ARKANSAS DEPARTMENT OF HUMAN SERVICES

Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 028835

Date of Incident: 4/4/2025

Date Received: 4/7/2025

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] client in our PRTF program and resided in [redacted] Incident Report date/time: 04/04/25 7:15pm Location of Incident: [redacted] Incident Description: Threat to Safety, Patient Injury Staff Involved: [redacted] Events Leading: Client was told that she is not allowed any sugar and became escalated to the point of cursing staff and slamming her room door. She barricaded herself in her room and refused to open the door. While the door was closed, Client began to scream and stated she will be screaming as long as she is in [redacted] and stated she "needs to to go to [redacted]". Staff went into the room and client was sitting in the corner at which point she began banging her head against the wall. Staff attempted to talk with her to help deescalate client but this was not an effective approach at this time. A personal restraint was initiated when client would not stop banging her head and it was deemed necessary for her safety. 7:15pm-Personal Restraint: Staff had to push open door because patient refused to remove herself from entrance of room. Once access was granted to room patient began banging head against wall which resulted in personal restraint. At this time, staff were calming talking with patient attempting to deescalate her and help her regulate. She kept banging her head with a staff member having to place their hand between the wall and her head. She continued to curse, talk loudly and demand to go to acute. 7:22pm-Personal Restraint End: Staff was able to talk with client for her to calm down. Client was able to comply to directives, including deep breaths and releasing one arm at a time. Client was able to listen to directions and contract to chair in milieu where she was offered water, cold towel, and assessment from nurse. Patient Debriefing date/time: 04/04/25 7:30pm: Staff and patient debriefed about the incident and what led to her barricading herself in her room. Patient does not want to be discharged and go home and is fearful that she is close to being discharged. She was able to talk with staff calmly and

discussed some strategies of how to handle her strong emotions in a more constructive way. Nursing Assessment date/time: 04/04/25 7:45pm: [redacted] was placed in hold following barricading herself in her room and banging back of head against the wall. This nurse assessed the pt following incident. No noted knots or bruising to back of head. Pt c/o of 9/10 pain to head. Administered [redacted] for pain. [redacted] Steady gait. Speech clear. No petechiae noted. Notified provider on call. Orders received. Guardian was notified on 04/04/25 at 8:55pm, 8:56pm, and 9:00pm. [redacted] was transported to [redacted] on 04/04/25 at 10:05pm for an [redacted]. She will not return to Youth Home and was discharged from our program on 04/07/25.

Interim Action Narrative: Resident was assessed and transported to acute care.

[redacted] **Narrative:**

Licensing Narrative: Licensing reviwed provider reported incident for licensing concerns. Facility provided documentation for this provider reported incident. Documentation reviewed and uploaded. Resident will not return after acute care. Resident was discharged from the facility on 4/4/2025.