DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 01/07/2025

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 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 on 1/6/25 through 1/7/25. Wellfully was found not in compliance with the following requirement: N215.	N 000	The following changes were made: 1. Wellfully Case Manager will train staff at monthly all staff meeting in what constitutes contraband, procedures on ensuring cabinets and laundry doors are locked, and contraband is secured or immediately removed from the unit at all times on a PRTF. These trainings will occur on 1/29/2025, clinical staff in the clinical meeting on 1/22/2025, and Youth Development Specialist meeting on 1/22/2025. Documentation of these trainings will be kept by the Case Manager. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Case Manager within 7 days. 2. Wellfully Clinical Director will train staff at monthly all staff meeting on effective communication and Wellfully moving procedures on 1/29/2025, clinical staff in the clinical meeting on 1/22/2025, and Youth Development Specialist meeting on 1/22/2025. Documentation of these trainings will be kept by the Case Manager. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Clinical Director or Case Manager within 7 days. 3. An alarm was ordered for the storage pod door on 1/17/2025. It is scheduled to arrive on 1/22/2025 and will be installed on 1/24/2025. Locking doors have been installed on all the rooms in the storage pod on 1/15/2025.	2/20/2025
N 215	EDUCATION AND TRAINING CFR(s): 483.376(a)(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations; This ELEMENT is not met as evidenced by: Based on a South Dakota Department of Health (SD DOH) complaint review, observation, interview, record review, video observation, psychiatric treatment residential facility (PTRF) unit staff daily responsibility log review, and policy review, the provider failed to ensure: *One of one sampled client (1) who had a history of suicidal ideation (SI) and self-harm (SH) had been protected from SH by staff during one of two SI/SH attempts. *The PRTF unit was maintained, and unit staff training and policies were followed, in a manner to prevent client access to contraband items during two of two SH attempts by one sampled client (1), and one of two PRTF unit observations which identified all the PRTF clients to be in an unsafe living environment. *Unit staff education had been provided following three of four incidents that involved two of six sampled clients (1 and 5) and occurred on	N 215		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 1/20/25

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 215	Continued From page 1 12/20/24 and 12/31/24. *Communication between coworkers (A, B, C, D, E, G, H, I, J, and K) had been effective in preventing confusion and an unsafe environment for one sampled client (1) and all the clients who resided in the PRTF during a PRTF unit move that occurred on 12/31/24. Findings include: 1. Review of the SD DOH complaint intake regarding two comprehensive incident reports dated 12/20/24 and 12/31/24 revealed: *On 12/20/24 at approximately 6:00 p.m. client 1 was put on a self-harm (SH) watch by a counselor, then client 1's behavior escalated. She attempted to grab at "anything to put around her neck" and was "throwing herself into walls and banging her head." Staff had been successful in preventing her from causing SH. She was removed by police and taken to a local hospital for a suicidal ideation (SI) evaluation. -Review of the 12/20/24 comprehensive incident report revealed that while on the PRTF unit, client 1 had attempted to use towels, a medication computer charging cord, and a vacuum cord, as potential neck ligatures. She had also "grabbed a tote [from] above a snack cabinet." -A debriefing form completed by staff members on 12/20/24 at 7:16 p.m. identified a need to "Get the cabinet locks fixed" and "having secure places (more) to store items" as assistance that was needed to prevent the recurrence of similar incidents in the future. *On 12/31/24 at approximately 11:30 a.m. client 1 was having escalating behaviors during the process of the PRTF clients moving into a larger, newly repaired, PRTF unit. She went into a bathroom on the larger unit that did not have an installed door handle and was able to grab a	N 215	Continued from page one. 4. To ensure continuity of care during the holiday seasons, If regularly scheduled meetings fall on an agency holiday, the meetings will be rescheduled to two days prior to the holiday. Unit Coordinators will be responsible for ensuring these changes in scheduling. This change was documented in the Youth Care Worker manual on 1/17/2025 and staff was informed of this change at the Youth Development Specialist meeting on 1/22/2025 by the Unit Coordinators. Documentation of this will be kept by the Unit Coordinators. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Unit Coordinators within 7 days. 5. A procedure has been created that every Youth Development Specialist coming on shift will complete a checklist that includes ensuring that all cabinets on the PRTF are locked, laundry doors are locked, closet doors are locked, cleaning supplies and vacuum are locked up, all client pencils are accounted for, sharps are counted and locked up, and the unit is free of contraband. These documents will be collected and reviewed daily by the Unit Coordinators. On 1/22/2025, They will also review responsibility sheets and incident reporting with staff on this date. This change was documented in the Youth Care Worker manual and added to the YDS training checklist on 1/17/2025. Unit Coordinators will train Youth Development Specialist staff of this change at the Youth Development Specialist meeting on 1/22/2025. Documentation of this training will be kept by the Unit Coordinators.	

