STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43L018	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFULLY	22 WATERLOO ST POST OFFICE BOX 1087 RAPID CITY, SD 57701

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N 000	Initial Comments A complaint survey for compliance with CFR 42, Part 483, Subpart G, Subsection 483.354-483.376, Condition of Participation for the use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 was conducted from 2/14/24 through 2/15/24. Areas reviewed included the following: response times, emergency safety intervention (ESI) process, debriefing process, and staff education. Wellfully was found not in compliance with the following regulations: N0100, N0145, and N0214.	N 000		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on interviews, record reviews, Serious Occurrence report review, video observation, and policy review, the provider failed to ensure: *One of one sampled resident (1) was protected from self-harm through close monitoring, routine surveillance, and oversight by the staff. *The policies and procedures supported the following: -How many staff should have been on the Psychiatric Residential Treatment Facility (PRTF) unit during medication (med) pass. -The process for who should respond to emergency situations on another unit.	N 100	The following changes were made: a. Per N100, staff were re-educated on the client and staff expectations during the time of day in which medications are being passed by staff to clients, hereafter referred as "med time". This training was conducted on 3/6/24. Staff who were not in attendance have been scheduled for follow-up to ensure consistency. Please see the current Med Pass-Time Policy: • **Med Pass-time** - youth need to be in QT (also known as Quiet Transition,	3/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 3/14/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 100	Continued From page 1 -The monitoring process for residents when they were in their rooms before bedtime, during med pass, and after bedtime. -What the debriefing and education/re-training requirements were for the staff after a serious occurrence. -A policy and procedure was in place for the staff to follow during med administration. Findings include: 1. Review of resident 1's medical record revealed: *She was admitted to the Alcohol Rehabilitation Unit (ARU) on 9/14/23 and transferred to the PRTF on 12/12/23. -There was no documentation to support why she had been transferred to a more secured area. *She had a history of depression, post traumatic stress disorder, substance abuse, headaches, auditory hallucination of voices that told her to do bad things, and a history of self-harm. *On 2/3/24: -At 8:30 p.m. she attempted self-harm by strangulation with the use of a pillowcase. -Through staff interviews she verbalized continuing desire to commit self-harm, was transferred to the local hospital and was admitted to the behavioral hospital. Review of the provider's 2/5/24 Serious Occurrence Report regarding resident 1 revealed: *She was 15 years old and was admitted to the PRTF on 12/12/23. *On 2/3/24 the resident had been making comments of wanting to harm herself. *She had tried to strangulate herself by wrapping a pillowcase around her neck. *Those acts were not witnessed by the staff but verbalized by her.	N 100	Continued from page 1. which means to not talk, to stand or sit still, and remain in that way until the Transition is over) and also not asking distracting questions. All clients need to sit in their assigned unit group area chair in its assigned place. They may ask "med related" questions or to use the restroom, they may not use the restroom within 15 minutes of medication consumption. During this time, they may not step down to their rooms or anything else except using the restroom. This allows a quiet, calm environment for med-certified staff to complete med-pass. The TV may be on but only at a low volume level. If clients cannot follow QT appropriately then the staff members need to turn off the TV. Staff can be creative and give a 15-minute transition to med time, have a client recite the med time rules to the group etc. Clients are not permitted to make/receive phone calls, play games, grab snacks (during the pass) etc. during this time. Additionally, these items are to be added to this current policy:	

