Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L018	05/21/2026
Name of Provider or Supplier	**Street Address, City, State**	
Sequel Tsi Of Alabama, Llc	135 Mildred Street, 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 at Brighter Path of Montgomery from 5/19 /2026 to 5/21/2026. Brighter Path of Montgomery was found to be in compliance with the Center for Medicare and Medicaid Services requirements for Emergency Preparedness.
N0000	A recertification survey was conducted at Brighter Path of Montgomery from 5/19 /2026 to 5/21/2026. Standard level deficiences were written and will require an acceptable Plan of Correction.
N0115	INDIVIDUAL PLAN OF CARE CFR(s): 441.155(c) The plan must be reviewed every 30 days by the team specified in 441.156 to- (1) Determine the services being provided are or were required on an inpatient basis, and (2) Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient. (d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for - [paragraph and subparagraphs (1) and (2) relevant for utilization control hospitals only] This ELEMENT is not met as evidenced by: Based on review of Medical Records (MR) and interviews with staff, it was determined the staff failed to ensure the Treatment Plans were developed, reviewed, and updated every 30 days. This deficient practice affected two out of four MR's reviewed and had the potential to negatively affect all residents served at this facility. Findings include:

	1. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation Disorder. Review of MR # 1 revealed the Treatment Plan (TP) was completed on 12/5/25. The TP was updated 2/5/26, and 5/21/26. This was greater than 30 days. 2. MR # 4 was admitted on 11/3/25 with diagnoses including Child Neglect. Review of MR # 4 revealed the TP was completed on 11/4/25 . No documentation of an updated TP was found for 12/2025. This was greater than 30 days. An interview was conducted on 5/21/26 at 12:45 PM with Employee Indentifer # 3, Assistant Licensed Counselor who confirmed the facility staff failed to ensure the Treatment Plans were reviewed and updated every 30 days.
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: 1. Obtain the physician or other licensed practitioner signature verification for a verbal restraint order. 2. Ensure a verbal order was received by a registered nurse or other licensed staff qualified to accept orders. This affected five of six MR's including MR # 6, MR # 1, MR # 2, MR # 3, and MR # 4 and had the potential to negatively affect all patients restrained at this facility. Findings Include: Department of Mental Health Mental Illness Community Programs Administrative Code Chapter 580-2-9 Rule 580-2-9-.23 Child and Adolescent Seclusion and Restraint ...(g) Each verbal order received from a physician, certified registered nurse practitioner, or physician's assistant must be signed within 48 hours.

	1. MR # 6 was admitted on 1/6/26 with diagnoses including Conduct Disorder. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 2/17/26 at 7:40 AM, on 3/30/26 at 12:00 PM and on 3/30/26 at 7:40 PM. Further review of the MR revealed the Licensed Independent Practitioners (LIP) Form dated on 2/17/26 documented the order for the restraint was taken by Employee Identifier (EI) # 11, Certified Medical Assistant (CMA), an unlicensed staff member. An interview was conducted on 5/21/26 at 1:39 PM with EI # 1, Executive Director who confirmed the facility failed to obtain a physician or other licensed practitioner's signature verification for the verbal restraint order. 2. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 12/20/25 at 9:30 AM. Further review of the MR revealed the LIP Form dated on 12/20/25 documented the order for the restraint was taken by EI # 11, an unlicensed staff member. 3. MR # 2 was admitted on 3/23/26 with diagnoses including Parent-Child Relational Problem. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 3/27/26 at 8:50 PM. Further review of the MR revealed the LIP Form dated on 3/27/26 documented the order for the restraint was taken by EI # 11, an unlicensed staff member. 4. MR # 3 was admitted on 3/26/26 with diagnoses including Conduct Disorder. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 3/27/26 at 10:20 PM. 5. MR # 4 was admitted on 11/3/2025 with diagnoses including Child Neglect. A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 2/13/26 at 2:20 PM. Further review of the MR revealed the LIP Form dated on 2/13/26 documented the order for the restraint was taken by EI # 11, an unlicensed staff member. An interview was conducted on 3/21/26 at 2:20 PM with EI # 1, who confirmed the facility failed to ensure all verbal orders were received by a licensed staff member and signed by a physician or other licensed practitioner.
N0145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f)

Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention.