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N 215	Continued From page 2 metal screw that had been left on the counter by a maintenance worker and swallowed the screw. -A debriefing form completed by staff members on 12/31/24 at an unknown time identified her escalating behavior began during a "move from one unit to another." The interventions listed to prevent the incident were "not changing units today" and "give multiple choices otherwise." The procedures listed to prevent a recurrence of similar incidents in the future were "coordination with staff and improving protocol for moving." 2. Observation and interview on 1/6/25 from 2:15 p.m. through 2:45 p.m. with Unit Coordinator (UC) (C) during a walk-through of the PRTF unit revealed: *The PRTF clients were in the unit and were on a holiday break until school resumed on the next day on 1/7/25. -There were seven clients in the main living area watching television and one client lying in bed in her room. -Two PRTF unit staff members were sitting at a desk in the main living area observing the clients. *Observation of the storage area located behind an unlocked door adjacent to the main PRTF unit living area revealed an unused wing of PRTF client rooms, a small central area, and a fire escape door and stairwell that led to an outdoor exit. -The fire escape door had an alarm system that would sound if it was opened. -The inside door separating the storage area from the main client living area was not alarmed or locked. UC C stated the inside door could not have been locked because of the fire exit door's location. -He was unsure why the inside door did not have an alarm system to alert staff to the storage	N 215	Continued from page 2. Follow-up training for those unable to attend the YDS meeting on 1/22/2025 will be conducted and documented by the Unit Coordinators within 7 days. Quality Assurance Director will conduct random audits of this documentation weekly for four weeks, monthly for two months, then quarterly after that. 6. Unit Coordinators and/or Shift Leads will begin to do one random visual audit on each shift of staff on the PRTF to monitor Youth Development Specialists' competencies and compliance as stated in their job descriptions indefinitely beginning 1/20/2025. Unit Coordinators and/or Shift Leads will report their findings to the Clinical Director. 7. On 1/20/2025, Wellfully's Contraband List was updated to include how often the staff were to ensure contraband was to be kept inaccessible to clients. Staff will be updated on this change by the Case Manager at the all staff meeting on 1/29/2025, clinical staff in the clinical meeting on 1/22/2025, and the Youth Development Specialist meeting on 1/22/2025. Documentation of these trainings will be kept by the Case Manager. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Case Manager within 7 days. 8. On 1/20/2025. Wellfully's Youth Supervision policy was updated to include environmental sweeps for contraband or potentially dangerous items. Staff will be updated on this change by the Case Manager at the all staff meeting on 1/29/2025, clinical staff in the clinical meeting on 1/22/2025, and Youth Development Specialist meeting on 1/22/2025.	

