Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Via Email
December 22, 2025

Administrator
Hoffmann Center
1715 Sheppard Drive
Saint Peter, MN 56082

Re: Event ID: ZSWZ12

Administrator:

A revisit survey was conducted on 11/17/2025 to follow up on deficiencies issued related to a certification survey exited on August 28, 2025. Your facility was found to be in compliance with the Conditions of Participation (COP) at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21.

Feel free to contact me with any questions related to this letter.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24L003	A. BUILDING _____ B. WING _____	R-C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMANN CENTER	1715 SHEPPARD DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 000}	Initial Comments An onsite revisit was conducted on 11/17/25, to follow up on deficiencies issued related to a complaint survey exited on 8/28/25. Your facility was found in compliance with the Conditions of Participation (COP) at §483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. .	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

September 11, 2025

Administrator
Hoffmann Center
1715 Sheppard Drive
Saint Peter, MN 56082

RE: Event ID: ZSWZ11

Dear Administrator:

On August 28, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the Conditions of Participation (COP) at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21.

At the time of the survey, the survey team from the Minnesota Department of Health noted one or more deficiencies. At the conclusion of this survey, the surveyors advised you of the findings, including the fact that your facility does not meet the requirements with the Conditions of Participation (COP) at 483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. The facility was found not in compliance.

At the time of this survey it was determined that the following Condition(s) of Participation were found not met:

0100 - 42 CFR 483.354 - Use of Restraint and Seclusion

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC).

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by October 12, 2025, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

Feel free to contact me with any questions related to this letter.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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N 000	Initial Comments Susie Haben received 9/24/25 Approved 9/25/25 POC 10/8/25 From 8/27/25 through 8/28/25, a complaint investigation was conducted at Hoffmann Center by the Minnesota Department of Health (MDH) to determine compliance with the Conditions of Participation (COP) at §483. subpart G for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21. The facility was not in compliance. The following complaint was reviewed: HL0039989C (MN00114675) with a condition level deficiency issued at N-0100 related to N-0126, N-0132 and N-0222. As a result of the investigation, a deficiency was also issued at N-0222. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations had been attained in accordance with your verification.	N 000	See N-126 & N-132	
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One.	N 100		

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N 100	Continued From page 1 This CONDITION is not met as evidenced by: The Psychiatric Residential Treatment Facility (PRTF) was found to be out of compliance with the Condition of Participation (COP) when the facility failed to ensure emergency safety interventions (ESI) were performed in a manner that was safe, appropriate and with out coercion and failed to ensure staff was trained in Crisis Prevention Intervention (CPI) on a 6-month basis. Findings include See N-0132: The facility failed to ensure emergency safety interventions (ESI) were performed in a manner that was safe for 1 of 1 resident (R1) when R1's door was kicked open by staff during a behavioral event resulting in R1 being placed in an inappropriate hold with no evidence of least restrictive measures implemented. See N-0126: The facility failed to ensure 1 of 1 resident (R1) was free from restraint as a means of coercion when an employee kicked the resident's door open during a behavioral event leading to a unsafe restraint, additionally revealing similar historical facility practices. See N-0222: The facility failed to ensure completion of Crisis Prevention Intervention (CPI) training semi-annually (every 6 months) for 1 of 1 employee, youth counselor (YC)-A, reviewed for demonstration of competencies in the safe use of restraint and seclusion.	N 100		
N 126	PROTECTION OF RESIDENTS CFR(s): 483.356 (a)(1) Each resident has the right to be free from	N 126		

