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)
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.