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N 100	Continued From page 2 *She was in her room alone and lying on the floor with her hands on her chest during the observations that were made by the staff. *The staff observed petechiae (red marks) and bruising around her neck. *"[Resident's name] was not on any watches and was not showing any kind of behaviors that would warrant a safety watch. The staff to resident ratio was met and there was also a counselor on the unit as well. So they were in ratio." -There were issues on another unit at the same time of the occurrence and it did not support who was on the PRTF unit when the event occurred. -There was no documentation to support how many residents were on the unit at the time of the occurrence. Review of the 2/5/24 Quality Assurance Committee Incident Review Form revealed: *Staff debriefing had been marked with the comment written in "no debriefing done." *"Were any staff given continued education due to the incident?" -Comment written under the question was "Staff involved will need trained on the full, proper policy for checking on clients. Supervisors will be notified." *There was no documentation to support the following: -Why a staff debriefing had not been completed. -When and if the staff involved with the incident had been educated. -Why all staff would not have been required to be educated. Observation on 2/14/24 at 9:45 a.m. of resident 1's room with PRTF supervisor A revealed: *There were three beds in the room and her bed was located closest to the entrance.	N 100	Continued from page 2. Additionally, these items are to be added to this current policy: • The Staff who is *not* passing medications posted in the group area to actively monitor all clients and should not be completing any other duties at this time. • Clients are not to go to their rooms or the restroom until 15 minutes after med pass has been completed. • Staffing ratio remains the same as waking hours ratio with med-cert staff included in ratio. b. Per N100, an addition to the Emergency Safety Intervention Policy was added to specify who responds in an emergency or critical incident within the building regarding one of the clients. That addition reads as follows: • In the event that the staff in ratio on the floor cannot safely manage a situation, they are to call over their walkie talkies for assistance to whatever location they	

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N 100	Continued From page 3 *Two of the pillows on her bed had pillowcases covering them. *Underneath her bed was a quart size Ziploc plastic baggie with small pieces of paper inside of it. Interview with PRTF supervisor A at the time of the above observation revealed: *Before her suicide attempt the resident's bed had been in the middle of the two beds. *For safety her bed had been moved by the entrance of the room for better visualization. *The Ziploc baggie should not have been in the resident's room as it was considered contraband (items that could have been harmful when used improperly). *The staff were required to complete five-minute checks on the residents when they were awake and in their rooms. *During the med pass the residents should have been in the group area, in their chairs, and quiet. Interview on 2/14/24 at 10:10 a.m. with nurse coordinator B regarding resident 1 revealed: *There was no full-time nurse here when she started in September 2023 and she was completing self-training for her position. *On the night of 2/3/24 she was called at approximately 9:08 p.m. and informed the resident had attempted to commit suicide. *She stated: -"When she was in the bathroom [YDS (youth development specialist) (direct care-giver for the residents) G's name] had knocked on the door and when she didn't answer she opened it." -"[YDS G's name] saw her neck had bruising and petechiae around it and her eyes were puffy." -"When I got here, [YDS G's name] was with her and I took her out into the hallway to talk with	N 100	Continued from page 3. are at. Whomever is within the building and able to respond to this call is then obliged to respond as quickly as possible to the location described. Upon arrival, any individual should seek guidance from the staff involved on what is needed and how they are to help. If an employee is present who has rapport with the client in the incident, they should be the employee to speak with said client to provide the least restrictive alternative. • Please note that the person with rapport with the client might not always be a counselor or ancillary staff member. If the employee with client rapport was previously working on another unit, another employee should cover their responsibilities until they can return after the incident. Once approved, this policy will be communicated to staff through training that occurs weekly. The projected date of this training is 3/13/24. Staff who are not in attendance will be scheduled for follow-up with the PRTF Case Manager to ensure consistency.	3/13/24

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N 100	Continued From page 4 her." -"She said she enjoyed the effects and feelings of it and denied really wanting to kill herself but that she wanted to do it again." -"This was the first time she mentioned hearing voices and having headaches." -"She told me that she has these all the time but didn't want to be labeled as crazy. Apparently she has a loved one who has mental illness." -"She was timing the checks and would stop then. She had a pillowcase and would hide it." -"She has a history of self-harm of cutting herself but at the time was not on any safety watches." -"We watched the video because there was a discrepancy with stories. Staff said they checked on her and she told the doctor at the hospital that no one checked on her." Review of the provider's 2/3/24 video recording of resident 1's serious occurrence event revealed: *From 7:38 p.m. through 8:13 p.m.: -There were three staff members working on the unit. -Resident 1 was by the desk in the group area until 7:55 p.m. and then went to her room --She had been wearing a black hooded sweatshirt with the hood pulled up over her head and her hair pulled out. -Lead care coordinator (LCC) D was sitting at the desk working with a resident and got up once to have a resident leave the quiet room. -YDS E was passing meds from a closet in the hallway by the resident rooms. She had occasionally peeked her head into the resident's room. -YDS G had been going back and forth from the group area to the resident's room. -At 7:59 p.m. YDS E came out of the resident's room making choking gestures with her hands	N 100	Continued from page 4. c. Per N100, staff were re-educated on room-time expectations per the handbook and policies in place. These points are taken from various policies within the Youth Handbook provided to every client and staff member. • Youth must stay in staff sight at all times, if a youth walks off the unit or into their rooms without permission this is considered AWOL. • Youth must ask to relocate before moving to a different position. If they want to step down the hallway, they must ask to "step down" then ask to "step in" to their room or bathroom and youth must wait for staff's approval before doing so. • Youth are only allowed to go into their own bedrooms, at no time is it allowed for a youth to step into another youth's room. If two or three youths share a room	