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N 126	Continued From page 2 restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. This ELEMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 1 resident (R1) was free from restraint as a means of coercion when an employee kicked the resident's door open during a behavioral event leading to a unsafe restraint, additionally revealing similar historical facility practices. Findings include: R1's Treatment Plan dated 8/6/25, indicated diagnoses of attention deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity, and impulsiveness), and disruptive mood dysregulation disorder (a condition that involves chronic irritability and frequent, intense temper outbursts) with a history of aggression, assaultive behaviors, property damage, and difficulty maintaining relationships. R1's Incident Report dated 7/21/25 at 2:27 p.m., written by youth counselor (YC)-A, indicated the following: R1 argued with YC-B and then went to his room and shut his door. YC-A opened R1's door, and prompted R1 to keep the door open, but R1 attempted to slam the door shut continuously. YC-A forced the door open, stood in the doorway, and R1 continued to try to close the door, and other staff was called to the unit. When R1 put all his weight against the door, YC-A escorted R1 out of the room towards the common area, off the unit. When the door to the common area was open, other staff aided YC-A, and put	N 126	**N-126-** Executive Director and Training Specialist will implement a 2 week CPI refresher for new hires. This will be scheduled as a part of the orientation process. ∞ Target completion: Oct 1st, 2025 ∞ By Who: Training Specialist ∞ How do we sustain: CQI indicator to ensure 2 week refresher is completed for all new hires, add this training to the orientation check list, training compliance manual revision **N-126:** The Executive Director and Director of Quality and Compliance (ED and DQC) will evaluate full course and refreshers of CPI, Ukeru, and Trauma training. Evaluation will review thoroughness of training and that it addresses staff responsibility to prohibited intervention, coercion, discipline, retaliation, or convenience. Any areas that revision is identified will be relayed to the Training Specialist that will then review the revisions with staff in the weekly staff meeting. **Target Completion:** Oct 1st, 2025 **By Who:** ED and DQC **How do we sustain:** Annual evaluations of trainings provided to staff will be completed by the DQC.	

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N 126	Continued From page 3 R1 in a supine hold. During the debriefing with R1 after the incident, R1 complained of a sore neck, left arm, and shoulder. The staff debriefing did not include YC-A who was excused from the debriefing. Administrative review of the incident on 7/22/25 at 1:34 p.m., indicated proper procedures for the use of physical hold were not followed. During an interview and observation of the video footage of R1's 7/21/25 incident on 8/27/25 at approximately 12:30 p.m., director of quality and compliance (DCQ)-A, revealed R1 came out of his room, looked around and shut the door. YC-A approached the door, "vehemently kicked the door open with leg in the air with the bottom of his foot, and then stood in [R1's] doorway". YC-A and R1 exchanged words, [no audio on video], and then YC-A held R1 by the back of the neck, lifted R1's left arm straight up behind R1, and moved R1 towards the unit door by himself. R1 removed himself from YC-A's hold, and turned towards YC-A, and YC-A wrapped his left arm around R1's body, near the neck, and YC-A's right arm was on R1's right shoulder. The DCQ acknowledged it appeared YC-A's hand was on R1's neck, and then YC-A wrapped his arm around R1's body during transport, with the assistance of another staff to transport R1 off the unit. During an interview on 8/27/25 at 3:58 p.m., YC-A stated when he removed R1 from the unit it, "was a little more intense than it usually is," and thought he put his hand on R1's back initially to move R1 off the unit. R1 tried to fight him, and then YC-A wrapped an arm around R1. YC-A acknowledged the CPI protocol was to use two staff for escort, and would not indicate to grab a	N 126	**9/24/25 Addition:** **N-126:** All current unit supervisors, lead support counselors, and youth counselors will be re-trained in policy and procedure related to: Staff duty to prohibited interventions that would meet definitions of coercion, discipline, retaliation, and convenience. **Target Completion**: 10/8/25 **By who**: Training Specialist and designated leadership **How do we sustain**: With the implementation of the annual training evaluation, these topics are evaluated on the evaluation form to ensure reviewers are assessing these topics in the intervention training.	

