ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Placement and Residential Licensing Unit**
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## Notice of Serious Incident

**Case Number: 027154**

**Date of Incident: 1/28/2025**

**Date Received: 1/29/2025**

**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: 01/28/25 8:45pm Location of Incident: [redacted] House Incident Description: Aggressive to Adults, Threat to Safety Staff Involved: LaDonna Ford, Zharieah Foreman, Dejuan Williams, Diana Coleman, Joseph Davis Events Leading: Client was instructed to go to bed around 8pm, client stated "I don't have to follow rules, I'm not going to sleep." Client wanted to stay up and draw. Client insisted that he did not get his "free time" today but was allowed to draw with staff. Staff reassured client several times that they were able to continue their drawing tomorrow. After several redirections, client did not want to go to bed. Client did go into their room but was slamming the door and beating on the walls as well as punching his bed. Client was cursing, threatening, and yelling at staff. Client stated multiple times "I should have stabbed you that day" to a specific staff member. Staff members entered the room to calm client down. Client then picked up a water bottle and attempted to harm staff with it. While staff was trying to retrieve the water bottle, client then began to pull on staff's hair, this prompted a hold at 8:50pm. During hold, client still had staff's hair and kneed another staff member in the stomach. Hold lasted until 8:53pm, when client was calm contracted for safety. 8:50pm-Personal Restraint: Client was observed pulling staff member's hair, which prompted a personal restraint. While staff members were restraining, another attempted to get staff member's hair released. During this time, client was irate and yelling at staff to give his water bottle back. Once staff member's hair was released, said staff member exited the room where the remaining staff continued personal restraint. While in restraint, client was trying to exit the room and attempting to get out of hold. Client also kneed staff member in the stomach during hold. While in hold, staff members were trying to get client to calm down and breathe. Client slowly began to calm. 8:53pm-Personal Restraint End: Staff members were able to get client to calm down and contract for safety. Staff members gave a count down and was able to release client. Client was offered water and a**

**towel to cool down. Once out of restraint, client sat down on their bed and was calm. Client was then looked over by nursing. Patient Debriefing date/time: 01/28/25 9:30pm: Client claimed that he just wanted to draw and that staff "stole" his water bottle from him. Staff reassured client that his water bottle wasn't stolen and was still allowed to get water when needed. Staff members comforted client and explained to them that bed time is the same time every night and that next time, client should opt for better coping skills. Staff also reminded client that they could not make threats and put hands on others. Client talked to guardians on the phone after incident as well. While on the phone, client seemed to have a little bit of a hard time taking full accountability but did appear remorseful. Nursing Assessment date/time: 01/28/25 9:00pm: Client required personal restraint due to physical aggression towards staff. Client was released and began to process with staff. Client reports left thumb is "broken". Client has limited ROM to left thumb due to pain, declined PRN pain medications, declined ice. Left hand skin appears intact, brisk capillary refill noted. Client is alert and oriented, gait is steady, vitals are stable. Client reports that he is still angry at staff, encouraged client to forgive staff. Client was offered water and allowed to speak with family on the phone. Client tearful afterwards, he was instructed to go to his room and go to bed. He refused at first, but then went voluntarily. Client will need to be reevaluated in the morning. Injury to staff or client: Client reports left thumb is "broken". Follow-up to Injury: Client has limited ROM to left thumb due to pain, declined PRN pain medications, declined ice. Left hand skin appears intact, brisk capillary refill noted. Guardian was notified on 01/28/25 at 9:37pm. [redacted] was transported by [redacted] to [redacted] for an [redacted] on 01/29/25 at 12:45am.**

**Interim Action Narrative: Resident placed in restraint for safety, assessed by the nurse, and transported to [redacted].**

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**[redacted] Narrative:**

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**Licensing Narrative: Facility provided documentation for this provider reported incident. Licensing reviewed provider reported incident for licensing concerns. 1/30/2025, licensing inquired about resident's reported injury. Facility reported: There was no follow up before acute as nursing had planned to re-evaluate the injury the next day. However, he then went to acute. We have not received word on his physical status.**