Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L008	08/01/2025
Name of Provider or Supplier	**Street Address, City, State**	
Alabama Clinical Schools, Inc.	1221 Alton Drive, 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 at Alabama Clinical Schools from 7/29/25 to 8/1/25. The facility was found to be in compliance with the Center for Medicare and Medicaid Services requirements for Emergency Preparedness.
N0000	A recertification survey was conducted on 7/29/25 to 8/1/25 at Alabama Clinical Schools and to investigate a Psych - 21` report of an injury while in restraints resulting in a fractured arm. The injury, complaint number AL00051742, was determined to have occurred in the RISE residential program and not the Psychiatric Residential Treatment Facility (PRTF). Condition level deficiencies and related standards were cited at 483.35 Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. An Immediate Jeopardy (IJ) occurred on 1/18/25 when a review of the MR revealed a patient suffered a fracture of the right arm as a result of restraint use. On 7/31/25 at 3:28 PM, Employee Identifier (EI) # 1, Chief Financial Officer, was notified of the Immediate Jeopardy at 483.35 Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. A removal plan was received and accepted on 8/1/25 at 9:30 AM which included: 1. Having a supervisor present at each restraint occurrence to ensure that restraint techniques are executed properly and provide adjustments/corrections as needed. 2. A plan was put in place to conduct camera/video review/audits of 100 % of restraint incidents to monitor for accurate execution of restraint protocol.

	3. Provided retraining on Verbal De-Escalation and Handle With Care. All employees will be retrained prior to returning to work. 4. Provided each employee with a copy of the restraint policy. 5. Requiring that all settle (sitting) and supine (standing) restraints are to be maneuvered by two or more employees. The surveyors validated the IJ was removed on 8/1/25 at 4:00 PM after reviewing the restraint training materials and observation of a staff training session.
N0100	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: A recertification survey was conducted on 7/29/25 to 8/1/25 at Alabama Clinical Schools. Based on review of medical records (MR), observations, facility policy and procedure, and review of facility video recordings, it was determined the facility failed to properly execute restraints/holds to prevent harm to residents. This affected two of six MR's reviewed with restraint use, including Patient Identifier (PI) # 9 and PI # 10, and had the potential to affect all residents requiring restraints. Refer to tags: N 128, N 197, and N 207.
N0128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observations, review of video recordings, facility policy and procedure, medical record (MR) review, review of Hospital B, receiving hospital MR, and interviews with staff, it was determined the facility failed to properly execute restraints /holds to prevent harm to residents. This affected two of six MRs reviewed with restraint use including Patient Identifier (PI) # 9, PI # 10, and had the potential to affect all 48 patients in the psychiatric treatment program. Findings include: Facility Policy: Proper Use and Monitoring of Physical/Chemical Restraints and

Seclusion.

Policy Number: Not Listed

Reviewed: 4/24

Purpose: To assure compliance with all laws, rules and regulations relating to federal and state health programs.

Policy:

It is the policy of ... to support each resident's right to be free from restraint ... and therefore limit the use of these interventions in which there is an imminent risk of a resident physically harming him/herself or others... The resident has a right to be free from restraint/seclusion imposed as a means of coercion, punishment, discipline, or retaliation by staff...

Definitions:

Physical Escort: Using a "light" grasp to escort a resident to a desired location. If the resident can easily remove or escape the grasp, it is not a physical restraint. If the resident cannot easily remove or escape the grasp this would be a physical restraint.

Physical Restraints: The application of any manual method that immobilizes or reduces the ability of the resident to move his or her arms, legs, body, or head freely...

Procedure:

... 4.0. Restraint Application and Assessment/Monitoring during the Use of Restraints:

4.1. If Physical restraint is indicated, at least 2 (two) staff must participate in the physical hold application.

... If the physical restraint/hold is on a child resident, one staff may implement the hold ... while a second staff serves as a witness...

1. PI # 9 was admitted on 8/28/24 to the 12 to 14 year old psychiatric unit with diagnoses including Reactive Attachment Disorder and Post-Traumatic Stress Disorder.

Review of the facility Incident Log revealed PI # 9 was placed in a restraint on 1/18 /25.

Further review of the Incident Log revealed the facility documented "Resident stated that after getting out of the restraint, (he/she) leaned back and hurt (his/her) elbow /arm." PI # 9 complained of pain on 1/19/25 and was sent to the hospital for a fracture of the humerus.

Review of the Physical Intervention Form dated 1/18/25 revealed Employee Identifier (EI) # 6, Mental Health Assistant (MHA) documented PI # 9 was placed in a Settle (sitting) restraint by EI # 11, MHA at 1/18/25 at 7:25 PM and released at 7:27 PM.

Review of the physician's orders dated 1/19/25 at 7:00 AM revealed orders for an x-

ray of the left arm.

Review of Radiology Report dated 1/19/25 1:19 PM revealed an acute left humeral shaft fracture.

Review of the Staff/Administrative/Supervisory Debriefing dated 1/19/25 at 5:24 PM revealed EI # 8, Medical Social Worker, documented "Resident had to be taken to the hospital for broken arm."

Video recordings of the restraint incident were requested on 7/30/25, 7/31/25, and 8/1/25. No video recordings were provided.

An interview was conducted on 8/1/25 at 9:10 AM with EI # 11 who stated PI # 9 had a fall prior to the restraint which hurt (his/her) arm. EI # 11 stated PI # 9 was placed in a Settle hold due to his/her elopement risk.

A review of the Incident Log revealed no documentation of a recent fall with injury of PI # 9 prior to the restraint on 1/18/25.