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N 215	Continued From page 3 area's door being opened and stated staff were instructed to always keep that door within sight. -He stated if a client had entered that space, it would have been considered an AWOL (away without leave) incident and interventions would be initiated with the client. *The central area of the storage room contained multiple miscellaneous boxes of clothing, a plastic garbage bag full of unidentified objects tied with the bag's plastic ties, a hard plastic door file holder, various boxes filled with supplies, and totes of miscellaneous items that included holiday decorations and strings of electric decorative lights. -The storage area's bedrooms had some of the bedrooms locked. Some bedrooms had no doors and contained office furniture, beds, mattresses, and more holiday decorations. -UC C confirmed the storage area was within direct access to the clients and contained many items that could be used by clients as strangulation, suffocation, and cutting devices. *Observation of the main living area of the PRTF revealed: -An unlocked, large, upright metal cabinet behind and to the left of the staff desk that contained various items such as charting binders, a corded charger, a woman's purse, a Keurig-style coffee pot with cord, and miscellaneous staff supplies. An unidentified male staff member stated he had just pulled a binder out to look up a number and would lock the cabinet once he returned the binder. -UC C stated the metal cabinet should have been locked as it contained confidential client information and staff supplies. *Two laundry room closets had roll-down locking door mechanisms. UC C stated the doors were to remain locked unless staff or a client was using	N 215	Continued from page 3. Documentation of these trainings will be kept by the Case Manager. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Case Manager within 7 days. 9. On 1/20/2025, Wellfully's Emergency Safety Intervention (ESI) policy was updated to include staff education following an ESI. Staff will be updated on this change by the Case Manager at the all staff meeting on 1/29/2025, clinical staff in the clinical meeting on 1/22/2025, and the Youth Development Specialist meeting on 1/22/2025. Documentation of these trainings will be kept by the Case Manager. Follow-up training for those unable to attend the meetings listed above will be conducted and documented by the Case Manager within 7 days.	

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N 215	Continued From page 4 the washer or dryer. -The door to the laundry room closest to the main living area was unlocked and when the door was rolled up, it revealed the dryer had three liquid detergent pods, a box of dryer sheets, and liquid laundry sanitizer sitting on the top's surface. Neither machine was running. -UC C stated he was unsure why it was unlocked unless a client had been washing clothes that morning. *Observation of a sink and countertop with locking cabinets and drawers located in the client's main living area revealed: -The cabinet under the sink was unlocked and contained several opened boxes of latex gloves, four liquid laundry detergent pods, two large jugs of Argon Oil shampoo, and a partially empty plastic jug of "Lice Out" liquid. There was a tote tub full of bathroom cleaning supplies that included bathroom sanitizers, Windex window cleaner, Irish spring soap, and a bottle of body lotion. -UC C confirmed the soaps and lotions should not have been with cleaning supplies and the cabinet should have been locked. -A pull-out drawer was unlocked and contained several small approximately four-ounce thick rubber cups with numbers on them and two bottles of body lotion. -An upper left-hand cabinet was unlocked, and it contained the client's plastic totes of hygiene and personal care supplies. -UC C confirmed they should have also been locked. *The inside basin of the handwashing sink contained a soiled plastic plate, a soiled metal fork, and a metal table knife. -UC C stated if a client was ill and ate on the unit, staff were to return the tray and silverware to the	N 215		

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N 215	Continued From page 5 kitchen immediately after use. He stated he thought those items had been left by a staff member who had eaten on the unit. -He informed the PRTF clients ate in the main dining room and were "wanded" with a hand-held metal detector wand before coming back into the PRTF unit. -He confirmed the metal silverware was less than five feet away from the clients and could have been utilized by clients as weapons. He immediately removed those items from the unit following the tour. 3. Review of client 1's electronic medical record (EMR) revealed: -She was a 14-year-old female who was admitted on 12/2/24 with the diagnoses and conditions of: generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), depression, attention deficit hyperactivity disorder (ADHD), cannabis substance abuse, and hallucinogen use disorder. She had a self-reported history of mental, verbal, and sexual abuse. She had been in treatment for psychiatric issues twice in the past and had a history of elopement from those facilities. Her guardian was DSS and previous placements in foster care had been unsuccessful. -She self-reported a one-year history of substance abuse with two previous overdoses of ibuprofen and Benadryl. She had seizures for a brief period following the ibuprofen overdose and heart palpations related to having used a previously prescribed medication. She self-reported "liver issues" and identified using alcohol, cannabis, fentanyl, Ketamine, LSD (hallucinogenic), and wax (marijuana wax, a marijuana concentrate). -Her 12/7 through 12/16/24 treatment plan was	N 215		

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N 215	Continued From page 6	N 215		

completed promptly, addressed all the above issues, and had appropriate goals and approaches for treatment.
-Following her first SH/SI attempt on 12/20/24 she had two Collaborative Assessment and Management of Suicidality (CAMS) Suicide Status Form assessments performed on 12/24 and again on 12/25/24 following her readmission the afternoon of 12/23/24. She was assessed to be at low risk for suicide and was not on any type of SH/SI watch at the time of her second attempt on 12/31/24.

