Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L013	06/12/2026
Name of Provider or Supplier	**Street Address, City, State**	
Safetynet Youth Systems, Llc	5888 Cherry Hill Road, Montgomery, 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 from 6/9/26 to 6/12/26 at Safetynet Crossings. The facility was found to be not in compliance with the Conditions of Participation for Emergency Preparedness.
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 441.184(a)(1)-(2) 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 460.84(a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 483.475(a)(1)-(2), 484.102(a)(1)-(2), 485.68(a)(1)-(2), 485.542(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at 418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[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. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at 483.475(a):] Emergency Plan. The

	ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, it was determined the facility failed to develop and maintain an Emergency Preparedness Plan based on and including a facility and community-based risk assessment utilizing an all-hazards approach. This deficient practice had the potential to negatively affect all residents, staff, and visitors served by the facility. Findings include: 1. A review of the facility's Emergency Preparedness plan revealed no documentation a facility and community based all hazards risk assessment had been developed for this facility. An interview was conducted on 6/11/26 at 9:00 AM with Employee Identifier # 4, Program Director, who confirmed no facility and community-based all hazards risk assessment had been developed.
E0030	Names and Contact Information CFR(s): 441.184(c)(1) 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 460.84(c)(1), 482.15(c)(1), 483.73(c)(1), 483.475(c)(1), 484.102(c)(1), 485.68(c)(1), 485.542(c)(1), 485.625(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at 482.15(c) and CAHs at 485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at 403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at 416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at 418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at 484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under

	arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at 486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on review of the facility's Emergency Preparedness (EP) Plan and interview with staff, it was determined the facility failed to develop and maintain a list of contact information for use during emergencies. This deficient practice had the potential to affect all staff, residents, and visitors served by this facility. Findings include: A review of the facility's EP plan revealed no documentation of contact information for current staff, physicians, and contracted staff. An interview was conducted on 6/11/26 at 9:00 AM with Employee Identifier # 4, Program Director, who confirmed the facility failed to develop a list of contact information for use during emergencies.
E0031	Emergency Officials Contact Information CFR(s): 441.184(c)(2) 403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 460.84(c)(2), 482.15(c)(2), 483.73(c)(2), 483.475(c)(2), 484.102(c)(2), 485.68(c)(2), 485.542(c)(2), 485.625(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at 483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at 483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on review of the facility's Emergency Preparedness (EP) Plan, and interview with staff, it was determined the facility failed to include contact information for emergency personnel available for use in an emergency in the facility's EP plan. This deficient practice had the potential to affect all staff, residents, and visitors served by this facility. Findings include:

	A review of the facility's EP plan revealed no contact information for local emergency officials. An interview was conducted on 6/11/26 at 9:00 AM with Employee Identifier # 4, Program Director, who confirmed the facility failed to include contact information listed for emergency personnel available for use in an emergency.
N0000	A recertification survey was conducted at Safetynet Crossings from 6/9/26 to 6/12/26. The facility was found to be not in compliance with the Conditions of Participation for Psychiatric Residential Treatment Facility and related standards at 42 CFR 433.354 Use of Restraint and Seclusion, 42 CFR 483.358 Orders for Use of Restraint or Seclusion, and 42 CFR 483.362(a) Monitoring During and After Restraint.
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: Based on Medical Record (MR) review and staff interview, it was determined the facility failed to ensure: a. All orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints. b. All staff clinically trained in the use of emergency safety interventions continually assessed and monitored the residents during the use of a physical restraint. This deficient practice affected MR # 5, MR # 6, MR # 1, MR # 8, and MR # 7, and had the potential to negatively affect all residents restrained at this facility. Findings include: Refer to N 0140 and N 0165.
N0140	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on review of medical records (MR) and staff interview, it was determined the facility failed to ensure orders for restraints were given by a physician or other

licensed practitioner permitted by the State and the facility to order restraints.

This deficient practice affected five of eight MR's including MR # 5, MR # 6, MR # 1, MR # 8, and MR # 7 and had the potential to negatively affect all residents restrained at this facility.

Findings include:

1. MR # 5 was admitted on 9/27/24 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 3/22/25 at 11:05 AM

b. 3/25/25 at 5:57 PM

c. 7/3/25 at 6:09 PM

d. 7/15/25 at 12:44 PM

e. 7/17/25 at 9:33 AM

f. 8/12/25 at 7:21 PM and 7:30 PM

g. 8/14/25 at 2:13 PM

h. 8/22/25 at 5:48 PM

i. 8/25/25 at 7:18 PM

j. 8/28/25 at 7:12 PM and 7:24 PM

k. 8/30/25 at 12:33 PM

l. 10/16/25 at 5:35 PM

m. 1/4/26 at 5:12 PM,

n. 1/12/26 at 7:45 AM

o. 1/31/26 at 6:00 PM

p. 2/25/26 at 10:06 AM and 10:17 AM.

