Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 026715

Date of Incident: 1/6/2025

Date Received: 1/10/2025

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] Private placement client in our PRTF program and resides in [redacted] Incident Report date/time: 01/06/25 3:09pm Location of Incident: [redacted] Incident Description: Aggressive to Adults Staff Involved: Dejuan Williams, Ben Malone, Anthony White, Jonathan Pulliam, Valerie Alvarez Events Leading: Client became upset due to remaining on run risk although he was taken off house restriction. Client stated that his mother was bringing him new shoes and he would not be able to wear them on run risk. Client became more upset due to his peers coming in from school being loud. Client went in his room slamming and hitting objects, so the staff opened his door, and he slammed it hitting staff with the door. 3:09pm-Personal Restraint: Client was placed into a restraint and was escorted to the seclusion area. Client is yelling and cursing at staff as staff continue trying to talk to him. 3:15pm-Personal Restraint End: Client begins to struggle and attempts to kick staff. Client continues to yell, curse and threaten staff as they continue trying to talk with him and ask him what he needs. Client begins to stop struggling and is able to be released from the personal restraint. 3:16pm-Unlocked Seclusion: Client is in unlocked seclusion where staff begin talking with him about what happened and how they much rather talk with him like this. Client stated that no facility can hold him. Client remains calm while talking with staff. Client is offered bathroom and water which he declines. 3:20pm-Unlocked Seclusion End: After contacting for safety, the client was able to be released from the personal restraint. Client was able to return to his area. 3:50pm-Other/None: After the client was de-escalated and walked out of the seclusion room, approx. 20 mins later, the client started to self-harm. He was redirected several times about this matter, which he eventually stopped, and was seen by the nurse after several minutes of asking. Patient Debriefing date/time: 01/06/25 3:45pm: Staff and [redacted] talked about why he became upset and trying to use better coping skills like asking staff to talk with him. Nursing Assessment 1 date/time: 01/06/25 3:21pm: [redacted] was observed processing with team members. He appeared

annoyed with information team members relayed as he stood with stooped posture and rolling his eyes. He became giddy and laughing when his posture and eye rolls were addressed. Calm and cooperative during this time. He admits he became angry and began throwing things in his room when he learned he is still on run risk. He also admits he became overstimulated when the boys returned to chestnut house and admits to slamming the door on a team member. AAOx4. No signs of respiratory distress. No apparent physical markings, erythema, bruising, abrasions, scratches, or edema. He appeared avoidant and rushed past this nurse in attempt to return to his room. When asked to assess his arms, he would flash them quickly then walk off. Skin intact. Good circulation. Hygiene appears to be lacking today as his shirt appears soiled and some sort of debris/residue that could be rubbed off easily noted to his arm. Active ROM to all extremities. Gait is steady. Denies any pain, soreness, or injuries from intervention. Gait is steady. He denies he nor staff could have intervened differently in order to prevent the intervention. This nurse explored coping skills with [redacted]. With assistance, he was able to identify listening to music, pacing, and the comfort room when upset, irritated, and/or overwhelmed. This nurse then explained how one transitions from house restriction, run risk, to no safety precautions in which he appeared receptive. He then began laughing and explained he just realized this nurse is shorten in height than him. Pt placed on freeze for physical aggression. Nursing Assessment 2 date/time: 01/06/25 8:51pm: At 7:52 PM, the nurse received an order from the on-call provider for the patient to be admitted to an [redacted]. Consent for the admission was obtained from the patient's parent at 8:05 PM. Police arrived at 8:20 PM, followed by [redacted] at 8:41 PM. The patient was compliant with both police and [redacted] workers. He had his belongings with him and was in no physical distress upon departure. The patient left the facility at 8:51 PM via [redacted] for acute placement Guardian was notified on 01/06/25 at 4:35pm with the following notes: Guardian voiced that while on the phone with [redacted] last night, he was upset and voiced that he did not want to be at YH. She voiced that he was making threats to harm hurt himself and explained he doesn't understand why they (his parents) can't bring him home and give him chance. He reportedly explained to them (his parents) on the phone last night that he has learned his lesson and ready to return home. Guardian, "he is obviously still making demands" and is hopeful he will begin working on this treatment. APRN notified of guardian's concern and [redacted] threats on their call last night. Order for Eyeball and front of house safety precaution received. This nurse then learned [redacted] was at chestnut house after breaking the plastic off the light cover and threatened to stab team members. This nurse found [redacted] packing his items to move rooms. APRN gave order to administer [redacted] to prevent further incident. [redacted] stated, "I'm not taking shit. I'm not even going to take my meds". Guardian was also contacted at 8:05pm on 01/06/25 with the following notes: At 7:52 PM, the nurse received an order from the on-call provider for the patient to be admitted to an [redacted]. Consent for the admission was obtained from the patient's parent at 8:05 PM. Police arrived at 8:20 PM, followed by [redacted] at 8:41 PM. The patient departed the facility at 8:51 PM via [redacted] for [redacted].

Interim Action Narrative: Resident was placed in a restraint/seclusion for safety, assessed by the nurse, and ordered for [redacted].

[redacted] Narrative:

Licensing Narrative: Licensing informed of provider reported incident and documentation provided. 1/10/2024, licensing reviewed provider reported incident for licensing concerns. Provided documentation uploaded. Licensing inquired if resident would return to the facility after [redacted]. Resident will return to the facility after [redacted].