Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	01L018	05/21/2026
Name of Provider or Supplier	**Street Address, City, State**	
Sequel Tsi Of Alabama, Llc	135 Mildred Street, 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)
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: 1. Obtain the physician or other licensed practitioner signature verification for a verbal restraint order. 2. Ensure a verbal order was received by a registered nurse or other licensed staff qualified to accept orders. This affected five of six MR's including MR # 6, MR # 1, MR # 2, MR # 3, and MR # 4 and had the potential to negatively affect all patients restrained at this facility. Findings Include: Department of Mental Health Mental Illness Community Programs Administrative

Code

Chapter 580-2-9

Rule 580-2-9-.23 Child and Adolescent Seclusion and Restraint

...(g) Each verbal order received from a physician, certified registered nurse practitioner, or physician's assistant must be signed within 48 hours.

1. MR # 6 was admitted on 1/6/26 with diagnoses including Conduct Disorder.

A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 2/17/26 at 7:40 AM, on 3/30/26 at 12:00 PM and on 3/30/26 at 7:40 PM.

Further review of the MR revealed the Licensed Independent Practitioners (LIP) Form dated on 2/17/26 documented the order for the restraint was taken by Employee Identifier (EI) # 11, Certified Medical Assistant (CMA), an unlicensed staff member.

An interview was conducted on 5/21/26 at 1:39 PM with EI # 1, Executive Director who confirmed the facility failed to obtain a physician or other licensed practitioner's signature verification for the verbal restraint order.

2. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation Disorder.

A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 12/20/25 at 9:30 AM.

Further review of the MR revealed the LIP Form dated on 12/20/25 documented the order for the restraint was taken by EI # 11, an unlicensed staff member.

3. MR # 2 was admitted on 3/23/26 with diagnoses including Parent-Child Relational Problem.

A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 3/27/26 at 8:50 PM.

Further review of the MR revealed the LIP Form dated on 3/27/26 documented the order for the restraint was taken by EI # 11, an unlicensed staff member.

4. MR # 3 was admitted on 3/26/26 with diagnoses including Conduct Disorder.

A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 3/27/26 at 10:20 PM.

5. MR # 4 was admitted on 11/3/2025 with diagnoses including Child Neglect.

A review of the MR revealed no documentation of a physician's or licensed practitioner's signature for the restraints ordered on 2/13/26 at 2:20 PM.

Further review of the MR revealed the LIP Form dated on 2/13/26 documented the order for the restraint was taken by EI # 11, an unlicensed staff member.

	An interview was conducted on 3/21/26 at 2:20 PM with EI # 1, who confirmed the facility failed to ensure all verbal orders were received by a licensed staff member and signed by a physician or other licensed practitioner.