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N 126	Continued From page 4 client by the neck. YC-A acknowledged he forcefully kicked R1's door open, which could have frightened R1, and identified the act as, "bad judgement," on his part, as R1 could have been behind the door and injured in the process. During a subsequent interview on 8/28/25 at 10:42 a.m., YC-A stated he had just seen the video of the 7/21/25 incident, and thought kicking the door open was the worst part of the incident. YC-A acknowledged his hand was on R1's neck during transport off the unit, but a basket hold should have been the intervention for that circumstance. When asked what part of the incident included unapproved CPI, YC-A responded, "honestly, the whole thing....in the video it looks like I was raging mad." YC-A further acknowledged prior to R1's incident on 7/21/25, when clients would slam their doors and kick them, he would tell clients staff could kick doors too, kick their doors, and then ask the clients how they like it, and say it in a, "Grounded and not super angry way." YC-A acknowledged kicking a door could be re-traumatizing to clients with a history of trauma, all the residents on the unit had a history of trauma, and stated, "It's just not a funny thing to do in a treatment center." During an interview on 8/28/25 at 9:58 a.m., YC-B stated R1 was in his room with the door closed, but the door was not allowed to be closed because R1 was on direct behavioral observations (DBO) meaning staff had to be able to observe R1 due to risk of self-harm. YC-B stated R1 and another resident were exchanging "typical pre-fight words" that escalated into physical altercations several times previously. Due the size difference between R1 and the other resident, YC-B and YC-A determined there was	N 126	**9/24/25 Addition: N-126** **Actions Taken with YC-A** YC-A was separated from the resident. YC-A was removed from working with the residents pending the results of the internal review and results from LAHC reporting to MDH. YC-A received a reprimand in the form of a final written warning (has never had a prior instance) regarding the use of non-approved physical interventions. YC-A was retrained in full course CPI, Ukeru, and Trauma Informed Services. These trainings included training on staff duty to prohibited intervention It was mandatory to complete these prior to returning to providing care to the residents. (These were completed prior to 9/5 the target return to care date). YC-A will meet with Residential Treatment Supervisor (RTS) weekly through 11/20/25 for additional clinical supervision with agenda items including: Anger management, self-care, psychoeducation regarding client diagnosis and history. YC-A was given directions to avoid interaction with identified client. YC-A reviewed the video footage of the incident with the (RTS) and processed his actions, understanding the residents perspective, trauma, and safety concerns.	

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N 126	Continued From page 5 imminent risk of harm to R1, so R1 needed to be moved off the unit for his own safety, and staff needed to open the door to be able to observe R1's DBO order. YC-B acknowledged YC-A kicked R1's door open to allow for visualization of R1. YC-B further acknowledged she had seen YC-A kick residents' doors open before, but, "most of the time it is done in jest." YC-B further acknowledged, "Any time you have to put your hands on a kid in a way that is not directly taught by CPI, it doesn't look good." YC-B denied seeing YC-A escort R1 with a hand on R1's neck. During a subsequent interview on 8/28/25 at 10:40 a.m., after YC-B had seen the video of the incident, YC-B stated it appeared YC-A had his hand on the base of R1's neck during the escort off the unit, and acknowledged it was not an approved CPI hold. YC-B further stated R1 could have been injured if he had been behind the door when YC-A kicked it open, and it didn't feel good to see the video, the same way she felt after the incident. YC-B did not report the incident, and further stated R1's mom would probably be happy about how the incident was handled because R1 was not assaulted by the other resident again. YC-B acknowledged all of the clients on the unit had a history of trauma, and could have been triggered by staff kicking the door in. During an interview on 8/28/25 at 12:02 p.m., the training specialist (TS)-A stated he reviewed the video for R1's incident on 7/21/25 at 2:27 p.m., and acknowledged it appeared YC-A kicked R1's door open, and YC-A had his hand on R1's neck while leading R1 off the unit. The TS-A further stated staff should not escort clients alone, and instead should have two staff to safely escort a resident to another area, with one staff on each	N 126		

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N 126	Continued From page 6 side of the resident, and never with an hand on a client's head or neck; a single-person transfer was not trained nor recommended. The TS-A stated the door kick, and then YC-A's interventions afterwards, were not safe or approved CPI interventions. The facility failed to provide evidence of training for all staff working with residents specific to protection of residents and their right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. The facility Staff Development policy dated 4/24, indicated staff members were required training in specific areas, including CPI, and failure to meet training requirements may result in disciplinary action. The policy indicated staff would attend CPI semi-annually.	N 126		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency safety interventions (ESI) were performed in a manner	N 132		