2. MR # 6 was admitted on 2/20/25 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 3/12/25 at 1:09 PM

b. 3/17/25 at 7:06 PM

c. 3/26/25 at 4:16 PM

d. 7/9/25 at 12:08 PM

e. 7/21/25 at 2:07 PM

f. 9/25/25 at 7:51 AM.

An interview was conducted on 6/12/26 at 8:13 AM with Employee Indentifer (EI) # 1, Director of Clinical Services, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

3. MR # 1 was admitted on 2/23/26 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 5/14/26 at 10:39 AM, 10:50 AM, and 11:14 AM.

An interview was conducted on 6/11/26 at 1:06 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were made by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

4. MR # 8 was admitted on 3/27/26 with a diagnosis of Adjustment Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 4/7/26 at 2:55 PM

b. 4/19/26 at 12:53 PM

c. 5/12/26 at 6:42 PM

d. 5/30/26 at 11:37 AM

e. 6/4/26 at 6:07 PM.

An interview was conducted on 6/11/26 at 12:48 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

5. MR # 7 was admitted on 7/15/2025 with a diagnosis of Conduct Disorder Childhood Onset.

	A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on: a. 8/3/2025 at 7:42 PM b. 8/4/2025 at 12:40 PM c. 8/10/2025 at 8:33 AM, 8:45 AM d. 8/16/2025 at 4:22 PM, 4:53 PM, and 5:03 PM e. 8/25/2025 at 1:52 PM, 2:08 PM f. 8/29/2025 at 4:30 PM, 4:38 PM, 6:13 PM, 6:37 PM, 6:45 PM, and 7:15 PM g. 9/21/2025 at 5:24 PM, 5:27 PM h. 9/29/2025 at 9:22 AM i. 10/14/2025 at 5:07 PM j. 10/21/2025 at 7:50 PM, 7:55 PM k. 10/25/2025 at 11:40 AM l. 10/29/2025 at 3:36 PM, 3:43 PM m. 11/1/2025 at 4:06 PM n. 11/6/2025 at 3:48 PM, 3:52 PM, 3:54 PM, 4:14 PM, and 4:18 PM o. 11/11/2025 at 11:37 AM p. 1/13/2026 at 1:38 PM q. 1/19/2026 at 8:23 AM r. 4/13/2026 at 12:12 PM, 1215 PM An interview was conducted on 6/11/26 at 1:05 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.
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 and interviews with staff, it was determined the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually assessed and monitored the resident during the use of a physical restraint.

This deficient practice affected five of eight MR's including MR # 5, MR # 6, MR # 1, MR # 8, and MR # 7 and had the potential to negatively affect all residents restrained at this facility.

Findings include:

1. MR # 5 was admitted on 9/27/24 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 5 during the use of a physical restraint on 7/3/25 at 6:09 PM, 8/25/25 at 7:18 AM, 10/16/25 at 5:35 PM, and 2/25/26 at 10:06 AM.

An interview was conducted on 6/12/26 at 8:13 AM with Employee Indentifer (EI) # 1, Director of Clinical Services, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

2. MR # 6 was admitted on 2/20/25 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 6 during the use of a physical restraint on 3/17/25 at 7:06 PM and 7/21/25 at 2:07 PM.

An interview was conducted on 6/12/26 at 8:13 AM with Employee Indentifer (EI) # 1, Director of Clinical Services, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

3. MR # 1 was admitted on 2/23/26 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 1 during the use of a physical restraint on 5/14/26 at 10:39 AM, 10:50 AM and 11:14 AM.

An interview was conducted on 6/11/26 at 12:48 PM with EI # 1, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

4. MR # 8 was admitted on 3/27/26 with a diagnosis of Adjustment Disorder.

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 8 during the use of a physical restraint on 4/7/26 at 2:55 PM,

	4/19/26 at 12:53 PM, 5/12/26 at 6:42 PM, 5/30/26 at 11:37 AM and 6/4/26 at 6:07 PM. An interview was conducted on 6/11/26 at 12:48 PM with EI # 1, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint. 5. MR # 7 was admitted on 07/15/2025 with a diagnosis of Conduct Disorder Childhood Onset. A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 7 during the use of a physical restraint on 08/19/2025 at 11: 47 PM. An interview was conducted on 6/11/26 at 01:05 PM with EI # 1, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.