4. Interview on 1/7/25 at 10:35 a.m. with UC C revealed:
*He confirmed there were no current clients on any type of safety watch. He stated, "We have a really good client population right now."
*He stated:
-Staff had to complete daily responsibility sheets every shift and those sheets included monitoring the rooms and environment for contraband items and ensuring cabinets and supplies were locked. A copy of those sheets from 12/20/24 through the present day was requested.
-The counselors and leadership made random checks of the PRTF unit at least twice a week and unit staff were to complete a sweep of the common area three times a day. Video monitoring by leadership had also occurred.
-He felt the staff's complacency and the over-trusting of clients were an issue and confirmed facility policies and procedures were not being consistently followed by unit staff.
*He confirmed that no staff education had occurred following the 12/20 or the 12/31 incidents as their normal youth development specialist (YDS) meeting day was on Wednesdays, and the last two Wednesdays were

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N 215	Continued From page 7 on Christmas and New Year's Day. He stated YDS staff were going to meet tomorrow (Wednesday 1/8/25) to discuss the "failures of the 12/31/24 event" and to re-educate staff on facility protocols. -He confirmed there were no discussions on holding the YDS meetings on a different day during this holiday period. *He thought the metal utensils that had been in the sink on 1/6/25 were from a previous night shift staff member. He was concerned those items had continued to sit in the sink for the morning and early afternoon the following day. -He stated he was "very upset with the actions of the unit staff." *He agreed the clients were a vulnerable population and had depended on staff to ensure their safety. 5. Interview and video monitoring on 1/7/25 from 10:40 a.m. through 11:30 a.m. with administrator A, clinical director B, and counselor J, regarding client 1's 12/31/24 SH/SI incident revealed: *Administrator A stated he was "pretty sure" maintenance director H had completed a safety sweep of the unit before the move back into the larger unit. He stated: -He was in meetings and "staff and clients had started moving before he could get up there [to look things over]." -Maintenance director H was aware of what contraband was but could not recall if he had received any training on that subject. -Maintenance director H had told staff he would be done with repairs on the larger unit by Monday night (12/30/24) and they could move in on Tuesday (12/31/24). *Review of the 12/31/24 video footage of client 1 and the PRTF's move into the larger unit from a	N 215		

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N 215	Continued From page 8 timestamp of 11:19 a.m. to 12:22 p.m. revealed: -11:19 -11:20 a.m. Maintenance director H arrived at the larger unit and was in and out of the bathroom which did not have a door handle. -11:20 a.m. Maintenance director H was also moving around the unit assisting UC C with moving beds and securing plywood to a bedframe. During this time, staff and clients arrived and went back and forth from unit to unit moving personal belongings and clothing that was bundled up in bedding. The scene appears chaotic. The bathroom door remained without a handle. -Administrator A informed the surveyors, "Not sure why clients are helping with the move as the initial plan was to not have clients help with the move. The plan was not followed, and all of management was in a meeting when this occurred." -11:24 a.m. A staff member was seen walking 1:1 with client 1 from the hallway into the larger PRTF unit and was observed walking into her bedroom and all over the main living area with a staff member following her. -Clinical director B stated client 1 was starting to show behaviors before the move, so a staff member was monitoring her one-on-one. -11:26 a.m. The upright metal cabinet was observed to be unlocked, unmanned, and sitting open with supplies inside, while staff and clients moved about the unit. -11:29 a.m. Client 1 ran into the bathroom that did not have a handle (to the right of the staff desk) and attempted to slam the door shut. Care coordinator E was seen sticking her foot in the door to block it and then going into the bathroom and placing objects in her pants pockets. Care Coordinator G entered the bathroom. Maintenance director H peaked his head into the	N 215		

