ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159

March 11, 2021

Gary Sneed , Administrator
Habilitation Center, Llc
P.O. Box 727
Fordyce, AR 71742

Dear Mr. Sneed:

A Complaint Investigation survey was conducted on March 4, 2021. We are pleased to inform you that no deficiencies were cited during the survey and that your facility was in compliance with the requirements of 42 CFR Part 483, Subpart G, Requirements for Psychiatric Residential Treatment Facilities. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program.

We have enclosed form CMS 2567, "Statement of Deficiencies and Plan of Correction" for the March 4, 2021 Complaint Investigation survey conducted at your facility for participation in the Medicaid program. **CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to** Amanda M Smith **at (501) 682-6159 or email to amanda.m.smith@dhs.arkansas.gov as soon as possible.**

If you have any questions please contact your reviewer at 501-**320-3963**.

Sincerely,

Amanda M Smith

RN Manager
DPSQA/Office of Long Term Care
Survey and Certification Section

ams

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L103	A. BUILDING _____ B. WING _____	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HABILITATION CENTER, LLC	1810 INDUSTRIAL DRIVE FORDYCE, AR 71742

(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 Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center. Complaint #AR00026284 was unsubstantiated.	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L103	HABILITATION CENTER, LLC

Type of Survey (select all that apply)

A				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. (b)(6), (b) (7	03/04/2021	03/04/2021	0.50	0.00	1.50	0.00	2.50	1.25
2.	03/04/2021	03/04/2021	0.50	0.00	1.50	0.00	2.50	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.25

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**