This ELEMENT is not met as evidenced by:
Based on medical record (MR) review and interviews with staff, it was determined the facility failed to ensure a face-to-face (F2F) evaluation was performed within one hour after the application of restraint or seclusion.

This affected five of six MR's reviewed including MR # 1, MR # 2, MR # 3, MR # 4, and MR # 6 and had the potential to negatively affect all patients restrained at this facility.

Findings include:

1. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation

Disorder.

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 12/20/25 at 9:30 AM.

2. MR # 2 was admitted on 3/23/26 with diagnosis including Parent-Child Relational Problem.

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 3/27/26 at 8:50 AM, on 4 /1/26 at 12:00 PM, and on 4/13/26 at 12:04 PM.

3. MR # 3 was admitted on 3/26/26 with diagnoses including Conduct Disorder.

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 3/27/26 at 10:20 PM.

4. MR # 4 was admitted on 11/3/2025 with diagnoses including Child Neglect.

A review of the MR revealed no documentation of a Nursing F2F Assessment after a physical restraint on 2/13/26 at 2:15 PM.

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 2/13/26 at 2:15 PM.

An interview was conducted on 5/21/26 at 2:20 PM with Employee Identife # 1, Executive Director, who confirmed the facility failed to ensure a F2F assessment was performed within one hour after the initiation of restraint.

	5. MR # 6 was admitted on 1/6/26 with diagnoses including Conduct Disorder. A review of the MR revealed MR # 6 was placed in a restraint on 2/17/26 from 7:35 AM to 7:38 AM and the Nursing F2F Assessment was performed on 2/17/26 at 4:00 PM by EI # 11. Further review of the MR revealed MR # 6 was placed in a restraint on 3/30/26 from 7: 45 PM to 7:50 PM and the F2F Assessment was performed on 3/31/26 at 7:05 AM by EI # 10, Licensend Practical Nurse (LPN). An interview was conducted on 5/21/26 at 1:39 PM with Employee Identifier # 1, Executive Director who confirmed the facility failed to ensure a F2F assessment was performed within one hour of the initiation of a physical restraint.
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, review of facility policy and procedure, 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 affected four of six MR's including MR # 1, MR # 2, MR # 3, and MR # 4 and had the potential to negatively affect all patients restrained at this facility. Findings include: 1. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive 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 12/20/25 at 9:30 AM. 2. MR # 2 was admitted on 3/23/26 with diagnoses including Parent-Child Relational Problem. A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 2 during the use of a physical restraint on 3/27/26 at 8:50 PM and 10:00 AM, on 4/1/26 at 12:00 PM, and on 4/13/26 at 12:04 PM. 3. MR # 3 was admitted on 3/26/26 with diagnoses including Conduct Disorder. A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 3 during the use of a physical restraint on 3/27/26 at 10:20 PM.

	4. MR # 4 was admitted on 11/3/2025 with diagnoses including Child Neglect. A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 4 during the use of a physical restraint on 2/13/26 at 2:15 PM. An interview was conducted on 5/21/26 at 2:20 PM with Employee Identifier # 1, Executive Director, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed the residents during the use of a physical restraint.
N0178	NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN CFR(s): 483.366 If the resident is a minor as defined in this subpart: 483.366(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. This STANDARD is not met as evidenced by: Based on medical record (MR) review, review of facility policy, and interviews with staff, it was determined the facility failed to ensure a parent or legal guardian was notified after use of a physical restraint. This affected four of six MR's including MR # 1, MR # 2, MR # 3, and MR # 4 and had the potential to negatively affect all patients restrained at this facility. Findings include: Facility Policy: Use of Physical Holds with Children and Youth Policy Number: CTS-11022019 Revised: 4/15/2022 Policy: 1. It is the policy of Brighter Path of Alabama to comply with all regulatory, legal and accreditation standards regarding the use of any physical holds... ...15. As soon as possible, but no later than one business day after the hold, if a client is a minor, their guardian must be notified... 1. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation Disorder. A review of the MR revealed there was no documentation the parent or legal guardian was notified after the use of a physical restraint on 12/1025 at 9:30 AM. 2. MR # 2 was admitted on 3/23/26 with diagnoses of Parent-Child Relational

