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)
N0165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on medical record (MR) review and interviews with staff, it was determined the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually assessed and monitored the resident during the use of a physical restraint. 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 there was no documentation of continuous monitoring and assessment of MR # 5 during the use of a physical restraint on 7/3/25 at 6:09 PM, 8/25/25 at 7:18 AM, 10/16/25 at 5:35 PM, and 2/25/26 at 10:06 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 staff

clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

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

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 6 during the use of a physical restraint on 3/17/25 at 7:06 PM and 7/21/25 at 2:07 PM.

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 staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

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

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 1 during the use of a physical restraint on 5/14/26 at 10:39 AM, 10:50 AM and 11:14 AM.

An interview was conducted on 6/11/26 at 12:48 PM with EI # 1, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

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

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 8 during the use of a physical restraint on 4/7/26 at 2:55 PM, 4/19/26 at 12:53 PM, 5/12/26 at 6:42 PM, 5/30/26 at 11:37 AM and 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 staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.

5. MR # 7 was admitted on 07/15/2025 with a diagnosis of Conduct Disorder Childhood Onset.

A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 7 during the use of a physical restraint on 08/19/2025 at 11: 47 PM.

An interview was conducted on 6/11/26 at 01:05 PM with EI # 1, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed residents during the use of a physical restraint.