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N 132	Continued From page 7 that was safe for 1 of 1 resident (R1) when R1's door was kicked open by staff during a behavioral event resulting in R1 being placed in an inappropriate hold with no evidence of least restrictive measures implemented. Findings include: R1's Treatment Plan dated 8/6/25, indicated diagnoses of attention deficit hyperactivity disorder (a chronic condition including attention difficulty, hyperactivity, and impulsiveness), and disruptive mood dysregulation disorder (a condition that involves chronic irritability and frequent, intense temper outbursts) with a history of aggression, assaultive behaviors, property damage, and difficulty maintaining relationships. R1's Incident Report dated 7/21/25 at 2:27 p.m., written by youth counselor (YC)-A, indicated the following: R1 argued with YC-B and then went to his room and shut his door. YC-A opened R1's door, and prompted R1 to keep the door open, but R1 attempted to slam the door shut continuously. YC-A forced the door open, stood in the doorway, and R1 continued to try to close the door, and other staff was called to the unit. When R1 put all his weight against the door, YC-A escorted R1 out of the room towards the common area, off the unit. When the door to the common area was open, other staff aided YC-A, and put R1 in a supine hold. During the debriefing with R1 after the incident, R1 complained of a sore neck, left arm, and shoulder. The staff debriefing did not include YC-A who was excused from the debriefing. Administrative review of the incident on 7/22/25 at 1:34 p.m., indicated proper procedures for the use of physical hold were not followed.	N 132	**N132-** Evaluate training of verbal de-escalation techniques and staff responsibility to prohibited procedures. This will be reviewed in the full course and refreshers of CPI, Ukeru, and the trauma training. If content needs revisions the Executive Director will advise the training specialist to update the content and attend weekly staff meetings to provide updated content to staff members. ∞ Target completion: October 1st, 2025 ∞ By Who: Training Specialist ∞ How do we sustain: ED and DQC will revise the training compliance manual to incorporate a training content evaluation plan to have core trainings reviewed for content annually. **9/24/25 Addition:** **N-132:** All current unit supervisors, lead support counselors, and youth counselors will be re-trained in policy and procedure related to: Staff duty to prohibited interventions that would meet definitions of coercion, discipline, retaliation, and convenience. **Target Completion**: 10/8/25 **By who**: Training Specialist and designated leadership **How do we sustain**: With the implementation of the annual training evaluation, these topics are evaluated on the evaluation form to ensure reviewers are assessing these topics in the intervention training.	

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N 132	Continued From page 8 During an interview and observation of the video footage of R1's 7/21/25 incident on 8/27/25 at approximately 12:30 p.m., director of quality and compliance (DCQ)-A, revealed R1 came out of his room, looked around and shut the door. YC-A approached the door, "vehemently kicked the door open with leg in the air with the bottom of his foot, and then stood in [R1's] doorway". YC-A and R1 exchanged words, [no audio on video], and then YC-A held R1 by the back of the neck, lifted R1's left arm straight up behind R1, and moved R1 towards the unit door by himself. R1 removed himself from YC-A's hold, and turned towards YC-A, and YC-A wrapped his left arm around R1's body, near the neck, and YC-A's right arm was on R1's right shoulder. The DCQ acknowledged it appeared YC-A's hand was on R1's neck, and then YC-A wrapped his arm around R1's body during transport, with the assistance of another staff to transport R1 off the unit. During an interview on 8/27/25 at 1:00 p.m., YC-C stated transporting clients off the unit required the use of two staff, and acknowledged he had not had re-training recently about approved CPI holds since the 7/21/25 incident with R1. During an interview on 8/27/25 at 1:11 p.m., R1 stated he was escorted off the unit while YC-A held one of his hand in the air, and used his other hand to hold the back of his neck; then YC-A switched to a, "Choke hold." R1 stated a normal hold was a seated hold or a supine hold, and staff should not be using a choke hold. During an interview on 8/27/25 at 1:26 p.m., YC-E stated he had not received re-training recently	N 132	**9/24/25 Addition: N-132:** Actions Taken with YC-A YC-A was separated from the resident. YC-A was removed from working with the residents pending the results of the internal review and results from LAHC reporting to MDH. YC-A received a reprimand in the form of a final written warning (has never had a prior instance) regarding the use of non-approved physical interventions. YC-A was retrained in full course CPI, Ukeru, and Trauma Informed Services. These trainings included training on staff duty to prohibited intervention It was mandatory to complete these prior to returning to providing care to the residents. (These were completed prior to 9/5 the target return to care date). YC-A will meet with Residential Treatment Supervisor (RTS) weekly through 11/20/25 for additional clinical supervision with agenda items including: Anger management, self-care, psychoeducation regarding client diagnosis and history. YC-A was given directions to avoid interaction with identified client. YC-A reviewed the video footage of the incident with the (RTS) and processed his actions, understanding the residents perspective, trauma, and safety concerns.	