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N 100	Continued From page 5 around her neck to LCC D. --Neither LCC D or YDS G checked on the resident and YDS E resumed passing meds. -At 8:07 p.m. YDS E briefly stepped in the resident's doorway and left. --That was three minutes longer past the required room check time of five minutes. -At 8:10 p.m. YDS G stepped into the doorway and checked on the resident. She received a call and left the unit in a hurry. -Her roommates went in and out of the room or peeked inside of the room several times. *At 8:14 p.m. YDS E stepped into the resident's doorway to check on her and went right back to passing meds. -There was no observation of a room check on her until 8:22 p.m. by YDS E. That was three minutes past the required room check time of five minutes. *From 8:26 p.m. through 9:11 p.m.: -YDS E randomly checked on the resident while she continued to pass meds to the other residents. -YDS G was in and out of the unit and would check on the resident briefly upon return. -LCC D was not observed checking on the resident. -At 8:42 p.m. the resident came out of her room and LCC D assisted her to the bathroom. The door to the bathroom remained shut the entire time. She was wearing a black hooded sweatshirt with the hood pulled up over her head. You could not visualize her neck and no staff were observed checking it. -At 8:47 p.m. YDS E and G checked on the resident in the bathroom. YDS G knocked on the door, opened it, and stood in the doorway until the resident came out. -At 8:50 p.m. the resident came out of the	N 100	Continued from page 5. only one is allowed at a time except for bedtime. Clients are not allowed at any time to talk to other clients (their roommate) in their rooms. If staff cannot hear the conversation, youth could be talking about running or other inappropriate behaviors, so it is important that they are held accountable for this. Clients should not be standing in the doorway of another client's room for any reason at any time, especially if the client in the doorway is of the opposite gender. Clients should never change clothing in their rooms, ever for any reason. Client must not go in the room without permission from a staff member otherwise this is considered an "AWOL To Bedroom". Without permission or perhaps staff knowledge, clients could do harmful or suspicious things in their bedroom. When clients are in their bedroom staff members must conduct room checks every 10 minutes or less. When conducting room checks, staff must obtain a verbal response from the client before the room check is complete. If the client is sleeping, the staff must observe at least 3 respirations before the room check is complete. If the staff cannot see the client, staff must ask for an additional staff to come to the unit so they can enter the room and see that the client is safe.	