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N 215	Continued From page 9 bathroom. Staff called for assistance. -11:30 a.m.(approximate) Unit staff and leaders escorted the other clients back to the smaller PRTF unit while several staff remained in the large unit's central area. -Clinical director B stated that was when a call was placed for medical advice, and a decision was made for a mobile medic to be summoned because she had put a metal screw in her mouth and was either attempting to swallow it or had swallowed it. -11:32 a.m. Client 1 left the bathroom, went into her room, began to throw clothing into a pillowcase, while walking around in her room. She was continually observed by staff in the doorway. -11:35 a.m. Client 1 went to the handwashing sink and had her back to the camera but appeared to attempt to drink from the faucet. She was blocked by a staff member, then she quickly walked over to the windows. -11:35-36 a.m. Client 1 wandered around the central area and then quickly walked over to the unlocked metal cabinet and removed a half-empty blue colored drink (Gatorade-type bottle) from the metal cabinet and walked over to the windows in the central area. There were no staff observed that attempted to block her from the metal cabinet. She was seen putting her hand to her mouth and then tipped her head back while she took a large swallow of the drink. -Clinical director B stated it is believed that was when she successfully swallowed the screw. -11:37 a.m. Client 1 placed the drink on the staff desk and returned to her room. Several staff were standing in her doorway and a multitude of staff were in the central area observing and recording. -11:44 a.m. Maintenance director H was seen coming back onto the unit with more hardware in his hands and went into the bathroom that did not	N 215		

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N 215	Continued From page 10 have a handle. -11:46 a.m. A mobile medic arrived and went into the client's bedroom to speak with client 1. -11:47 a.m. The medic left her room and spoke with staff members E and I in a room located several doors away from the client. -11:50 a.m. The mobile medic left the unit. -11:55 a.m. Client 1 rolled off her bed, onto the floor, and rolled under her bed to be out of reach from staff. Staff removed her bed and frame from the room. -Clinical director B stated that was when Client 1 was told by staff she was being put on a safety watch. -11:58 a.m. Client 1 exited her room voluntarily. -11:59 a.m.-12:01 p.m. Client 1 was allowed to leave the unit with staff and an attempt was made to return her to the smaller unit where the other clients were located. In the hallway, she began to become very agitated and was repeatedly attempting to access the counselor's hallway and the elevator. She was body-blocked by staff. She quickly moved all around the hallway while trying to open doors and she came near the stairs several times. Staff body blocked her attempts. She attempted to grab a Wii gaming system cord and place it around her neck. The Wii and cords were immediately removed by staff and placed into a locked area. -12:01 p.m. She told a staff member she wanted to kill herself and then ran, with her head forward, toward a door. That was when staff intervened physically, and the ESI began with three staff placing her into an upper body biceps hold. Four staff stood by observing and documenting. She lowered herself onto the floor and the staff lowered down to the floor with her. After several minutes they reduced to a two-person hold, and then once she calmed down further one person	N 215		

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held her.
-Clinical director B stated that was when 911 was summoned.
-12:08 p.m. The ESI was removed, and she sat leaning independently against the wall while UC C sat in a chair and calmly talked to her. UC C informed staff she complained of "chest pain due to swallowing that damn screw." Registered nurse I briefly assessed the client as she sat in the hallway.
-12:22 p.m. An officer arrived and spoke with client 1. She voluntarily left the building with the officer at that time.
*During the viewing of the video, administrator A and clinical director B identified and confirmed areas of needed improvement were:
-Maintenance director H had hardware supplies and tools in the larger unit while PRTF staff, along with the clients, were moving into the unit all at the same time.
-The clients were active participants in moving and administrator A stated they were not supposed to be assisting staff with the move.
-The moving of beds, supplies, and client belongings occurred all at once, and it caused a chaotic environment of staff and client movement between both PRTF units.
-That chaotic environment was a potential trigger of increased behaviors with client 1 who had PTSD and anxiety.
-The bathroom to the right of the staff desk did not have a handle lock installed, and its hardware was left sitting unattended on the bathroom counter.
-Staff had also left the upright metal cabinet unlocked allowing the client to access a drink, thus enabling her to swallow the screw.
*Administrator A stated the first youth development specialist (YDS) staff meeting since

