ARKANSAS DEPARTMENT OF HUMAN SERVICES

Placement and Residential Licensing Unit
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Notice of Serious Incident

Case Number: 029148

Date of Incident: 4/17/2025

Date Received: 4/21/2025

Facility Name: Youth Home, Inc.

Facility Number: 128

Incident Type: Licensing

Report Description: Incident Report for [redacted] client in our PRTF program and resides in [redacted] Incident Report date/time: 04/17/25 2:29pm Location of Incident: [redacted] Incident Description: Aggressive to Adults, Threat to Safety Staff Involved: [redacted] Events Leading: PT became upset after staff redirected him to stop calling staff slurs. Client began to curse at staff and proceeded to fart on his peers. PT farted on staff and laughed about it. Client has been on freeze for over a week and has not fully restored with staff. Staff informed client that his freeze will be extended due to behaviors and refusal to restore in genuine matter. Client was told that he could do anything that is safe in his area that was not in direct vision of the television. PT has colored pencils and paper and refused to engage in those activities. PT began to threaten to hit staff due him being upset he will not be removed from freeze. Client continued to curse at staff and grabbed staff computer. 2:29pm-Personal Restraint: Pt grabbed and attempted to throw staff computer. Staff removed the computer from client reach. Pt ran behind staff desk and attempted to hit staff. Client was placed in a personal restraint. PT was in a personal restraint and hit a staff member while fighting against the hold. Client was in a personal restraint in a chair behind staff desk in the beginning of the hold. Staff tried to ask the client to calm down and told him that we want to let him go when he could calm down. Pt was refusing to listen to staff and screamed. Client told staff he wanted to attack a staff member and was still angry. PT was escorted away from staff desk while in a personal restraint. Client was restrained in hallway area behind staff desk area away from other client's view. 2:40pm-Personal Restraint End: Pt began struggling again, attempting to walk away from staff and thrash arms while in hold. Additional staff helped support pt and staff and tagged out a team member. Pt was offered more water and a cool cloth. He accepted staff wiping his forehead with the cloth. Pt

ceased in struggling as verbal support continued. Staff encouraged pt to take deep breaths. Pt was able to contract for safety. Staff asked pt if he needed anything or wanted space and pt stated he was ok and he continued to decompress. After a few minutes he asked to return to his room and this was allowed as he was not in seclusion. Patient Debriefing date/time: 04/17/25 2:45pm: Following intervention pt was asked if he was injured to which he pointed at a superficial mark on his right arm consistent with resisting restraint. Staff asked pt if he was willing to be assessed by the nurse and he agreed. Staff talked with pt about making positive choices following mistakes. Pt appeared sad but shook his head in understanding. Pt was transported via [redacted]. Nursing Assessment date/time: 04/17/25 2:42pm: [redacted] was observed standing in the time out room, continuing to calm and de-escalate while processing with staff and pacing. He was observed holding a wet wash cloth. His arms appeared erythemic and a small superficial scratch noted to (R) antecubital fossa area. Minimal bleeding with scant amount of blood. Erythema also noted to clavicle area. [redacted] boasted proudly about being combative and resistant against the restraint while stating, "He is weak. He can't do anything to me. He isn't a man". This nurse attempted to explore with [redacted] the relationship with the team member that [redacted] continues to target and threaten. During debriefing the previous day, [redacted] told the unit manager that he would continue to go after [redacted] throughout the shift. [redacted] began shifting blame and minimizing his behaviors reporting his freeze was extended for no particular reason. When recalling the behaviors reported, [redacted] snidely grinned endorsing and admitting to: farting on peers and staff, cursing and threatening, intimidating, attempting to destroy property, becoming physically aggressive to staff, walking into restricted area with intent to harm staff, testing limits, and refusing to follow instructions. He continued to arrogantly boast about team members running away from him when he is becoming hostile and aggressive. He admits that the team member that he seems to target the past few days, sets clear limits, behavioral expectations, and holds him accountable thus [redacted] endorsed deliberately targeting, intimidating, and assaulting this team member in hopes of getting the team member fired. He appeared to lack any remorse and discussed plan to continue to attempt to go after this team member with intent to harm. AAOx4. No signs of physical or mental distress. Appears calm although unpredictable as he continues to voice threats and display a tense hostile glare. Active ROM to all extremities. Reports is only injury is the scratch noted to his (R) AC while boasting about how strong he is and endorsing he was combative and resistant against restraint. No further physical markings, erythema, bruising, abrasions, deformities, protrusions, lacerations, or edema noted. Gait is steady. [redacted] was encouraged to make acceptable choices and reminded of clear behavioral guidelines. Denies need or desire for wound care for his scratch. Encouraged to explore coping skills to help defuse tension and while still getting his needs met. Denies concerns. Feels interventions were appropriate. Attending notified. Freeze for physical aggression continued. Residential services director working on [redacted]. Guardian was notified on 04/17/25 at 3:05pm. 3:11pm. [redacted] on 04/17/25 at 4:45pm for an [redacted].

Interim Action Narrative: Resident was placed in restraints for safety and transported to [redacted].

[redacted] Narrative:

Licensing Narrative: Licensing reviewed provider reported incident for licensing concerns. Facility provided documentatoin for this provider reported incident. Documentation reviewed and uploaded. Resident was discharged.