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)
N0145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on medical record (MR) review and interviews with staff, it was determined the facility failed to ensure a face-to-face (F2F) evaluation was performed within one hour after the application of restraint or seclusion. This affected five of six MR's reviewed including MR # 1, MR # 2, MR # 3, MR # 4, and MR # 6 and had the potential to negatively affect all patients restrained at this facility. Findings include: 1. MR # 1 was admitted on 11/24/25 with diagnoses including Disruptive Mood Dysregulation Disorder. A review of the MR revealed no documentation a F2F assessment was performed

within one hour after the initiation of a physical restraint on 12/20/25 at 9:30 AM.

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

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 3/27/26 at 8:50 AM, on 4 /1/26 at 12:00 PM, and on 4/13/26 at 12:04 PM.

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

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 3/27/26 at 10:20 PM.

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

A review of the MR revealed no documentation of a Nursing F2F Assessment after a physical restraint on 2/13/26 at 2:15 PM.

A review of the MR revealed no documentation a F2F assessment was performed within one hour after the initiation of a physical restraint on 2/13/26 at 2:15 PM.

An interview was conducted on 5/21/26 at 2:20 PM with Employee Identife # 1, Executive Director, who confirmed the facility failed to ensure a F2F assessment was performed within one hour after the initiation of restraint.

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

A review of the MR revealed MR # 6 was placed in a restraint on 2/17/26 from 7:35 AM to 7:38 AM and the Nursing F2F Assessment was performed on 2/17/26 at 4:00 PM by EI # 11.

Further review of the MR revealed MR # 6 was placed in a restraint on 3/30/26 from 7: 45 PM to 7:50 PM and the F2F Assessment was performed on 3/31/26 at 7:05 AM by EI # 10, Licensend Practical Nurse (LPN).

An interview was conducted on 5/21/26 at 1:39 PM with Employee Identifier # 1, Executive Director who confirmed the facility failed to ensure a F2F assessment was performed within one hour of the initiation of a physical restraint.