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N 100	Continued From page 6 bathroom with her hood pulled up over her head. -At 8:52 p.m. YDS G and the resident were talking back by her room and YDS F entered the unit. After YDS F entered the unit, YDS G left. -From 8:52 p.m. through 9:07 p.m. the resident remained by YDS F. *At 9:07 p.m. YDS G entered the unit and took the resident back to her room. The resident was combative to the corner just outside of her room. *At 9:10 p.m. nurse coordinator B entered the unit, went and got the resident from YDS G, and left the unit with her. *The resident wore her hood over her head at all times when out of her room and bathroom. -No staff were observed assessing or checking her neck for signs of strangulation. *The other residents on the unit were restless and constantly busy. Such as going to the bathroom, in and out of their assigned chairs, entering the quiet room to make calls, wandering back and forth to their rooms. *LCC D was observed assisting a resident with pulling her mattress out of her room. It was propped up against a wall and was never observed being used. *YDS E was attempting to pass meds to all the residents but would have to stop that process to check on the resident. *The unit was very chaotic, busy, and staff went in and out of the unit. Interview on 2/14/24 at 2:05 p.m. with LCC D regarding resident 1 revealed: *She was working the night the resident had attempted to commit suicide. *She typically worked the group home unit but they had low census so she was assisting with a resident on the PRTF. *Since she was in the unit she would have been	N 100	Continued from page 6. • **Bed-time** - at 8:30pm all youth transition to their bedrooms, this is the only time both youths are allowed in their room at one time. Absolutely no talking is tolerated in bedrooms, as these conversations cannot be monitored. Failure to comply can result in early lights out or one of the youths sleeping in a group area. These additional items will be added to the "Daily Routines" portion of the Youth Development Specialist Handbook: • Clients will not be permitted to enter their rooms outside of wake-up and bedtimes except for grabbing something (i.e. treatment work, a book, etc...) and then return to programming. • If a client is struggling to cope with a difficult emotion and requests to go to their room, this is allowed with the expectation that they will follow all other guidelines for following the unit schedule and programming. o Clients CANNOT stay in their room when the programming and policies state otherwise. This applies to transitions. o Clients on self-harm or suicide watch CANNOT go to their room at any time. If the client is requesting to go to their room, staff can redirect the client to the sensory room or the timeout room instead as outlined in Youth Care	

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N 100	Continued From page 7 considered to be part of the staff. *She stated: -"I saw [resident's name] go to her room and a staff member had come up to me and said she had concerns that [resident 1's name] was choking herself. She said the resident responded and the palms of her hands were on her chest and open." -"I told [YDS E's name] to do five to ten minute checks on her and [resident 1's name] always responded." -"She was refusing her meds and telling staff to get out of here." -"When I tried to get her to take her meds she said it's too late." -"When she went to the bathroom she made a statement it doesn't matter." -"After a while I told staff to check on her in the bathroom and [YDS G's name] did and that's when she saw the bruising and petechiae around her neck and puffy eyes." -"When we do room checks you can't go inside of the room unless another staff person is with you or the resident gives permission." -"We check to make sure they are breathing, nothing around their neck, and that they respond." *She could not recollect why YDS F was on the unit as he was assigned to work elsewhere. *She was not aware that the resident had attempted to strangulate herself until YDS G told her. *The resident was then placed on one-to-one safety watches until the counselor arrived. *There had recently been an incident similar to hers and there was staff training that had followed it. *To her knowledge there was not any other training or updates since then.	N 100	Continued from page 7. Worker Manual. If the client goes to their bedroom, staff will ask the client to relocate to the timeout room or the sensory room. If the client refuses, the staff will call for assistance. o to meals, off unit groups and activities, med-pass time, and other times it is necessary to be off the unit. o Youth who refuse to comply with this expectation will be subject to the levels of intervention which could result in Learning Opportunity for creating an unsafe environment. Once approved, staff will be trained on this addition in the weekly training on 3/13/24. Staff who are not in attendance will be scheduled for follow-up with the PRTF Case Manager to ensure consistency. d. Per N100, additions were made to the ESI (Emergency Safety Intervention) Debriefing policy to include staff debriefing and assessment for re-education. The following additions were made: • In addition to necessary debriefs for the client(s) involved in the incident, group staff debrief also must occur within 24 hours for all staff directly involved in the	3/13/24

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N 100	Continued From page 8 Interview on 2/14/24 at 2:45 p.m. with YDS E revealed: *She worked on the PRTF unit and did the med pass when she worked. *On the PRTF the med cart was located inside of a closet by the resident room *She should have been replaced by another YDS while passing meds so she could have concentrated on just that task. *She would have to make sure they took their meds and got the right meds. -That process had been difficult to do when she was not replaced by another YDS *She stated: -"I'm rarely if ever replaced and I constantly have to stop the med pass, lock the closet door and assist with a resident or check on someone." -"When I was trained I was told I was not considered a part of the staff on the unit during that time because of possible errors to happen." -"The residents need to be watched and should be in the group area and not going to the bathroom to make sure they aren't throwing them up." -"I'm not sure of the policy but I think they are supposed to all be in the group area and quiet at that time." -"We are supposed to do five-minute checks [on the residents] when they are in their rooms before the scheduled bedtime." -"I understand if I have to stop for an emergency, but otherwise I'm not to be part of the staff at that time." -"We rarely have a float and are so short staffed." *Regarding resident 1: -"She has many many episodes of self-isolating herself and doesn't like to engage." -"She does this all the time and randomly hurts	N 100	Continued from page 8. incident if the incident required physical intervention. • Should a staff member not be able to be present for the group debrief, an individual debrief must be scheduled with them within 24 hours and occur in no more than 72 hours. • Group staff debrief will assess the necessity of the intervention, the efficacy of the intervention, improvements that could be made, assessment of ethicality of the intervention, and compliance with policy and procedure. • This debrief will also assess the need for retraining or re-education. The person completing the assessment will take input from the staff involved, but ultimately will review the disclosed information to SCM trainers and Supervisors to create a plan for education and training.	

