Placement and Residential Licensing Unit
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Case Number: 026731

Date of Incident: 1/8/2025

Date Received: 1/9/2025

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: [redacted] from 01/07/25. [redacted] is a [redacted] client from [redacted] in our PRTF program and resides in [redacted] House. [redacted] was transported to [redacted] on 01/07/25 and then transported to [redacted] at 6:25am 01/08/25 for an [redacted]. [redacted] will not be returning to Youth Home and was discharged from our PRTF program on 01/08/25.

Interim Action Narrative: Resident was transported to acute placement.

[redacted] Narrative:

Licensing Narrative: Licensing informed of provider reported incident via email. Facility provided licensing with documentation for this provider reported incident. Per facility, resident was involved in 3 different incidents on 1/7/2025. Facility reported that resident will not be returning to the facility. 1/10/2025, facility reported being unable to submit the provider reported incident into ELS due to receiveing error messages after 3 attempts. Program Coordinator entered provider reported incident and uploaded provided documentation. Licensing requested for camera footage to be saved to be reviewed. 1/15/2025, Program Coordinator visited the facility and reviewed camera footage. Program Coordinator observed all three incidents.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education

P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437

P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

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: Mary Kelly

Record Visit Date: 1/15/2025

Home Visit Date: 1/15/2025

Purpose of Visit: Self Report Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of visit: 11:00 am to 12:15 pm

Census: 10

Licensing received a provider reported incident on 1/9/2025 for ELS Case #026731.

Program Coordinator Slade reviewed camera footage on 1/15/2025 with Mr. White.

The provider reported incident happened in the milieu at the Mabee House. This provider reported incident has three (3) different parts. The first incident happened at the school at the other two (2) at Mabee House.

Program Coordinator observed the resident pacing an area of the school, ratio 4:1. When resident started punching herself staff intervened by placing her in a restraint. Due to resident struggling to get out of the restraint, staff repositioned the restraint. Resident could be heard breathing hard and the staff repositioned the resident. During this time, resident was observed trying to assault (hitting, pulling hair, kicking, biting, spitting) staff.

A staff member was observed placing a pillow under the resident's head due to her trying to bang her head on the floor. Program Coordinator observe the resident bite a staff and the staff member tapped out of the restraint. Staff could be heard offering verbal de-escalation and resident did not comply.

Once back at Mabee House, the resident and a peer were observed in the milieu, ratio 2:1. The resident was observed sitting at a table and appeared to be coloring/drawing. While sitting at the table, resident was observed tapping and pressing her arm with what appeared to be a marker. When staff approached her, resident got up from the table and walked down the bedroom hall.

12:18 to 12:38 The resident returned to the milieu and continued to pace the area. The peer was escorted to the game room by a staff member. The resident was observed tearing things off the wall, flipping tables, messing with and throwing items off the staff's work desk, yelling at staff, she pulled the cords from the staff's work area from the wall, and attempted to turn over furniture. Resident was observed writing on the whiteboards. Program Coordinator was informed that the resident wrote comments about staff and her peers.

The cords that the resident pulled from the wall were not visible cords. There was a covering over the cords. At this time the cords have not been replaced and the staff's equipment has not been put back in that area. The resident continued to display disruptive behaviors and was placed a restraint, ratio 4:1. Due to the resident resisting the restraint and showing aggression (hitting, biting, kicking, pulling hair, spitting) to the staff, the restraint was moved to the floor. Resident could be heard crying while staff provided verbal de-escalation.

18:33 to 19:13 The residents were informed to go to their bedrooms due to the resident pacing the milieu and displaying disruptive behavior, ratio 6:1. Program Coordinator observed a nurse on her phone. It was reported that she was consulting with the doctor. Due to her behavior, the resident was placed in a restraint. The ratio of the restraint went from 2:1 to 5:1.

A chemical restraint was administered by the nurse, the resident eventually calmed down, and the restraint ended. The police and MEMS were observed entering the house. The police talked with the resident before MEMS arrived. The resident was assessed by MEMS, placed on the gurney, and exited the building.

Program Coordinator was informed that the resident was upset because she was informed that she was going to acute but was not provided with a timeframe and this caused her to be upset. The resident was placed in a total of three (3) restraints. Each restraint observed was to ensure the safety of the resident due to her disruptive and aggressive behaviors. When staff were injured by the resident, staff were observed tapping out and another staff member took over the restraint.

Staff intervened when resident displayed disruptive, aggressive, and self-harming behaviors. Staff provided verbal de-escalation and restraints were initiated for safety.

Provider Comments:

CCL Staff Signature : Date: 1/15/2025

Provider Signature : Date: 1/15/2025