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N 132	Continued From page 9 related to approved CPI holds but acknowledged he was required to do CPI training either annually or twice a year, but wasn't sure. YC-E stated two staff were required to transport a client off the unit. During an interview on 8/27/25 at 1:43 p.m., unit supervisor (US)-A stated she walked in during the incident, and it appeared R1 was being transported with one of YC-A's arms around R1's shoulder, in the neck area, which was not a typical hold, and, "It was like the staff's arm was around his [R1] neck." US-A indicated there was a mandatory staff meeting on July 15th about CPI, and not all staff attended. The US-A acknowledged not all staff received the training, and it was the responsibility of the supervisors to ensure each staff received the training. Per the training record YC-C and YC-E did not attend the training as stated. Review of the attendance sheets for the staff meeting dated 7/15/25, included CPI techniques indicated YC-A and YC-B received the training, which was prior to R1's incident on 7/21/25. An additional training was offered after the incident on 8/12/25, in which YC-B attended, but YC-A was listed as N/A, not applicable. During an interview on 8/27/25 at 3:58 p.m., YC-A stated when he removed R1 from the unit it, "was a little more intense than it usually is," and thought he put his hand on R1's back initially to move R1 off the unit. R1 tried to fight him, and then YC-A wrapped an arm around R1. YC-A acknowledged the CPI protocol was to use two staff for escort, and would not indicate to grab a client by the neck. YC-A acknowledged he forcefully kicked R1's door open, which could	N 132		

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N 132	Continued From page 10 have frightened R1, and identified the act as, "bad judgement," on his part, as R1 could have been behind the door and injured in the process. During a subsequent interview on 8/28/25 at 10:42 a.m., YC-A stated he had just seen the video of the 7/21/25 incident, and thought kicking the door open was the worst part of the incident. YC-A acknowledged his hand was on R1's neck during transport off the unit, but a basket hold should have been the intervention for that circumstance. When asked what part of the incident included unapproved CPI, YC-A responded, "honestly, the whole thing....in the video it looks like I was raging mad." YC-A further acknowledged prior to R1's incident on 7/21/25, when clients would slam their doors and kick them, he would tell clients staff could kick doors too, kick their doors, and then ask the clients how they like it, and say it in a, "Grounded and not super angry way." YC-A acknowledged kicking a door could be re-traumatizing to clients with a history of trauma, all the residents on the unit had a history of trauma, and stated, "It's just not a funny thing to do in a treatment center." During an interview on 8/28/25 at 9:58 a.m., YC-B stated R1 was in his room with the door closed, but the door was not allowed to be closed because R1 was on direct behavioral observations (DBO) meaning staff had to be able to observe R1 due to risk of self-harm. YC-B stated R1 and another resident were exchanging "typical pre-fight words" that escalated into physical altercations several times previously. Due the size difference between R1 and the other resident, YC-B and YC-A determined there was imminent risk of harm to R1, so R1 needed to be moved off the unit for his own safety, and staff	N 132		

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N 132	Continued From page 11 needed to open the door to be able to observe R1's DBO order. YC-B acknowledged YC-A kicked R1's door open to allow for visualization of R1. YC-B further acknowledged she had seen YC-A kick residents' doors open before, but, "most of the time it is done in jest." YC-B further acknowledged, "Any time you have to put your hands on a kid in a way that is not directly taught by CPI, it doesn't look good." YC-B denied seeing YC-A escort R1 with a hand on R1's neck. During a subsequent interview on 8/28/25 at 10:40 a.m., after YC-B had seen the video of the incident, YC-B stated it appeared YC-A had his hand on the base of R1's neck during the escort off the unit, and acknowledged it was not an approved CPI hold. YC-B further stated R1 could have been injured if he had been behind the door when YC-A kicked it open, and it didn't feel good to see the video, the same way she felt after the incident. YC-B did not report the incident, and further stated R1's mom would probably be happy about how the incident was handled because R1 was not assaulted by the other resident again. YC-B acknowledged all of the clients on the unit had a history of trauma, and could have been triggered by staff kicking the door in. During an interview on 8/28/25 at 12:02 p.m., the training specialist (TS)-A stated he reviewed the video for R1's incident on 7/21/25 at 2:27 p.m., and acknowledged it appeared YC-A kicked R1's door open, and YC-A had his hand on R1's neck while leading R1 off the unit. The TS-A further stated staff should not escort clients alone, and instead should have two staff to safely escort a resident to another area, with one staff on each side of the resident, and never with an hand on a client's head or neck; a single-person transfer	N 132		