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N 100	Continued From page 9 herself by cutting in the bathroom." -"She refused her meds that night and didn't want to engage with me. Kind of blows you off." -"She was lying on the floor when in her room and had her arms and hands crossed and on her chest." -"Normally she doesn't respond but she told me to go away when I checked on her." -"I showed [LCC D's name] with my hands that I thought she was trying to choke herself because of how her arms and hands were." -"I was told to check on her and that's when she told me to go away." -"I was then told to go back to doing my meds." -"I'm not sure why [YDS F's name] was on the unit I was just trying to focus on giving the meds." -"We had a training exercise recently after another resident but not after this one so if there were any more changes I'm not aware of them." Interview on 2/14/24 at 3:50 p.m. with YDS F regarding resident 1 revealed: *He was working in the ARU that night but had switched with YDS G to assist with de-escalating one of the residents in that unit. *There should have been two staff members on the unit at all times. *Someone was supposed to step-in during med pass and that would have totaled three staff in the unit. *All the residents were to have been in the group area during med pass -There should have been three staff total on the unit during a med pass. *He had worked with the resident when she was in the ARU but because of her attempts at self-harming she had been moved to the PRTF. *He knew she was a suicide watch and had to be with her at all times.	N 100	Continued from page 9. • A form will be utilized to document the need, or lack thereof, for re-training or re-education. • Upon completion of re-education, a re-education completion form will be filled out and submitted to their employee file. Once approved, staff will be trained on these forms and this procedure in the weekly training on 3/13/24. Staff who are not in attendance will be scheduled for follow-up with the PRTF Case Manager to ensure consistency.	3/13/24

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N 100	Continued From page 10 *He was not aware that she had tried to strangulate herself. *She had been down that night [2/3/24] and didn't interact with him much but that was not uncommon. *After an incident there was supposed to have been a debriefing with all the staff involved. *There had not been a debriefing after the incident involving the resident on 2/3/24. *He stated: -"I didn't even know it was a thing with her or that she tried to strangulate herself and yes I should have known." -"All I knew was that she was on suicide watch an nothing else." -"She went to the bathroom and I saw what looked like a type of razor burn on her neck and it was red but didn't know she had wrapped a pillowcase around it." -"I'm not sure if they can have the pillowcases back after they attempt suicide with it." -"There was no debriefing that I'm aware of and we are supposed to." -"We had a recent training after another similar incident like this but no, nothing since and no process changes or re-education that I know of." Interview on 2/14/24 at 4:30 p.m. with YDS G regarding resident 1 revealed: *She was the shift lead for the YDS employees. *During med pass: -Two YDS staff should have been on the unit watching the residents while another YDS staff passed meds. -It is a quiet time on the unit, all the residents should have been in the group area, and sitting in their assigned chairs. -The residents should not have been allowed to go in and out of their rooms during that time.	N 100		