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N 215	Continued From page 12 those events had occurred was scheduled for 1/8/25. He confirmed no educational meetings were held for several weeks because the holidays occurred on the scheduled Wednesday YDS meeting times. -He stated he was very disappointed with the unit staff as they had all been trained on the facility's protocols. 6. On 1/7/25 at 1:00 p.m., UC C stated he was not able to locate any daily PRTF responsibility sheets for 12/31/24 or 1/1/25. He confirmed staff re-education training following an incident event should have been documented on the comprehensive incident report forms. Review of the last 90 days of comprehensive incident report forms revealed four comprehensive incident report forms had been completed: *One report was on 11/20/24 that was marked "N/A" for continuing education since a client 6 had thrown a dictionary into a window and shattered it. Client 6 stated it was an accident. *One report for client 5 was on 12/20/24 which was related to the 12/20/24 client 1 incident. -Client 5 had been physically aggressive towards staff members and a police officer after observing officers taking client 1 into custody. -No charges were pressed by the staff or the police. This report was marked "NO" for continuing education. *Two reports were for client 1. The 12/20/24 SH/SI incident report was marked "NO" for staff continuing education. -The 12/31/24 SH/SI incident report was marked "NO" for staff continuing education. 7. Interview on 1/7/25 at 1:04 p.m. with UC C	N 215		

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N 215	Continued From page 13 revealed: *He started in this position on August 12, 2024. *He stated, "Staff were busy moving, and no staff responsibility forms were located for those days. I have no documentation to show safety walk-through's were completed on those days. I can see where the process breaks are. Moving and those types of decisions should not be made by floor staff. It won't happen again; we need to stay on our A game." *He stated: -Staff could have managed the hallway better during the move. -He was currently looking into those processes and was trying to determine what could have been done differently and who had made the decision to move the clients in that manner. -He was not sure who decided it was safe to move into the larger PRTF. -"I was moving beds and then all [the clients] moved in at once and chaos." -ESI training involved education on environmental sweeps for contraband. -"[Name] UC D and I do bathroom breaks for staff and won't tell them when we are coming over, we study what they are doing, and will meet with them for real-time correction. Education and corrective action occurs on the spot." -The YDS educational meetings were delayed due to the holidays. 8. Interview on 1/7/25 at 1:32 p.m. with maintenance director H regarding the 12/31/24 incident with client 1 revealed: *He was the only maintenance person and began working about one and a half months ago. -No training on contraband screening of the units was provided to him. -There was no training or discussion with him on	N 215		

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N 215	Continued From page 14 what could have been done differently. -He had decided, and it was approved, that all clients were to be removed from the large PRTF unit for six weeks so he could repair holes in walls, paint, and perform carpet cleaning or replacement. *He stated: -The plan was in place the previous week for moving back into the unit. -On Monday (12/30/24) he discussed with management changing the door handles and he told them he would do it Tuesday 12/31/24. -He told staff the bathroom was not to be used until the handle could be installed. -He had communicated the day before for staff to give him a 30-minute heads-up before moving so he could change the door handles before they moved. -That morning, he had told YDS K and O that he needed time before they moved in to change the door handle. -He felt he had told them loud enough to have heard his request. -He started to change the door handle and left to retrieve some supplies, and when he returned "all hell was breaking loose" and one 3/4-inch screw was missing. -He was very frustrated staff did not give him the time frame he requested to complete repairs to the door locks. -"I won't rely on staff to do what I ask anymore." 9. Interview on 1/7/25 at 1:50 pm., with UC D regarding client safety and the 12/31/24 move revealed: *She has worked in that capacity since August 23, 2024. *She stated staff responsibility sheets from shift to shift were to ensure safety room checks were	N 215		

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performed twice a week and environmental chemicals were checked.
*She stated:
-"There was a safety check before moving as a plan and it did not go how we wanted it to go. From what I saw, unit staff took the initiative to start the move without reaching out to management."
-"We did not give them [unit staff] the go-ahead [to move]. We did not know the door handles were not completed so I called him [maintenance director H] to get them switched over. We were trying to get all the clients to the other unit. It was a chaotic day in of itself, and we were trying to keep it controlled."
-"We discussed amongst ourselves what went wrong. Not explicitly decided who had made that decision [to move]."
-"In hindsight, there should have been a step-back taken."
-She was "disappointed and frustrated correct precautions were not taken and it will be addressed at Wednesday's meeting."
*She confirmed the Wednesday meetings had not occurred for a few weeks due to Christmas and New Year's falling on Wednesdays.

