Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L008	08/01/2025
Name of Provider or Supplier	**Street Address, City, State**	
Alabama Clinical Schools, Inc.	1221 Alton Drive, 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)
N0128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observations, review of video recordings, facility policy and procedure, medical record (MR) review, review of Hospital B, receiving hospital MR, and interviews with staff, it was determined the facility failed to properly execute restraints /holds to prevent harm to residents. This affected two of six MRs reviewed with restraint use including Patient Identifier (PI) # 9, PI # 10, and had the potential to affect all 48 patients in the psychiatric treatment program. Findings include: Facility Policy: Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion. Policy Number: Not Listed Reviewed: 4/24 Purpose: To assure compliance with all laws, rules and regulations relating to federal and state health programs. Policy:

It is the policy of ... to support each resident's right to be free from restraint ... and therefore limit the use of these interventions in which there is an imminent risk of a resident physically harming him/herself or others... The resident has a right to be free from restraint/seclusion imposed as a means of coercion, punishment, discipline, or retaliation by staff...

Definitions:

Physical Escort: Using a "light" grasp to escort a resident to a desired location. If the resident can easily remove or escape the grasp, it is not a physical restraint. If the resident cannot easily remove or escape the grasp this would be a physical restraint.

Physical Restraints: The application of any manual method that immobilizes or reduces the ability of the resident to move his or her arms, legs, body, or head freely...

Procedure:

... 4.0. Restraint Application and Assessment/Monitoring during the Use of Restraints:

4.1. If Physical restraint is indicated, at least 2 (two) staff must participate in the physical hold application.

... If the physical restraint/hold is on a child resident, one staff may implement the hold ... while a second staff serves as a witness...

1. PI # 9 was admitted on 8/28/24 to the 12 to 14 year old psychiatric unit with diagnoses including Reactive Attachment Disorder and Post-Traumatic Stress Disorder.

Review of the facility Incident Log revealed PI # 9 was placed in a restraint on 1/18 /25.

Further review of the Incident Log revealed the facility documented "Resident stated that after getting out of the restraint, (he/she) leaned back and hurt (his/her) elbow /arm." PI # 9 complained of pain on 1/19/25 and was sent to the hospital for a fracture of the humerus.

Review of the Physical Intervention Form dated 1/18/25 revealed Employee Identifier (EI) # 6, Mental Health Assistant (MHA) documented PI # 9 was placed in a Settle (sitting) restraint by EI # 11, MHA at 1/18/25 at 7:25 PM and released at 7:27 PM.

Review of the physician's orders dated 1/19/25 at 7:00 AM revealed orders for an x-ray of the left arm.

Review of Radiology Report dated 1/19/25 1:19 PM revealed an acute left humeral shaft fracture.

Review of the Staff/Administrative/Supervisory Debriefing dated 1/19/25 at 5:24 PM revealed EI # 8, Medical Social Worker, documented "Resident had to be taken to the hospital for broken arm."

Video recordings of the restraint incident were requested on 7/30/25, 7/31/25, and 8/1

/25. No video recordings were provided.

An interview was conducted on 8/1/25 at 9:10 AM with EI # 11 who stated PI # 9 had a fall prior to the restraint which hurt (his/her) arm. EI # 11 stated PI # 9 was placed in a Settle hold due to his/her elopement risk.

A review of the Incident Log revealed no documentation of a recent fall with injury of PI # 9 prior to the restraint on 1/18/25.

Review of MR from Hospital B, receiving hospital, revealed the Emergency Department (ED) physician documented PI # 9 "...Presents today for left elbow pain. The patient apparently was restrained yesterday and (he/she) pushed back and has had pain and swelling in the left arm since that time ..."

An interview was conducted on 8/1/25 at 9:30 AM with EI # 3, Assistant Director of Nurses, who confirmed the facility failed to protect a resident from harm and confirmed the injury to PI # 9 was a result of the restraint on 1/18/25.

2. PI # 10 was admitted on 7/9/24 to the 12 to 14 year old psychiatric unit with diagnoses including Bipolar Disorder, Unspecified and Conduct Disorder, Unspecified.

On 7/30/25 at approximately 9:00 AM, surveyors witnessed EI # 10, MHA, with hands on PI # 10's shoulders and arm pushing him backward towards the nursing station. EI # 10 pushed PI # 10 up against nursing station wall and grabbed him/her by his/her shirt. EI # 2, Director of Nurses, stepped in, spoke with PI # 10 and he/she went with EI # 2.

Review of the facility Seclusion/Restraint Order dated 7/30/25 at 9:30 AM revealed PI # 10 was placed in a restraint on 7/30/25.

Review of the Physical Restraint Form dated 7/30/25 revealed EI # 10 documented PI # 10 was argumentative and combative with staff after getting out of his/her seat without permission.

Review of the Post Intervention Face to Face Evaluation dated 7/30/25 at 9:40 AM revealed PI # 10 with a small scratch on right forearm and slight redness to bilateral neck.

A review of the recorded video of the restraint was conducted on 7/31/25 at 9:15 AM with EI # 4, Director of Risk Management. The following is a summary of the video review:

On 7/30/25 at 8:30:26 AM, PI # 10 got up from table and went into the laundry room.

At 8:30:46 AM EI # 10 grabbed PI # 10 by his/her right arm.

At 8:30:51 AM EI # 10 grabbed PI # 10 by his/her shirt and began to walk towards the hall.

At 8:30:54 AM EI #10 was seen shaking PI # 10 while pulling/holding his/her shirt collar.

	At 8:31:03 AM EI # 10 was seen walking PI # 10 backwards down hall while twisting his/her right arm. An interview was conducted on 7/31/25 at 9:50 AM with EI # 2, Director of Nursing, who confirmed the hold on PI #10 was an improper restraint.