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N 100	Continued From page 11 *She confirmed that the resident: -Will have episodes when she was quiet and self-isolated. -Would become anxious and had difficulties with loud voices and she often would sit with her until she calmed down. *She had to go to another unit that night to help with a de-escalation of a different resident. *When she returned to the unit a resident had told her that [resident 1] was gasping for air. -She checked on the resident and she was talking to another resident. *She had to leave the unit again and when she returned the resident was in the bathroom. *She opened the door because the resident had not responded when checked on. -That was when she noticed the bruising on the resident's neck and her puffy eyes. -The resident then admitted to her what had happened. *She assigned the resident to YDS F while she had made a phone call to the nurse. *She stated: "When someone refuses their meds we are supposed to do five-minute checks [visualize the resident, make sure they respond, and that they are breathing]." *She would have expected: -LCC D to have kept control of the unit while YDS E passed her meds. LCC D would have been considered the float staff. -YDS E to have stopped passing meds and complete the required five-minute checks if LCC D was not doing them. *She stated: -"When the residents are in their rooms they [the YDS staff] have to do those five-minute checks." -"[Resident 1] does have pillowcases on her pillows but that night she had an extra one and I'm not sure where she got it."	N 100		

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N 100	Continued From page 12 -"Maybe from her roommate, but I don't know." -"I'm not sure if there was education or a debriefing after this, but I do know that [LCC D's name] did say she should have done more frequent checks." -"We work frequently with a float so we can't leave the unit during our shift." Interview on 2/15/24 at 1:55 p.m. with nurse coordinator B revealed: *The unit should have been in quiet time during the med pass. -All the residents should have been in their assigned chairs during that time. -When the YDS staff was passing meds they were not considered a part of the staff. -The YDS would return as part of the staff in the unit once all the meds were administered. *She was aware that there was not always an assigned float staff. *She stated: -"That is an ideal situation but we are battling at keeping it fully staffed." -"Technically that night they were fully staffed and I can't speak to the communication between those three that night." -"But I would have expected them to be clear on who was doing what." -"There should have been a debriefing and education after this incident and I don't know why there was not." -"I would need to follow-up with the [PRTF supervisor A and LCC D] on the debriefing and education maybe it just wasn't documented." -"I know not documented, not done." -"I do know we were just recently informed that if a resident is in their room they must be checked on every five-minutes."	N 100		

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N 100	Continued From page 13 Interview on 2/15/24 at 2:35 p.m. with PRTF supervisor A revealed: *She confirmed: -Residents were to have been checked on every five-minutes while they were in their rooms. -Residents should have been in their assigned chairs and quiet during the med pass. -There had not been a debriefing for [the 2/3/24 serious occurrence involving resident 1] and she was unsure as to why. -There had not been any process changes or re-education completed with the staff after the incident with resident 1. *The residents had to have pillowcases on their pillows because the pillows were not cleanable. *She gave no comment as to why YDS G left the PRTF unit that she was assigned to instead of LCC D. Review of the provider's May 2023 Staffing policy revealed: *There was no documentation to support the following: -How many staff should have been on the PRTF unit during the med pass. -The process of who should have remained in the unit or leave the unit when another unit required assistance. Review of the provider's 2/28/23 Supervision policy revealed: *"Every youth will be observed by the person responsible for their care at least every 15 minutes." *More observations may be indicated if the youth is suspected or assessed to be a risk. *There was no documentation or processes to support the following: -What process the staff should have followed to	N 100		

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N 100	Continued From page 14 ensure the safety of the residents during the med pass. -The process for monitoring and observing a resident who was in their room before bedtime, during med pass, and after bedtime. Review of the provider's 2/28/23 Debriefing and ESI follow-up policy revealed there was no documentation to support the staff were required to have been debriefed after a serious occurrence or ESI to ensure the processes and policies that were in place had been followed. No policy or procedure was found to support the process on the PRTF unit during medication pass.	N 100		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and	N 145	Per N145, Licensed Practitioners were trained in the protocol following Emergency Safety Interventions and the necessary steps that must be taken. The training occurred on 3/5/2024. This protocol specifies that when there is an ESI, Licensed Practitioners, if not the nursing coordinator, will call and notify the nursing coordinator of the incident. Licensed Practitioners will respond to the building within one hour to conduct a face-to-face assessment with the client and debrief about the incident immediately following the face-to-face assessment. Following the assessment and debrief,	3/5/24

