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)
N0189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the 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 perform a staff debriefing within 24 hours of the initation of a restraint episode. This affected MR # 6, 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 Policy: ...Staff/Administrative Debriefing: Within 24 hours of the initiation of any restraint episode, all staff involved in the inicident participate with staff in a

	debriefing... MR # 6 was admitted on 5/30/24 with a diagnoses of Disruptive Mood Dysregulation Disorder and Attention-Deficit Hyperactivity Disorder. A review of the MR revealed the staff failed to perform a staff debriefing within 24 hours of the initiation of the restraint episode on 7/4/24. An interview was conducted on 3/26/26 at 11:23 AM with Employee Identifier # 1, Chief Nursing Officer, who confirmed the facility failed to perform a staff debriefing within 24 hours of the initation of the restraint episode.