10. Interview on 1/7/25 at 2:09 p.m. with counselor J regarding the 12/31/24 move and safety issues revealed:
*She confirmed the last ESI was on 12/31/24 with client 1.
-She was involved in the debriefing around 3:30 or 4:00 p.m. that day and they discussed what could have been done differently but no follow-up staff training had occurred.
-She stated every shift needed to do an environmental check at the end of the shift.
*She was transporting two other clients when the

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N 215	Continued From page 16 incident occurred and was not aware the move had begun. She stated she was aware that administrator A had said the move would occur once maintenance was done with repairs. 11. Interview on 1/7/25 at 2:15 p.m. with care coordinator (CC) E regarding the 12/31/24 move and safety issues revealed: *She stated she had been the lead clinical coordinator for the PRTF for two and a half years but has not overseen the supervising of staff since August of 2024. -She supervised clients only and client 1 was one of her clients. *She stated the last ESI was on 12/31/24 in the PRTF with client 1. -She had attended the debriefing, but follow-up training with staff had not occurred yet. -She stated the usual attendance at YDS and clinical meetings occurred on Wednesdays. -She had trained staff on monitoring for environmental safety in the past and stated, "...what I train is to do frequent checks and scan environment and check cabinets [locked]..." *She stated she was told the unit move would occur on Monday and a plan was in place. -"Then [Names of clinical director (CD) B and UC C] told me on Monday the move would occur on Tuesday." She stated she was in her office when the move had started. *She stated just before the incident occurred, client 1 had AWOL'd into the counselor's hallway. She stated client 1 had accessed the hall's keypad and came into the counselor's hallway unattended. -"I tried to talk with [name of Client 1] and she ran upstairs and was pacing, and I had been told the goal was to get her back on a unit, either one. I told her she would be safe, and she stated she	N 215		

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N 215	Continued From page 17 did not wish to harm herself. Other staff did not disagree with that, and she was let into the new [larger] unit." -"I did not know what that unit looked like, and didn't know it wasn't ready." 12. Interview on 1/7/25 at 2:30 p.m. with Clinical Director (CD) B regarding client safety and the events on 12/31/24 revealed: *She had worked for Crisis Care since August of 2024 and was the Clinical Director since March of 2024. *She stated leaders try to do training for the staff involved in an ESI and normally would do training within a few days. -She stated, "Since this [12/31/24 move and ESI] included all staff we will do training on this [upcoming] Wednesday and historically, we have not moved the meetings due to holidays." -She stated that contraband checks and environmental checks should be on the log sheets. "We send a contraband list periodically via email to refresh staff." -She confirmed cabinets should be locked immediately after opening and retrieving the needed item. *She stated, "Regarding the Plan for the move? I spoke with [Names of UC C and UC D] and planned for Tuesday (12/31/24). Originally I thought the kids would be in school, and forgot they were off. Never in a plan to have clients move themselves." -"The plan was for staff to move the client's packed belongings. There should have been staff in both places. Not sure who decided to start the move. Not aware that management decided to start the move. I would expect a safety sweep would have been done before the clients began to move. Was not aware the door handle was	N 215		

