Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 027091

Date of Incident: 1/26/2025

Date Received: 1/27/2025

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] House Incident Report date/time: 01/26/25 6:50pm Location of Incident: Gymnasium Incident Description: [redacted] Staff Involved: Tatiana Shelor, Gregory Nesdahl, Brianna Alexander, Don Rose, Matthew Chrysler Events Leading: Client was playing Basketball with staff and peers in the gym. Client appeared to be hot/ overheating then as staff was talking to her about getting water her eyes twitched and she had a controlled fall to the floor because staff and peers caught her as she was falling. Nursing Assessment 1 date/time: 01/26/25 6:55pm: Patient presents in gym on floor laying on back with staff member and peers present. This nurse arrived and repositioned patient to her side in case of aspiration occurs. Patient presents with reoccurring [redacted] with [redacted] and [redacted] displayed. Patient non-responsive to verbal stimuli and painful stimuli. Patient vitals obtained at 7:14pm and unremarkable BP118/83, Pulse 115, Respiration 17/minute. Multiple vitals obtained and unremarkable and pulse ox always above 97% on room air. Vitals at 7:27pm blood pressure125/98, pulse 113/minute. Called on-call provider and reported incident at 7:07pm and orders received to monitor patient and provide supportive and comfort and monitor vital signs. Patient at time of initial occurrence reported to be overheated and perspiration was noted. Staff provided supportive comfort and care and attempted to fan patient and cool patient with cool compresses. Practitioner updated frequently on patient status and practitioner advised to continue monitoring and provide supportive care. Nursing Assessment 2 date/time: 01/26/25 7:35pm: [redacted]. Patient is not responding to painful or verbal stimuli. Patient presented with [redacted]. Patient vitals at 7:45pm were [redacted] pressure 109/81, and pulse 108, pulse ox 97% at all times, respiration 16/minute and even and unlabored. Dr. Shy updated frequently on patient condition and advised to provide

supportive comfort care and monitor vital signs. Nursing Assessment 3 date/time: 01/26/25 8:30pm: pt currently laying on the floor on her R side, appears calm with no rigidity or movements. pupils reactive to light. airway clear as witnessed by even/unlabored respirations. pt not alert and not arousing to verbal/tactile/painful stimuli. GCS 3. VS 132/82, HR 99, RR 16, Spo2 97% on RA. Nurse Don and Matt given report on pt condition and on current MD instructions to provide safe and supportive care to the pt and monitor condition and VS. Nursing Assessment 4 date/time: 01/26/25 8:37pm: Arrived to the gym to assess the patient who was laying on her right side unresponsive. Blood pressure was 132/82, pulse 99 and pulse ox of 98%. Shortly after arriving, patient began to have at least 3 uncontrolled seizures lasting 10-15 seconds. MD order obtained to transport patient to [redacted] via [redacted]. Last blood pressure before [redacted] arrived was 119/83, pulse 105 and pulse OX of 98% Respirations even and unlabored when patient not having [redacted]. [redacted] arrived to the scene at approximately 2115. Patient continued to [redacted] once placed on the gurney. Nursing Assessment 5 date/time: 01/26/25 9:44pm: THIS IS NOT A FACE TO FACE: [redacted] was called 2046 for transport to [redacted] While on the phone she had [redacted] about [redacted]. Pt left with [redacted] around 2138. Nursing Assessment 6 date/time: 01/27/25 1:50am: THIS IS NOT A FACE TO FACE: Pt returned back from [redacted] around 0150. On call provider notified. Order received to give pt her [redacted] and [redacted]. As well as hold her [redacted], due to her receiving this in her am medications within the next couple hours and [redacted]. She can go to school after lunch due to getting back from the [redacted] so late. Pt was in her bed on left side, eyes close, responded to verbal stimuli. she had even gait, no slurring of words, even tone and non-pressure speech. She verbalized understanding. Nursing Assessment 7 date/time: 01/27/25 2:10am: Patient assessed after returning from [redacted]. Blood pressure 98/69, pulse 72. Patient appears alert and oriented and pleasant. Moves all extremities. Patient states that she does not remember the events of the prior evening. Guardian notified on 01/26/25 at 8:51pm.

Interim Action Narrative: Resident was assessed by the nurse and evaluated at [redacted].

[redacted] **Narrative:**

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Facility provided licensing with documentation for this provider reported incident. Licensing inquired if resident was placed on any safety precautions. Documentation reviewed and uploaded. 1/28/2025, facility reported upon resident's return from the [redacted] she

was allowed to sleep in. Once she woke up, no additional issues were noticed and resident reported feeling great.