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)
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, review of facility policy and procedure, 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 affected four of six MR's including MR # 1, MR # 2, MR # 3, and MR # 4 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 there was no documentation of continuous monitoring and assessment of MR # 1 during the use of a physical restraint on 12/20/25 at 9:30 AM. 2. MR # 2 was admitted on 3/23/26 with diagnoses including Parent-Child Relational Problem.

	A review of the MR revealed there was no documentation of continuous monitoring and assessment of MR # 2 during the use of a physical restraint on 3/27/26 at 8:50 PM and 10:00 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 there was no documentation of continuous monitoring and assessment of MR # 3 during the use 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 there was no documentation of continuous monitoring and assessment of MR # 4 during the use 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 Identifier # 1, Executive Director, who confirmed the facility failed to ensure staff clinically trained in the use of emergency safety interventions continually monitored and assessed the residents during the use of a physical restraint.