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N 145	Continued From page 15 (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the policy for two of three sampled residents (3 and 5) who required an emergency safety intervention (ESI) with use of a restraint had a face-to-face evaluation by a licensed practitioner, licensed professional counselor, or a registered nurse within one hour of the initiation of the restraint had been followed. Findings include: 1. Review of resident 3's 2/5/24 Comprehensive Incident Report form revealed: *The resident required two emergency safety interventions (ESI). *The first ESI was initiated at 10:17 a.m. and ended at 10:18 a.m. *The second ESI was initiated at 10:19 a.m. and ended at 10:21 a.m. *She required an upper torso (chest area) hold that was then extended into a kneeling hold. -The first ESI was initiated at 10:17 a.m. and ended at 10:18 a.m. but then was extended into the second ESI which was initiated at 10:19 a.m. and ended at 10:21 a.m. *Documentation on the ESI written order form revealed no documentation to support the following: -A face-to-face evaluation and assessment of the resident had occurred within one hour of the initiation of the first restraint. -The resident was assessed for her safety to determine her physical and mental status was during and after the ESI. *There was no documentation to support the	N 145	Continued from page 15. all documentation from the Licensed Practitioners will be entered into Simple Practice and forms will be turned in to the Data Entry Specialist upon completion. The incident report associated with the ESI will then be updated to reflect the face-to-face and debrief being completed.	

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N 145	Continued From page 16	N 145		

nurse or the physician were notified of that occurrence.

Interview on 2/15/24 at noon with crisis care director C regarding notification of staff when an ESI occurred revealed she knew that the nurse or the on-call physician should have been notified. She was not aware the staff/resident debriefing and the face-to-face evaluations were two separate assessments.

Surveyor: 45383
2. Review of resident 5' 2/6/24 Comprehensive Incident Report form revealed:
*She required an ESI that had begun at 10:44 a.m. and ended at 10:52 a.m.
*After the ESI she complained of abdominal pain and was hyperventilating (breathing fast).
*During the ESI she required the following holds:
-An upper torso to seated kneeling hold.
-Bicep (upper arm muscle) assisted standing hold.
-Two-person upper torso hold until law enforcement arrived.
*Documentation on the report indicated staff that received that notification included:
-Clinical coordinator H.
-Parent/Guardian.
-Lead clinician, counselor, and supervisor A.
*There was no documentation on the form that a nurse or the physician were notified.

Interview on 2/15/24 at 1:35 p.m. with nurse coordinator B regarding the assessment of resident 5 before leaving the facility revealed:
*She was informed of the ESI and her complaint of abdominal pain.
*She documented her assessment of the resident in the EMR.

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N 145	Continued From page 17 *She stated: -"I may not have documented in a timely manner and I should." -"I know if it's not documented it's not done." *She confirmed she had not been notifying the physician of all the ESI's that had been ordered or occurred per policy. Review of the provider's 3/27/23 Emergency Safety Procedures policy revealed: *"For all units, you must notify the Licensed Practitioner (LP) FIRST to receive approval for an ESI order, followed by the on-call counselor." *"The general procedure all units are as follows: -Staff must call the on-call Licensed Practitioner (LP) within 5 minutes after the initiation of an ESI. A calendar and contact information will be attached to the unit clipboard. -The on-call LP must come to Wellfully and conduct a face-to-face assessment with the client placed in an ESI or seclusion within the hour of the initiated ESI or seclusion. -The LP will assess the client's physical and psychological status, behavior, appropriateness of the intervention measures and any complications resulting from the intervention. -The assessment must affirm the client's rights, confirm that the ESI or seclusion was necessary and appropriate. -Notation of the assessment will be placed in Simple Practice immediately following the assessment. The Simple Practice documentation will be included with the ESI forms given to the compliance specialist."	N 145		
N 214	EDUCATION AND TRAINING CFR(s): 483.376(a) The facility must require staff to have ongoing	N 214		

