Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L023	07/30/2026
Name of Provider or Supplier	**Street Address, City, State**	
Southeastern Psychiatric Management, Inc.	3001 Scenic Highway, Gadsden, 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 Mountain View Hospital Summit Crest Lodgefrom 7/28/2026 to 7/30/2026. Mountain View Hospital Summit Crest Lodge 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 Mountain View Hospital Summit Crest Lodge from 7/28/2026 to 7/30/2026. Standard level deficiencies were cited and will require an acceptable Plan of Correction.
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 a review of the medical records (MR) and interview with staff, it was determined the facility failed to ensure that a face to face assessment was completed within one hour of the initiation of the restraint and/or seclusion. This affected five of eight MR's reviewed to include MR # 1, MR # 7, MR # 8, MR # 3, and MR # 6, and had the potential to negatively affect all residents restrained or secluded at this facility.

	Findings include: 4. MR # 3 was admitted on 7/9/2026 with a diagnosis of Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation of the dates and times of the face to face assessments for restraints on 4/27/2026, 5/2/2026, 5/3/2026, 5/7/2026, 6/10/2026, 7/6/2026, 7/7/2026, and 7/18/2026. An interview was conducted on 7/30/2026 with EI # 2, who confirmed there was no documentation of the dates and times of the face to face assessments. 5. MR # 6 was admitted on 7/29/2026 with a diagnosis of Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation of the face to face assessments for restraints on 4/26/2026 and 4/27/2026. An interview was conducted on 7/30/2026 with EI # 2, who confirmed there was no documentation of the dates and times of the face to face assessments. 1. MR # 1 was admitted on 2/7/25 with a diagnosis of Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation of the dates and times of the face to face assessments for restraints on 5/3/25, 5/13/25, 7/9/25, 7/15/25, and 9/17/25. An interview was conducted on 7/30/2026 at 3:22 PM with Employee Identifier (EI) # 2, Clinical Director of Residential, who confirmed there was no documentation of the dates and times of the face to face assessment for restraints. 2. MR # 7 was admitted on 6/10/26 with a diagnosis of Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation of the dates and times of the face to face assessment for restraints on 6/22/26. An interview was conducted on 7/30/2026 at 3:22 PM with EI # 2, who confirmed there was no documentation of the dates and times of the face to face assessment for restraints. 3. MR # 8 was admitted on 2/25/26 with a diagnosis of Conduct Disorder, Childhood Onset. A review of the MR revealed no documentation of the date and time of the face to face assessment for restraints on 6/7/26. An interview was conducted on 7/30/2026 at 3:22 PM with EI # 2, who confirmed there was no documentation of the dates and times of the face to face assessment for restraints.
N0171	MONITORING DURING AND AFTER SECLUSION

	CFR(s): 483.364(b) A room used for seclusion must- (1) Allow staff full view of the resident in all areas of the room; and This ELEMENT is not met as evidenced by: Based on a tour of the facility, staff interview, and facility policy and procedure, it was determined the facility failed to ensure the seclusion rooms were designed to allow continual visual monitoring of the resident while in the seclusion room. This deficient practice affected two out of four seclusion rooms and had the potential to negatively affect all residents who require seclusion. Findings include: Facility Policy Subject: Residential Restraints and Seclusions Policy: PC.021 ...Procedure Restraint and Seclusion Protocol: Seclusion Seclusion refers to the placement of a patient alone in any room from which the patient is physically prevented from leaving. Seclusion is predominantly utilized in the facility's quiet rooms; although, seclusion may be implemented in other rooms where the patient is physically prevented from leaving. One to One staff member will be placed at the door at all times to monitor the patient's status and the Registered Nurse will assess every 15 minutes. A tour of the facility was conducted on 7/28/2026 at 12:10 PM, with Employee Identifier (EI) # 1, Clinical Director of Acute Care. Two of the four seclusion rooms toured did not provide a complete view of the resident from the window used for observation. This finding was confirmed during the tour by EI # 1.