She departed the facility at 7:23 PM via MEMs, en route to ACH with the plan to transfer to Bridgeway for acute care. The on-call UM was present during the incident, and the on-call therapist was notified at 7:25 PM. The on-call MD was informed and approved the orders for the facility transfer and personal restraints at 7:29 PM. The patient's father was informed at 8:30 PM that she had been transferred to ACH with intentions to move to Bridgeway for acute care, and he had no further questions or concerns at that time.

Interim Action Narrative: Resident was placed in a restraint for saftey, assessed by the nurse, and transported via MEMS to the hospital.

Maltreatment Narrative:

Licensing Narrative: Program Coordinator received an email stataing facility was unable to enter provide reported incident and received an error message. 8/30/2024, Program Coordinator reviewed provider reported incident for licensing concerns and uploaded documentation. 9/3/2024, Program Coordinator reviewed documentation and inquired if light cover was replaced. Facility reported light cover has been replaced.