Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L003	03/26/2026
Name of Provider or Supplier	**Street Address, City, State**	
Hc Partnership	6869 5th Ave South, Birmingham, AL	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	A recertification survey was conducted on 3/24/26 to 3/26/26 at Hill Crest Behavioral Health Services. The facility was found to be in substantial compliance with the Conditions of Participation for Emergency Preparedness.
N0000	A recertification survey was conducted on 3/24/26 to 3/26/26 at Hill Crest Behavioral Health Services. Standard level deficiencies were cited and will require an approved Plan of Correction.
N0143	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on Medical Record (MR) review, facility policy, and interviews with clinical staff it was determined the facility failed to obtain the physician or other licensed practitioner signature verification for a verbal restraint order. This affected MR # 5, and had the potential to negatively affect all patients restrained at this facility.

	Findings Include: Policy: Proper Use And Monitoring Of Physical And Chemical Restraints And Seclusions... Policy ID: 20006691 Date Last Approved: 03/26 Definitions: ...Licensed independent practitioners (LIP) who may order the use of restraint Physician... Policy: ...3. 1. 6 The LIP/ physician shall authenticate the telephone/verbal order within 24 hours... MR # 5 was admitted on 4/1/25 with a diagnoses of Major Depressive Disorder, and Recurrent Conduct Disorder, Unspecified. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraint ordered on 10/15/25 at 9:55 PM. An interview was conducted on 3/26/26 at 11:25 AM with Employee Identifier # 1, Chief Nursing Officer, who confirmed the facility failed to obtain a physician or other licensed practitioner signature verification for the verbal restraint order.
N0165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on Medical Record (MR) review, facility policy, and interviews with facility staff it was determined the facility failed to continually assess and monitor the patient throughout the duration of the emergency safety intervention. This affected MR # 6, and had the potential to negatively affect all patients served by the clinic. Findings Include: Policy: Proper Use And Monitoring Of Physical And Chemical Restraints And Seclusions... Policy ID: 20006691 Date Last Approved: 03/26 Policy: 4. 5 The resident shall be continually assessed every while in restraint /seclusion by the assigned trained staff...

	..."Continually assessed" should be defined as observing, measuring and evaluating at all times and documentation every 15 minutes of the ongoing assessment of the behavior and physical status of the resident by the staff that are physically present throughout the duration of the restraint or seclusion. MR # 6 was admitted on 5/30/24 with a diagnoses of Disruptive Mood Dysregulation Disorder and Attention-Deficit Hyperactivity Disorder. A review of the MR revealed no documentation the staff continually assessed and monitored the patient throughout the duration of the emergency safety intervention conducted on 8/21/24. An interview was conducted on 3/26/26 at 11:23 AM with Employee Identifier # 1, Chief Nursing Officer, who confirmed the clinic failed to continually assess and monitor the patient throughout the duration of the emergency safety intervention.
N0189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on Medical Record (MR) review, facility policy, and interviews with clinical staff it was determined the facility failed to perform a staff debriefing within 24 hours of the initation of a restraint episode. This affected MR # 6, and had the potential to negatively affect all patients restrained at this facility. Findings Include: Policy: Proper Use And Monitoring Of Physical And Chemical Restraints And Seclusions... Policy ID: 20006691 Date Last Approved: 03/26 Policy: ...Staff/Administrative Debriefing: Within 24 hours of the initiation of any restraint episode, all staff involved in the inicident participate with staff in a debriefing... MR # 6 was admitted on 5/30/24 with a diagnoses of Disruptive Mood Dysregulation Disorder and Attention-Deficit Hyperactivity Disorder. A review of the MR revealed the staff failed to perform a staff debriefing within 24

	hours of the initiation of the restraint episode on 7/4/24. An interview was conducted on 3/26/26 at 11:23 AM with Employee Identifier # 1, Chief Nursing Officer, who confirmed the facility failed to perform a staff debriefing within 24 hours of the initation of the restraint episode.