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N 214	Continued From page 18 education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure all staff were re-educated on the processes for monitoring and routine surveillance of residents to ensure their safety had occurred after one of one sampled resident (1) attempted self-harm while remaining in her room during medication (med) pass. Findings include: 1. Review of resident 1's electronic medical record revealed: *She was admitted to the Alcohol Rehabilitation Unit (ARU) on 9/14/23 and then was transferred to the Psychiatric Residential Treatment Facility (PRTF) on 12/12/23. -There was no documentation to support why she was transferred to a more secure area [PRTF]. *She had a history of depression, post-traumatic stress disorder, substance abuse, headaches, auditory hallucination of voices that told her to do bad things, and a history of self-harm. *On 2/3/24: -At 8:30 p.m. she attempted self-harm by strangulation with the use of a pillowcase. -Through staff interviews she verbalized continuing desire to commit self-harm and was transferred to the local hospital and was admitted to the behavioral hospital. *On 2/8/24 she was re-admitted to the PRTF. Review of the provider's 2/5/24 Serious Occurrence Report regarding resident 1 revealed: *She was 15 years old and was admitted to the PRTF on 12/12/23. *On 2/3/24 the resident made comments of	N 214	Per N214, policy and documentation of staff re-education has been updated as seen in the updates under N100. Staff will be educated on room-time expectations and med-pass time expectations stated above on 3/6/24. Staff will be educated on the new policy of staff re-education including forms on 3/13/24 following approval. Staff who are not in attendance will be scheduled for follow-up with the PRTF Case Manager to ensure consistency.	

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N 214	Continued From page 19 wanting to harm herself. *She had tried to strangulate herself by wrapping a pillowcase around her neck. *Those acts had not been witnessed by the staff but verbalized by her. *She was in her room alone and lying on the floor with her hands on her chest during observations made by the staff. *The staff had observed petechiae (red marks) and bruising around her neck. *"[Resident's name] was not on any safety watches and was not showing any kind of behaviors that would have warranted a safety watch. Review of the 2/5/24 Quality Assurance Committee Incident Review Form revealed: *"Were any staff given continued education due to the incident?" -Comment written in under the question were "Staff involved will need trained on the full, proper policy for checking on clients. Supervisors will be notified." *There was no documentation to support: -When and if the staff involved with the incident had been educated. -Why all staff were not required to be educated. Interview on 2/14/24 at 10:10 a.m. with PRTF supervisor A confirmed the staff were required to complete five-minute checks on the residents when they were awake and in their rooms per policy. Interview on 2/14/24 at 2:05 p.m. with LCC D regarding the serious occurrence of resident 1 revealed: *There was no re-education or trainings provider after that event with the resident.	N 214		

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N 214	Continued From page 20 *No procedure or process changes that she had been aware of. Interview on 2/14/24 at 2:45 p.m. with YDS E revealed: *She had been doing med pass on the PRTF when the incident with resident 1 had occurred. *Per policy residents required to be checked on every five minutes when they had been in their rooms before bedtime. *She stated: -"We had a training exercise after another resident had a similar incident but not after this one." -"If there were any changes made I'm not aware of them." Interview on 2/14/24 at 3:50 p.m. with YDS F regarding resident 1 revealed: *He had been working in the ARU that night but had switched with YDS G to help de-escalate one of the residents in that unit. *He stated: -"There was no debriefing that I'm aware of and we are supposed to." -"We had a recent training after another similar incident like this but no, nothing since and no process changes or re-education that I know of." Interview on 2/14/24 at 4:30 p.m. with YDS G regarding resident 1 revealed she: *Was the shift lead for the YDS employees and had worked the evening of the incident with the resident. *She stated: "I'm not sure if there was any education or trainings following this incident." Interview on 2/15/24 at 1:55 p.m. with nurse coordinator B revealed:	N 214		

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N 214	Continued From page 21 *She confirmed there should have been education provided for all staff after this incident. *She was not aware as to why there was not education and training following this incident. *She stated: -"I would need to follow-up with [PRTF supervisor A and LCC D] on the education maybe it just wasn't documented." -"I know not documented, not done." Interview on 2/15/24 at 2:35 p.m. with PRTF supervisor A revealed she confirmed there was not any process changes or re-education provided to the staff following the incident with resident 1. Education or re-training on policies and procedures should have been completed per the provider's policy. Review of the provider's 2/28/23 Education policy revealed no documentation to support the processes for re-education or training requirements following a serious occurrence or ESI.	N 214		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 000}	Initial Comments An onsite revisit was conducted on 3/28/24 for deficiencies cited on 2/15/24. All deficiencies have been corrected, and no new noncompliance was found. Wellfully is in compliance with all regulations surveyed.	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.