	Problem. A review of the MR revealed there was no documentation the parent or legal guardian had been notified after the use of physical restraints on 3/27/26 at 8:50 PM and 10:00 AM, on 4/1/26 at 12:00 PM, and on 4/13/26 at 12:04 PM. 3. MR # 3 was admitted on 3/26/26 with diagnoses including Conduct Disorder. A review of the MR revealed there was no documentation the parent or legal guardian was notified after the use of a physical restraint on 3/27/26 at 10:20 PM. 4. MR # 4 was admitted on 11/3/2025 with diagnoses including Child Neglect. A review of the MR revealed there was no documentation the parent or legal guardian was notified after the use of a physical restraint on 2/13/26 at 2:15 PM. An interview was conducted on 5/21/26 at 2:20 PM with Employee Identifier # 1, Executive Director, who confirmed the facility failed to ensure a parent or legal guardian was notified after the use of a physical 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 and interviews 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 residents served by this facility. A copy of the facilities agreement with a Medicaid participating hospital was requested on 5/19/2026. There was no documentation of a current agreement provided. An interview was conducted on 5/21/2026 at 2:00 PM with Employee Identifier # 1, Executive Director, who confirmed the facility failed to have an agreement with a Medicaid participating hospital for resident emergencies.
N0218	EDUCATION AND TRAINING CFR(s): 483.376(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required. This ELEMENT is not met as evidenced by: Based on review of Employee Files (EF) and interviews with staff, it was determined

	the facility failed to ensure all employees with direct patient care were certified in Cardiopulmonary Resuscitation (CPR). This deficient practice had the potential to affect all residents, visitors, and staff served by this facility. Four of eight EF's reviewed, including Employee Identifier (EI) # 3. EI # 4, EI # 5, and EI # 6 for employees with direct patient care and revealed no current CPR certification. An interview was conducted on 5/21/26 at 1:03 PM with EI # 2, Business Office Manager who confirmed all employees with direct patient care were not CPR certified.
N0220	EDUCATION AND TRAINING CFR(s): 483.376(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations. This ELEMENT is not met as evidenced by: Based on review of Employee Files (EF) and interviews with staff, it was determined the facility failed to ensure staff demonstrated the techniques for managing emergency safety situations. This deficient practice had the potential to affect all residents served by this facility. Seven of ten EF's reviewed, including Employee Identifier (EI) # 7. EI # 8, EI # 9, EI # 1, EI # 3, EI # 5 and EI # 6 revealed no documentation of hands-on training techniques for managing emergency safety situations. An interview was conducted on 5/21/26 at 1:03 PM with EI # 2, Business Office Manager who confirmed the facility failed to ensure all staff demonstarted techniques for managing emergency safety situations.
N0222	EDUCATION AND TRAINING CFR(s): 483.376(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is not met as evidenced by: Based on review of Employee Files (EF) and interviews with staff, it was determined the facility failed to ensure staff were recertified in Cardiopulmonary Resuscitation (CPR) on an annual basis. This deficient practice had the potential to affect all residents served by this facility. Three of ten EF's reviewed, including Employee Identifier (EI) # 9. EI # 10, and EI # 11 revealed no documentation of annual CPR training.

	An interview was conducted on 5/21/26 at 1:03 PM with EI # 2, Business Office Manager who confirmed the facility failed to ensure all staff were recertified in CPR annually.