Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 023745

Date of Incident: 9/4/2024

Date Received: 9/5/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] client in our PRTF program and resides in Rose House Incident Report date/time: 09/04/24 1:12pm Location of incident: Siebert School on the Youth Home campus Incident Description: Aggressive to Peers, Threat to Safety, Medical Emergency(Trip to ER/Urgent Care) Staff Involved: Marilyn Howell, Valerie Alvarez, Caitlin Henthorne Events Leading: Peers were in conflict in class and pt was inserted into the conflict. Pt expressed not wanting to pick sides but a peer charged at pt, swinging fists. Pt raised her fists to fight back. Pt was restrained. 1:12pm-Personal Restraint: Pt was placed in a personal restraint and escorted away from her peer. Pt began swinging to hit peer several times but once she was guided away from peer, she ceased in attempting to fight. 1:14pm-Personal Restraint End: Once the classroom was clear of the other peers. Pt and staff sat on the floor. Pt contracted for safety and cried about her head hurting due to being struck by peer. Patient Debriefing date/time: 09/04/24 1:30pm: Time was spent validating pt's feelings as she explained her account of the incident. Pt stated she did not want to "pick sides" in the conflict. While debriefing, pt expressed no concerns with the restraint but stated her head her significantly from being attacked. Pt was also remorseful towards staff during debriefing. Pt asked if she could press charges and the nurse stated she would inform pt's parents of her wishes. After nursing assessment it was determined pt needed to be sent out for medical care to assess her post being struck in the head. Nursing Assessment 1 date/time: 09/04/24 1:19pm: [redacted] was observed sitting against the wall, next to staff, tearful, diaphoretic, exclaiming her head hurts. She voiced being struck by her peer on her (L) temple. She reported, "she hit me on my head, and I hit her back". She stated, "she ran up on me. I told her to calm down, and I told her I wasn't picking sides". AAOx4. Clear coherent speech although appears overwhelmed, distressed, and in pain. She voiced significant increased pain and pressure of her (L) temple. Rating pain 10/10. No signs of slurred speech. Responds appropriately. Pupils initially unequal and slow to

respond and small. Anisocoria noted. (L) pupil noted at 4mm and (R) pupil noted at 3mm. Denies any numbness, weakness, tingling, sensitivity to light or noise, nausea, vomiting, feeling lightheaded, or nausea. BP: 148/91, HR 90. Temp: 99.2. RR 22 breaths/min, unlabored. No signs of respiratory distress. No retractions, accessory muscle use, or nasal flaring. SpO2 saturation 99%. Grip strength bil equal +2. Gait is steady. Bruising beginning to form on (L) temple and swelling where patient reports being struck. Erythema noted below (L) eye that appears to be consistent with being struck and alongside (L) jawline. Able to open and close mouth without difficulty. MD notified of findings. Approved order to administer ibuprofen 600mg po x1 now and transport to ACH ER for further evaluation and rule out concussion. continued: [redacted] was able to swallow without difficulty. No signs of hoarseness, cough, SOB, or wheezing.She endorsed also being struck on her neck, left side. She voiced feeling as if her peer struck her in this location (near carotid sinus) with intent to cause a syncope episode. No visible or apparent physical markings, erythema, or edema noted to this area. Denies pain at this time. Voiced the pressure in her head continues to hurt, and is 10/10 pain with 10 being the worst pain. No palpable hematomas noted to scalp. No apparent physical markings, erythema, bruising, abrasions, deformities, edema, or protrusions noted from emergency interventions. Active ROM to all extremities. Gait is steady. To be noted: she has a split on her (R) hand/arm following punching the wall at some point over the weekend/Monday that was evaluated on Monday at urgent care with findings: Right hand swelling and tenderness to touch X-ray result [redacted] No apparent further injuries noted. Capillary refill less than 3 seconds and WNL. Injuries to Staff or client: Pt was struck in the head/face and peer was struck as well. Follow-up to injury: Nursing assessed both pts and sent this pt out to the ER for assessment due to being struck in the head. Actions that might have prevented injury: If staff had called for help, perhaps additional staff could've helped separate the class sooner. However, multiple pts were escalated in the school at the time, making help difficult to come by. If peer had used coping skills, not attempted to fight, or accepted pt's stance of not wanting to take sides, injuries would not have occurred. Guardian was notified on 09/04/24 at 1:40pm ER paperwork was emailed to Kendra Slade on 09/05/24

Interim Action Narrative: Resident was assessed by the nurse and evaluated at ER.

Maltreatment Narrative:

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Facility provided documentation for tihs incident.