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N 132	Continued From page 12 was not trained nor recommended. The TS-A stated the door kick, and then YC-A's interventions afterwards, were not safe or approved CPI interventions. The Orientation of New Employees policy dated 4/24, indicated staff should have the following training: CPI, professional boundaries, policies and procedures on use of physical holding, and safety/ supervision. The policy further indicated 8 hours of training prior to assuming job responsibilities included CPI, principles of positive support strategies, and staff responsibility related to prohibited procedures.	N 132	**N-172-** Ensuring the safety in seclusion rooms, Executive Director and the Office Manager will work with the electronic health record provider to update form # L370-1081 (incident report) to include an indicator to evaluate for potentially hazardous conditions in the seclusion room following use. If this is indicated the DQC will inspect and evaluate for safe usage. ∞ Target completion: October 1st, 2025 EHR company will receive work order. ∞ By who: Executive Director & Office Manager ∞ How do we sustain: the indicator added to the incident report following seclusion room use will trigger inspection of the room to ensure safe use. **N-172:** Ensuring staff members using the seclusion room understand the physical conditions of the seclusion room including an individualized posting in the small entry of the rooms for staff reference. **Target Completion:** 9/26/25 **By Who:** DQC & Residential Treatment Supervisors **How we will sustain:** Reviewing the plant is a portion of Orientation for new staff. Current staff will be informed during staff meetings of the physical plant conditions and RTS will review and make any revisions to the individualized posting each treatment week. A date will be on it, noting its last update.	
N 172	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(b)(2) [A room used for seclusion must] Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets. This ELEMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure the seclusion rooms on the Evergreen and North units were free of potentially hazardous conditions for all clients in the facility reviewed for restraint/seclusion. Findings include: During an observation and interview on 8/27/25 at 10:15 a.m., during a tour with the clinical director (CD)-A, the seclusion room on the Evergreen unit was noted to have padding missing the full height of the room, to the right of the door, with bare	N 172		

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N 172	Continued From page 13 pressed board exposed. Many pressed wood splinters were on the floor by the door. The protective pad on the inside of the metal door to the seclusion room was missing, but had marks where a pad had previously been attached. The CD-A stated the padding had been missing for a while and had been a problem to repair. During an interview on 8/27/25 at 1:26 p.m., youth counselor (YC)-E stated he was unaware the Evergreen seclusion room was out of order until he saw a sign that day, but hadn't seen it the day before, and had not been told to not use the seclusion room. During an interview on 8/27/25 at 1:43 p.m., unit supervisor (US)-A stated the seclusion room in the Evergreen building was last used, "About a month ago," and staff noticed the pad was missing, so the resident was transported to a seclusion room in another building. US-A stated she was not aware the padding was missing in the seclusion room before that. US-A stated the sign indicating the seclusion was out of order was put on the seclusion room door on 8/27/25. During an interview on 8/27/25 at 2:25 p.m., YC-D stated the whole seclusion room should be padded, including the door, and padding missing next to the a seclusion room door would not be a safe environment because the clients hit the walls and doors, and also bang their heads on both. YC-D stated the padding was present in the Evergreen seclusion room 3-4 months ago. Review of an incident report on 8/28/25, dated 8/7/25 at 8:26 p.m., revealed a client was placed in Evergreen seclusion at approximately 8:33 p.m., the client kicked the door a few times, and	N 172		

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N 172	Continued From page 14 then turned attention to the wall and stated he was going to give himself a sliver with the wood, and then picked at the exposed wooden wall. During an interview on 8/27/25 at 1:00 p.m., during an interview YC-C stated any client could require seclusion, and stated he seclusion room in the North building was operational but was missing the padding on the door. YC-C stated usually the clients leaned against the door in the seclusion room, and sometimes banged their heads on it. During an observation on 8/27/25 at 2:19 p.m., the seclusion room in the North building lacked padding on the inside of the seclusion room door, but had marks where a pad had previously been attached. Review of an incident report on 8/28/25, dated 8/17/25 at 5:05 p.m., revealed a client was placed in the North seclusion at approximately 5:08 p.m., and remained in the room with no pad on the door for approximately 28 minutes. At 5:18 p.m., the client hit the un-padded door a few times. At 5:36 p.m., the client punched the padded wall a few times. Review of a work order on 8/28/25, revealed the work order was dated 7/17/25, and specified, "One padded panel missing in the seclusion room." The work order did not indicate the pad was missing from the door, nor indicate the priority of the work order. There were no work	N 172		

