Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 026965

Date of Incident: 1/19/2025

Date Received: 1/21/2025

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Client: [redacted] Private Placement PRTF Client in [redacted] House Incident Date and Time: 1/19/25 6:40 PM Staff involved: Kelton Johnson (Reporting and observed), Charles Murphy (observed), Tatiana Shelor (nurse), Don Rose (nurse) Events Leading: Client was laying down in the rec room watching tv minding her business, Another client came in and attacked her. I grabbed the other client from attacking her. Client did not fight back she tried to protect herself. No restrictive interventions used with this client. Nursing face-to-face assessment: 1/19/25 @ 6:44 PM: Upon this RNs arrival, pt found in the rec room laying on the floor, alert and able to follow directions. Pt instructed to sit up and assisted to sit against the wall. Pt noted with dry blood on her face that appeared to have come from the nostril. Pt nose has mild hemorrhage and pt was holding pressure with paper towel. Pt a/o x4 and able to answer questions with no difficulty. Coherent speech. Reports that was hit on the head several times with a fist and that peer hit her head against the floor. Pt reports that she remembers feeling hazy during the attack. Unsure if had complete LOC. c/o feeling dizzy, HA 10/10 and pain to L eye with decreased vision to L eye. also reports aching all over. NO bumps noted to pt head on palpation, scalp skin intact. Pt neuro checks WNL. PERRLA. VS 129/88, HR 91, RR 16, temp 96.9, SPO2 98% on RA. Resp even/unlabored. no s/sx of acute physical distress. calm/cooperative. Pt R UA noted with redness throughout the R UA, pt reported that peer grabbed her on it. No broken skin. Full ROM noted to all extremities/joints during the assessment. No deformities observed. Dr McClellan notified of the assessment and ordered for staff to take pt to [redacted] for evaluation. UM on call notified of the order at 6:55 pm. Follow-up Nursing post [redacted] visit: 1/19/25 @ 11:35 PM: Patient returned from [redacted] with staff. Patient examined: Pupils are equal and both reactive to light. Grip strength good bilaterally. Moves all extremities. No complaints of dizziness. Appears alert and oriented. Patient last medicated for pain in the [redacted] at 9:47pm with [redacted] All vitals within normal limits. 111/77, pulse 79, SATS 98% on room air. Respirations 18. Denies pain presently. Guardian

notification of incident 1/19/25 7:01 PM Guardian notification upon return from [redacted] 1/19/25 11:45 PM

Interim Action Narrative: Staff intervened, resident was assessed by the nurse, and resident was evaluated at the [redacted] Peer was placed on freeze.

[redacted] Narrative:

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Facility provided documentation for this incident with the [redacted] discharge summary to follow. 1/24/2025, licensing inquried about [redacted] discharge summary and if peer was placed on any restrictions. [redacted] discharge summary reviewed and uploaded. 1/27/2025, licensing inquired about restrictions for peer involved. Per facility, the resident was placed on freeze after the incident. Facility reported that the resident's guardians will be pressing charges against the peer.