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 _____	03/11/2026

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

(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 A recertification survey for compliance with 42 CFR, 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 on 03/10/26 through 03/11/26. Wellfully was found in compliance. A complaint survey for compliance with 42 CFR 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 03/10/26 through 03/11/26. The area surveyed was the resident assessment and treatment plan. Wellfully was found in compliance.	N 000		

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

Bob Burke - Program Director | 3/25/2026

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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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 483, Subpart G, Subsection 441.184, Emergency Preparedness, requirements for Psychiatric Residential Treatment Facilities, was conducted from 03/10/26 through 03/11/26. Wellfully was found not in compliance with the following requirement: E0004.	E 000		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 441.184(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must	E 004	The following changes have been implemented: On 3/24/2026, the Wellfully Management Team (Program Director, Associate Program Director, Human Resources Coordinator, Maintenance Coordinator, Clinical Coordinator, Adolescent Crisis Care Coordinator) met and reviewed the Emergency Preparedness Plan. Moving into future, the Management Team will review the Emergency Preparedness Plan on the first Tuesday of every month indefinitely. Review and revision information will be documented by the Maintenance Coordinator. Reporting to the QAPI will be done by the Maintenance Coordinator.	3/24/2026 and ongoing.

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

Bob Burke - Program Director | 3/24/26

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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E 004	Continued From page 1 develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on review of the facility's Emergency Preparedness (EP) plan and interview, the facility failed to ensure completion of a review of the EP plan at least every two years or as needed. This failure had the potential to create a delayed response during an emergency due to the use of outdated information and training, and had the potential to place all nine residents receiving in-center treatment at this facility at risk of harm. Findings include: 1. Review of the October 23 revised "Wellfully Safety and Security Plan revealed that all documents attached to the plan were last updated in October of 2023. The policies and documentation of drills revealed no other date of review or revision. 2. Interview on 03/11/26 at 10:15 a.m. with maintenance coordinator B revealed he had been	E 004		

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E 004	Continued From page 2	E 004		

employed at the facility since 9/25/24. The only drill that was performed was an active shooter drill completed on 10/8/25. He had not reviewed the EP plan since he started at the facility. He was not aware of how often the EP plan needed to be reviewed. He agreed there was no documentation confirming any other date of review other than October 2023.

3. Interview on 3/11/26 at 1:30 p.m. with program director A revealed that the continuous quality improvement (CQI) committee that was formed as a suggestion of the last survey was no longer functioning because most of the staff no longer worked there. The CQI committee was responsible for reviewing and revising the emergency preparedness (EP) plan. He was not aware that the EP plan needed to be reviewed every two years. Maintenance coordinator B and program director A would reference the EP plan multiple times a month, they just did not document their actions. He confirmed the EP plan was last reviewed in October 2023.

4. Review of the EP plan revealed "Our CQI committee will meet quarterly to review any issues that may come up and will review the results of our various drills that have been conducted and problem solve any areas of concern. Any staff member can talk about recommended changes to the plan to a committee member, and any committee member can make recommendations for changes to the committee."