Review of MR from Hospital B, receiving hospital, revealed the Emergency Department (ED) physician documented PI # 9 "...Presents today for left elbow pain. The patient apparently was restrained yesterday and (he/she) pushed back and has had pain and swelling in the left arm since that time ..."

An interview was conducted on 8/1/25 at 9:30 AM with EI # 3, Assistant Director of Nurses, who confirmed the facility failed to protect a resident from harm and confirmed the injury to PI # 9 was a result of the restraint on 1/18/25.

2. PI # 10 was admitted on 7/9/24 to the 12 to 14 year old psychiatric unit with diagnoses including Bipolar Disorder, Unspecified and Conduct Disorder, Unspecified.

On 7/30/25 at approximately 9:00 AM, surveyors witnessed EI # 10, MHA, with hands on PI # 10's shoulders and arm pushing him backward towards the nursing station. EI # 10 pushed PI # 10 up against nursing station wall and grabbed him/her by his/her shirt. EI # 2, Director of Nurses, stepped in, spoke with PI # 10 and he/she went with EI # 2.

Review of the facility Seclusion/Restraint Order dated 7/30/25 at 9:30 AM revealed PI # 10 was placed in a restraint on 7/30/25.

Review of the Physical Restraint Form dated 7/30/25 revealed EI # 10 documented PI # 10 was argumentative and combative with staff after getting out of his/her seat without permission.

Review of the Post Intervention Face to Face Evaluation dated 7/30/25 at 9:40 AM revealed PI # 10 with a small scratch on right forearm and slight redness to bilateral neck.

A review of the recorded video of the restraint was conducted on 7/31/25 at 9:15 AM with EI # 4, Director of Risk Management. The following is a summary of the video review:

	On 7/30/25 at 8:30:26 AM, PI # 10 got up from table and went into the laundry room. At 8:30:46 AM EI # 10 grabbed PI # 10 by his/her right arm. At 8:30:51 AM EI # 10 grabbed PI # 10 by his/her shirt and began to walk towards the hall. At 8:30:54 AM EI #10 was seen shaking PI # 10 while pulling/holding his/her shirt collar. At 8:31:03 AM EI # 10 was seen walking PI # 10 backwards down hall while twisting his/her right arm. An interview was conducted on 7/31/25 at 9:50 AM with EI # 2, Director of Nursing, who confirmed the hold on PI #10 was an improper restraint.
N0197	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that- This ELEMENT is not met as evidenced by: Based on review of facility agreements, facility policy, and interview with staff, it was determined the facility failed to ensure a written transfer agreement was in effect with a hospital approved for participation in the Medicaid program. This deficient practice had the potential to affect all 48 residents of the facility. Findings include: Policy: Medical/Psychiatric Routing and Emergency Care Policy Number: Not Listed Reviewed: 9/24 Purpose: To establish guidelines to Medical and Psychiatric Routine and Emergency Care. Policy: ... 2. Alabama Clinical Schools utilizes local hospitals and physicians to provide 24 hour, seven (7) days a week emergency medical and mental health services for enrolled residents... Procedure: ... 6. If acute hospitalization is possible, the Director of Nursing will address funding issues with the family/legal guardian and possible admitting facility...

	1. A copy of the facilities agreement with a Medicaid participating hospital was requested on 7/29/25. There was no documentation of a current agreement provided. An interview was conducted on 7/29/25 at 2:00 PM with Employee Identifier # 2, Director of Nurses who confirmed the facility failed to have an agreement with a Medicaid participating hospital for resident emergencies.
N0207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section 483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on medical record (MR) review, facility policy and procedure, and interview with staff, it was determined the facility failed to ensure a serious injury involving a child resident was reported to the State Medicaid agency. This deficient practice affected one of one occurrence of a serious injury as a result of a restraint reviewed including Patient Identifier (PI) # 9 and had the potential to affect all 48 residents under the age of 21 in this facility. Findings include: Facility Policy: Proper Use and Monitoring of Physical/Chemical Restraint and Seclusion Policy Number: Not Listed Reviewed: 4/24 Purpose: To assure compliance with all laws, rules, and regulations relating to federal and state health care programs... Procedure: ... 12.7. The facility must report to ... the State Medicaid agency: Serious occurrences ... including a serious injury to the resident as a result of restraint use. Serious injury means any significant impairment of the physical condition of the

	resident as determined by qualified medical personnel. This includes ... bone fractures...whether self inflicted or inflicted by someone else. The report to ... the State Medicaid agency should be make by the close of the business day the next business day following knowledge of the resident's injury... 1. PI # 9 was admitted on 8/28/24 to the 12 to 14 year old psychiatric unit with diagnoses including Reactive Attachment Disorder and Post-Traumatic Stress Disorder. Review of the facility Incident Log revealed PI # 9 was placed in a restraint on 1/18 /25. Review of the Incident Log, facility comments revealed "Resident stated that after getting out of the restraint, (he/she) leaned back and hurt (his/her) elbow/arm." PI # 9 complained of pain on 1/19/25 and was sent to the hospital for a fracture of the humerus. Review of the physician's orders dated 1/19/25 at 7:00 AM revealed orders for an x-ray of the left arm. Review of Radiology Report dated 1/19/25 1:19 PM revealed an acute left humeral shaft fracture. Review of the Psych-21 Serious Occurrence Reporting Forms from 7/29/24 to 7/29/25 revealed no documentation the Alabama State Medicaid agency was notified of the serious injury to PI # 9. An interview was conducted on 8/1/25 at 3:30 PM with Employee Identifier # 1, Chief Financial Officer, who confirmed the facility failed to report the serious occurrence to the Alabama State Medicaid agency as required.