Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 024031

Date of Incident: 9/16/2024

Date Received: 9/17/2024

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] [redacted] DOB: [redacted] [redacted] client in our PRTF program and resides in Chestnut House Incident Report date/time: 09/16/24 12:29pm Location of Incident: Siebert School Incident Description: Aggressive to Peers, Aggressive to Adults, Threat to Safety, Property Destruction Staff Involved: Allison DeMay, Robert Page, Rodney Ellis, Ben Malone, Caitlin Henthorne, Clytrell Daniel, Kara Brooks, Valerie Alvarez, Taylor Tull, Charles Hoof, Samantha Henry, Melissa Price Events Leading: While in class pt was struggling with a peer instigating him. Neither pt nor peer would leave the class when asked to take a break. Pt's peer stood up and continued talking to pt. Pt then stood up and approached peer, shoving staff in effort's to get to peer. Personal restraint began at this time. 12:29pm-Personal Restraint: Patient charged at a peer, shoving a teacher in his class. A personal restraint was initiated. Patient fought the restraint and his feet tangled with staff's feet, causing all of them to fall to the floor. Patient attempted to bite staff members while in the restraint. Patient cried and screamed. Patient was offered PRN several times but declined. Staff attempted to provide verbal support to pt. 12:44pm-Personal Restraint: Client started to calm down. Client stopped fighting staff. Nurse offered a chemical by mouth. Client accepted. Nurse retrieved the chemical and administered. Staff encouraged client to take a deep breath. He was given a tissue. 12:45pm-Chemical Restraint: Client took chemical restraint by mouth. 12:46pm-Personal Restraint End: Client was given water. Client contracted for safety. Personal restraint ended and client eloped from the school. Client walked back to the house with staff and no further interventions. Patient Debriefing date/time: 09/16/24 1:00pm: Client was asked if he was injured and he initially said no, but then complained of pain in leg. Client also complained about the fall that occurred in the restraint, but acknowledged that staff tripped over feet. Client expressed concerns about potentially being placed on run risk, however client was only placed on freeze PA. Client was able to accept information and discussed restoring with peer and class. Verbalized that he did not have any other complaints or needs. He did not want any

fist bumps, but accepted a pat on the back from staff and verbalized feelings of sadness and was tearful. Staff offered verbal support and explained that no one is angry with him and they see him trying his best. Nursing Assessment date/time: 09/16/24 12:51pm: This nurse attempted to process with [redacted] following release of the restraint. He was tearful and crying and made his way to the door of the classroom where he exited the classroom and eloped from school. He jumped over the creek and stood there sobbing and crying while waiting on team members. He voiced just needing to get out of the building. He walked back to chestnut house amongst team members and endorsed being sad. Upon entering Chestnut house, he initially denied any injuries. This nurse asked if he could remove his hoodie to observe his arms. Erythema noted near/around posterior antecubital area. He also has a healing scabbing sore one his (R) elbow that he reports his from his last restraint. He then admits and c/o (R) leg pain below his calf area, rating pain 5/10. He complained about the fall that occurred in the restraint, but acknowledged that staff tripped over feet. No physical markings, erythema, bruising, abrasions, lacerations, or abnormalities noted. Gait is steady. Active ROM to all extremities. Can bear weight without difficulty. PRN ibuprofen 400mg administered. No further physical markings, erythema, bruising, abrasions, deformities, protrusions, lacerations, or abnormalities noted. Of note: mild bruising and edema noted to (R) hand, 5th carpal from patient punching the wall of some time recent. Capillary refill brisk, less than 3 seconds, and WNL. AAOx4. Fairly clear and coherent speech. Sometimes difficult to understand when he was crying and upset. No signs of respiratory distress. No retractions, accessory muscle use, or nasal flaring. He agreed to a cold pack. he was observed sitting on his bed, tearful, and appeared disappointed in self. He was looking down and tearful. Denies any numbness, tingling, or weakness in extremities. This nurse attempted to obtain vitals. [redacted] remained upset, tearful, and tense. Discussed his vitals will be obtained later when he feels better. 1315: MH, RN obtained vitals signs. BP: 126/74, HR 93. Temp. 97.2. SpO2 saturation 98%. Injuries to Staff or client: Pt stated he had no injuries but did mention pain in his leg (possibly from staff and pt tripping, falling to the ground). Staff were kicked and also suffered carpet burn. Follow-up to injuries: Pt was seen by the nurse. Staff will self-care. Additional Comments: Concerns were made about the initiation of the restraint, feeling as if the approach may have been too aggressive, furthering pt's escalation. Video review shows that one team member may have been attempting to use "team control" CPI hold but it was not communicated, making the initial restraint ineffective. This will be further discussed/trained with team member. Guardian was notified on 09/16/24 at 4:33pm, 4:34pm, 4:35pm [redacted] was transported to acute at Rivendell on 09/16/24 at 6:50pm.

Interim Action Narrative: Staff used verbal de-escalation and presonal restraint. Resident was assessed by the nurse and transported to acute care.

Maltreatment Narrative:

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Program Coordinator will requsest nursing note and inquire about camera footage. 9/18/2024, Program Coordinator reviewed camera footage. Staff were not observed preventing the resident from breathing. Resident was observed yelling and struggling to get out of the resident. The resident was also observe displaying physical aggression towards staff.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
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521 Visit Compliance Report

Licensee: Youth Home, Inc.

Facility Number: 128

Licensee Address: 20400 COLONEL GLENN ROAD
LITTLE ROCK AR 72210

Licensing Specialist: Kendra Slade

Person In Charge:

Record Visit Date: 9/18/2024

Home Visit Date: 9/18/2024

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 10:45 am to 12:00 pm

Census: 40

Licensing received a provider reported incident on 9/17/2024 for ELS Case #024031.

Program Coordinator discussed and reviewed camera footage with Youth Home's staff. The provider reported incident took place in [redacted] classroom. Residents and staff members were observed throughout the classroom, ratio 2:7.

Resident and peer could be heard having a verbal altercation. Staff was also heard given directives to both the resident and peer with both ignoring the directives. Assistance was called over the walkie and the residents along with the peer were escorted out of the classroom.

The resident was observed trying to run out of the classroom, staff intervened, and resident was placed in a restraint. More staff members entered the classroom, ratio 5:1. Restraint ratio 3:1. Resident was observed struggling to get out of the restraint.

Program Coordinator heard resident say, "I can't breathe" and the restraint was repositioned. Staff were not observed preventing the resident from breathing while in the restraint. It appeared that the resident was on his back side and not laying on the front of his body.

While in the restraint, staff members were heard using verbal de-escalation and offering encouragement. The resident continued to scream and did not comply with the directives. A staff member was also observed fanning the resident.

Once the resident calmed down, the restraint ended, and the resident was observed sitting against the wall with staff around him. It appeared that the nurse was sitting next to the resident before he got up and walked toward the door. Once the resident got closer to the door, he was observed running out the classroom. Per facility, the resident ran out the building into the field in the garden area. There are no cameras on the field.

Facility reported that resident was able to process with staff and walked to the house. Resident is currently in acute care.

Provider Comments:

CCL Staff Signature : Date: 9/20/2024

Provider Signature : Date: 9/20/2024