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N 172	Continued From page 15 orders for the North seclusion room to replace the pad on the door. During an interview on 8/28/25 at 9:24 a.m., the CD-A stated staff would not typically transport a resident from one building to the other for seclusion, and there was no rule to have padding on the door for the seclusion room. During an interview on 8/28/25 at 9:44 a.m., the maintenance worker (MW)-A stated the seclusion rooms were on a backlog list of work to do. The maintenance worker stated the work orders were not entered on the work order log until the work was complete, and he kept the requests that were not complete in his office. The MW-A stated supervisors got an email to not use the seclusion room, but was not sure if the YC's received the same email. The MW-A stated buying the pads was too expensive so he needed to custom make them, and was waiting for materials. In a subsequent interview on 8/28/25 at 11:24 a.m., the CD-A acknowledged the work order for the Evergreen unit seclusion room was dated 7/17/25, and the sign to designate the seclusion room was, "Out of order," was placed 8/27/25, but should have been placed on the door when the work order was completed. The CD-A acknowledged the seclusion room was not safe to use with the padding missing next to the door and without padding on the door. The General Maintenance Procedure dated 12/2/24, indicated in the event anything becomes damaged or in need of repair, staff should record it on a, "Maintenance Request Form," with the date, specific damage or repair needed, location, and should indicate whether the maintenance	N 172		

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N 172	Continued From page 16 concern is low, medium, or high priority to be repaired.	N 172		
N 222	EDUCATION AND TRAINING CFR(s): 483.376(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure completion of Crisis Prevention Intervention (CPI) training semi-annually (every 6 months) for 1 of 1 employee, youth counselor (YC)-A, reviewed for demonstration of competencies in the safe use of restraint and seclusion. Findings include: Review of the training record review for YC-A on 8/28/25 at 8:40 a.m., revealed YC-A was trained in CPI on 1/22/24, 8/29/24, and 4/23/25. During an interview on 8/28/25 at 12:02 p.m., the training specialist (TS)-A stated all staff were required to complete CPI training every 6 months, and staff were sent reminders a month before the training was due. The TS-A stated staff was considered compliant with the training requirement if it was completed within the 7th month, and acknowledged YC-A did not meet the training requirements. During an interview on 8/28/25 at 12:27 p.m., YC-A stated the facility's CPI training policy	N 222	**N-222:** Ensuring staff compliance with CPI training will be obtained with the use of disciplinary measures, withholding performance incentives (raises), and unpaid removal from the schedule until compliance is obtained. ∞ Target completion: October 1st, 2025 ∞ By who: Training Specialist, Human resources ∞ How do we sustain: TS continues to provide ED monthly compliance rates, HR continues to withhold raises, ED or HR will immediately alert direct supervisor to non-compliance who will immediately contact and remove staff member from schedule until compliance is achieved.	

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N 222	Continued From page 17 stipulated each staff would have training in CPI, but did not know the required frequency. YC-A acknowledged he "probably" received email reminders, and further acknowledged he had not completed the CPI training every 6 months as required. YC-A acknowledged CPI was offered in the evenings, outside of his normal shift, but stated, "No one is going to do that. We have lives and kids at home and stuff to do." During an interview on 8/27/25 at 1:43 p.m., unit supervisor (US)-A stated CPI training was required every 6 months. US-A stated during a staff meeting on 7/15/25 the facility had a mandatory staff meeting in which CPI holds were discussed, and it was the responsibility of the supervisors to provide the training to staff who did not attend. The US-A acknowledged not all staff were trained in the mandatory all-staff training, and stated it was offered again later on 8/12/25. Review of the Staff Meeting CPI training records indicated less than 50% of the staff on both Evergreen and North units completed the required training. The training documents indicated the training was offered again after an incident occurred on the North unit on 7/21/25, but not until 8/12/25. During an interview on 8/28/25 at 12:36 p.m., the director of quality and compliance (DQC)-A stated staff had CPI training during orientation, and semi-annually thereafter. The DQC-A acknowledged she was not aware YC-A had not met the training requirements for CPI every 6 months, but based on the dates of training, was out out compliance. The DQC-A further acknowledged being out of compliance with CPI training could cause a lapse in performing CPI	N 222		

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N 222	Continued From page 18 correctly. The facility Staff Development policy dated 4/24, indicated staff members were required training in specific areas, including CPI, and failure to meet training requirements may result in disciplinary action. The policy indicated staff would attend CPI semi-annually.	N 222		