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N 215	Continued From page 18 missing, I was in meetings when the move started." 13. Interview on 1/7/25 at 3:00 p.m. with CC G regarding the 12/31/24 unit move revealed: *She stated she was involved in the 12/31/24 PRTF unit move in the beginning but was not involved in the ESI or any follow-up training. -She stated, "We got a message from [Name of CD B] that the move was on Tuesday, so I went up to see when it would start and was told the move had already started." 14. Interview on 1/7/25 at 3:10 p.m. with youth development specialist (YDS) K regarding client safety and the unit move revealed: *He had been employed since April of 2023. *He stated, "Staff monitoring the environment for safety is when I go through the unit and keep it locked up and tidy." -"We have a responsibility sheet come out in the morning and we put it on our clipboard to complete through the day." *He confirmed he was working during yesterday's observation of the PRTF and stated, "The cabinet issue [not locked] from yesterday was left from nights and we didn't check it yet, now I will check them every morning." -"It [the responsibility sheet] had not been gone through yet." *He was working on the PRTF unit the day of the move and was a part of the move. -He stated, "The day prior we got an email on our connect team phones that the move would occur the next day." -He stated he was instructed by CC E on 12/30 at 6:37 p.m. by connect teams on the phone that the next morning staff would move primary objects in the morning and clients would bring their clothing	N 215		

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N 215	Continued From page 19 over. -He stated, "We were all under the impression it would occur once everyone was up for the day. I did not hear the maintenance man make any requests." -He stated he and YDS O decided to start the move once all the clients were awake. He stated he had already had started moving stuff over during his shift the evening before. -He was not sure if an environmental sweep was done before the move "...since I'm not a member of management." -He stated, "I've been a part of three other moves and all the clients have always moved their items. I was aware one of the beds was incomplete and we needed a few more beds and was aware they were getting that done but did not hear [Name of MD H] say anything about needing an extra 30 minutes to apply the door handles." 15. Interview on 1/7/25 at 3:14 p.m. with RN I regarding the 12/31/24 move and client safety revealed: *She had worked for the provider since September of 2023. *She stated the environmental sweeps would include: "Cabinets should be locked, no silverware on the unit, all contraband removed, and everyone should be up and moving around and monitoring during room sweeps." -She stated, "The handoff [communication] can be improved between shifts. I have been trying to identify how to make handoff better and the phone connect teams improved so [it] doesn't take the place of saying it, but it is like the top five things to look at." -She stated she was not involved in the planning of the move. "I had heard they would wait until the kids were in school and then the transition back	N 215		

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N 215	Continued From page 20 [to the larger unit] would happen. I was passing meds [medications] the morning of 12/31/24 and then the unit staff told the clients 'Gather your stuff and let's move!' It (the 12/31/24 move) was an uncoordinated event." 16. Interview on 1/7/25 at 4:41 p.m. with administrator A regarding the 12/31/24 move and ensuring the safety of the clients revealed: *He stated, "I blame myself on that [the 12/31/24 move]. I would have expected it [the larger unit] would have been screened for safety. I never mentioned the move to [Names of CD B and UC D]. I shouldn't have assumed, and I expected it [the move] to be coordinated. The kids should have been removed before they needed to be removed because of an ESI." -He stated that following an ESI event he would expect regroup and retraining. -"We delayed the training, because of the holidays and only half the staff would have been here since not a normal Wednesday. They [staff] have all been here long enough to know better." -He expected follow-up training to occur after every ESI. *Regarding the unlocked cabinets and the storage area, he confirmed staff complacency was occurring in the unit. -"There should not have been anything back there, besides furniture, that shouldn't be behind locked doors." -He stated he was, "Very disappointed." Review of the provider's 4/17/24 PRTF Staff Responsibilities daily log sheets revealed those sheets did not have a task listed to ensure all contraband was locked and inaccessible to clients or environmental sweeps were performed.	N 215		

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N 215	Continued From page 21 Review of the provider's 9/2024 Contraband list included the following items (in part): Metal objects, binders, plastic folders, plastic bags, aerosol cans, string, cord, eating utensils, plates, laundry detergent, soap pods, disinfecting wipes, dryer sheets, tools (hammer, screwdrivers). -The contraband list had not indicated how often the staff were to ensure contraband was to be kept inaccessible to clients. Review of the provider's 9/2024 Youth Supervision policy revealed it had not included environmental sweeps for contraband or potentially dangerous items. Review of the provider's 9/2024 Emergency Safety Intervention (ESI) policy revealed the area of "De-briefing and ESI follow-up" had not included staff education following an ESI.	N 215		