Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L013	06/12/2026
Name of Provider or Supplier	**Street Address, City, State**	
Safetynet Youth Systems, Llc	5888 Cherry Hill Road, 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)
N0140	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on review of medical records (MR) and staff interview, it was determined the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints. This deficient practice affected five of eight MR's including MR # 5, MR # 6, MR # 1, MR # 8, and MR # 7 and had the potential to negatively affect all residents restrained at this facility. Findings include: 1. MR # 5 was admitted on 9/27/24 with a diagnosis of Disruption Mood Dysregulation Disorder. A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on: a. 3/22/25 at 11:05 AM

b. 3/25/25 at 5:57 PM

c. 7/3/25 at 6:09 PM

d. 7/15/25 at 12:44 PM

e. 7/17/25 at 9:33 AM

f. 8/12/25 at 7:21 PM and 7:30 PM

g. 8/14/25 at 2:13 PM

h. 8/22/25 at 5:48 PM

i. 8/25/25 at 7:18 PM

j. 8/28/25 at 7:12 PM and 7:24 PM

k. 8/30/25 at 12:33 PM

l. 10/16/25 at 5:35 PM

m. 1/4/26 at 5:12 PM,

n. 1/12/26 at 7:45 AM

o. 1/31/26 at 6:00 PM

p. 2/25/26 at 10:06 AM and 10:17 AM.

2. MR # 6 was admitted on 2/20/25 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 3/12/25 at 1:09 PM

b. 3/17/25 at 7:06 PM

c. 3/26/25 at 4:16 PM

d. 7/9/25 at 12:08 PM

e. 7/21/25 at 2:07 PM

f. 9/25/25 at 7:51 AM.

An interview was conducted on 6/12/26 at 8:13 AM with Employee Indentifer (EI) # 1, Director of Clinical Services, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

3. MR # 1 was admitted on 2/23/26 with a diagnosis of Disruption Mood Dysregulation Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 5/14/26 at 10:39 AM, 10:50 AM, and 11:14 AM.

An interview was conducted on 6/11/26 at 1:06 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were made by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

4. MR # 8 was admitted on 3/27/26 with a diagnosis of Adjustment Disorder.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 4/7/26 at 2:55 PM

b. 4/19/26 at 12:53 PM

c. 5/12/26 at 6:42 PM

d. 5/30/26 at 11:37 AM

e. 6/4/26 at 6:07 PM.

An interview was conducted on 6/11/26 at 12:48 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.

5. MR # 7 was admitted on 7/15/2025 with a diagnosis of Conduct Disorder Childhood Onset.

A review of the MR revealed orders for restraint use were not provided by a physician or other licensed practitioner permitted by the State and the facility in the use of a physical restraint on:

a. 8/3/2025 at 7:42 PM

b. 8/4/2025 at 12:40 PM

c. 8/10/2025 at 8:33 AM, 8:45 AM

d. 8/16/2025 at 4:22 PM, 4:53 PM, and 5:03 PM

e. 8/25/2025 at 1:52 PM, 2:08 PM

f. 8/29/2025 at 4:30 PM, 4:38 PM, 6:13 PM, 6:37 PM, 6:45 PM, and 7:15 PM

	g. 9/21/2025 at 5:24 PM, 5:27 PM h. 9/29/2025 at 9:22 AM i. 10/14/2025 at 5:07 PM j. 10/21/2025 at 7:50 PM, 7:55 PM k. 10/25/2025 at 11:40 AM l. 10/29/2025 at 3:36 PM, 3:43 PM m. 11/1/2025 at 4:06 PM n. 11/6/2025 at 3:48 PM, 3:52 PM, 3:54 PM, 4:14 PM, and 4:18 PM o. 11/11/2025 at 11:37 AM p. 1/13/2026 at 1:38 PM q. 1/19/2026 at 8:23 AM r. 4/13/2026 at 12:12 PM, 1215 PM An interview was conducted on 6/11/26 at 1:05 PM with EI # 1, who confirmed the facility failed to ensure orders for restraints were given by a physician or other licensed practitioner permitted by the State and the facility to order restraints.