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
HUMANSERVICES.ARKANSAS.GOV

October 30, 2020

Bradley McDaris, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. McDaris:

On October 23, 2020 a Complaint Investigation survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction

A POC must be submitted within 10 calendar days of you receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

Amanda M Smith, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-3963;** Fax (501) 682-6159
or email to Amanda.M.Smith@dhs.arkansas.gov

Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

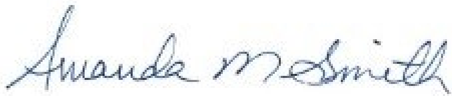
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

IDR/IIDR Program Coordinator
Health Facilities Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Phone: 501-661-2201
Fax: 501-661-2165
ADH.HFS@Arkansas.gov

If you have any questions, please call Amanda M Smith, RN Supervisor at 501-320-3963.

Sincerely,



RN Supervisor
DPSQA/Office of Long Term Care
Survey & 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
	04L117	A. BUILDING ______ B. WING ______	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	**2805 E ZION RD** **FAYETTEVILLE, AR 72703**

(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. Complaint #AR00025659 was unsubstantiated.	N 000		
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 observation and interview, the facility failed to ensure there were no sharp edges on doors for 2 of 2 seclusion rooms and door facings were without holes with sharp edges for 1 of 2 seclusion rooms to prevent possible injury to clients. The findings are: 1. On 10/23/20 at 11:45 a.m., in the West Hall seclusion room, there were two holes approximately one foot from the floor and two holes approximately five feet from the floor on the door facing. The holes had metal inside that ran to the outside and had sharp edges on the outer aspect of the holes.	N 172		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

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N 172	Continued From page 1 a. The Director of Performance Improvement was asked, are there sharp edges which could possibly cut someone? She stated, "I would prefer they be smoother." b. The Maintanenence Supervisor was asked, are there sharp edges? He stated, "Yes." c. There were two phillip head screws holding a metal plate on the inside of the seclusion room door with sharp edges on the screw heads. d. The Director of Performance Improvement was asked, are there sharp edges there that could possibly cut someone? She stated, "Yes." e. The Maintanenence Supervisor was asked, can you feel the sharp edges on them? He stated, "Yes, we can ground them off." 2. On 10/23/20 at 11:48 a.m., two screws were observed in a metal plate on the inside of the door of the East seclusion room. The screw heads were not flush with the metal plate. a. The Maintanenence Supervisor was asked, do they feel sharp? He stated, "Yeah, they can be screwed in further." 3. On 10/23/20 at 11:48 a.m., surveyor took pictures of above hazards.	N 172		
N 209	FACILITY REPORTING CFR(s): 483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated	N 209		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

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N 209	Continued From page 2	N 209		

Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a copy of a serious occurrence report was maintained in 1 (Client #2) of 1 (Client #2) sampled clients record who experienced a fractured ankle. The findings are:

1. Client #2 was admitted on 5/21/20 and had diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder, Combined Presentation.

a. A Serious Injury Reporting Form dated 9/21/20 at 3:39 p.m. documented, "On 9/19/20 [Client #2] at approx [approximately] 2110 [9:10 p.m.] busted through the East unit doors with several other residents and they were able to elope off the premises. Staff notified [Police] and officers assisted in searching for resident. Resident was recovered when he began calling for help from the woods after falling while trying to climb a fence. He had injured his ankle and had to be helped inside. Nurse noted severe swelling to rignt ankle, as well as bruising. MD [Doctor] ordered x-ray of ankle, results show 'soft tissue edema and swelling and displaced bone fragments in the joint secondary to acute trauma.'..."

b. There was no copy of the report found in the Client's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	**2805 E ZION RD** **FAYETTEVILLE, AR 72703**

(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 209	Continued From page 3 2. On 10/23/20 at 12:35 p.m., the Director of Nursing stated, "We have a copy of it, it just hasn't been put in the resident's chart yet."	N 209		

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
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HUMANSERVICES.ARKANSAS.GOV

November 16, 2020

Bradley McDaris, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. McDaris:

On October 23, 2020, we conducted a Complaint Investigation survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by November 09, 2020.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

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

Sincerely,

Amanda M Smith

Amanda M Smith, RN Manager
DPSQA/Office of Long Term Care
Survey & Certification Section

ams

Rec'd 11/13/2020
APOC 11/16/2020 AB

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

PRINTED: 10/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING ______ B. WING ______	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(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
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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 observation and interview, the facility failed to ensure there were no sharp edges on doors for 2 of 2 seclusion rooms and door facings were without holes with sharp edges for 1 of 2 seclusion rooms to prevent possible injury to clients. The findings are: 1. On 10/23/20 at 11:45 a.m., in the West Hall seclusion room, there were two holes approximately one foot from the floor and two holes approximately five feet from the floor on the door facing. The holes had metal inside that ran to the outside and had sharp edges on the outer aspect of the holes.	N 172		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad McDavis, RN, CEO
TITLE: CEO
(X6) DATE: 11/13/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(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 172	Continued From page 1 a. The Director of Performance Improvement was asked, are there sharp edges which could possibly cut someone? She stated, "I would prefer they be smoother." b. The Maintanence Supervisor was asked, are there sharp edges? He stated, "Yes." c. There were two phillip head screws holding a metal plate on the inside of the seclusion room door with sharp edges on the screw heads. d. The Director of Performance Improvement was asked, are there sharp edges there that could possibly cut someone? She stated, "Yes." e. The Maintanence Supervisor was asked, can you feel the sharp edges on them? He stated, "Yes, we can ground them off." 2. On 10/23/20 at 11:48 a.m., two screws were observed in a metal plate on the inside of the door of the East seclusion room. The screw heads were not flush with the metal plate. a. The Maintanence Supervisor was asked, do they feel sharp? He stated, "Yeah, they can be screwed in further." 3. On 10/23/20 at 11:48 a.m., surveyor took pictures of above hazards.	N 172		
N 209	FACILITY REPORTING CFR(s): 483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated	N 209		

PRINTED: 10/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING ______ B. WING ______	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

(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 209	Continued From page 2 Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a copy of a serious occurrence report was maintained in 1 (Client #2) of 1 (Client #2) sampled clients record who experienced a fractured ankle. The findings are: 1. Client #2 was admitted on 5/21/20 and had diagnoses of Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder, Combined Presentation. a. A Serious Injury Reporting Form dated 9/21/20 at 3:39 p.m. documented, "On 9/19/20 [Client #2] at approx [approximately] 2110 [9:10 p.m.] busted through the East unit doors with several other residents and they were able to elope off the premises. Staff notified [Police] and officers assisted in searching for resident. Resident was recovered when he began calling for help from the woods after falling while trying to climb a fence. He had injured his ankle and had to be helped inside. Nurse noted severe swelling to rignt ankle, as well as bruising. MD [Doctor] ordered x-ray of ankle, results show 'soft tissue edema and swelling and displaced bone fragments in the joint secondary to acute trauma.'..." b. There was no copy of the report found in the Client's record.	N 209	N209 FACILITY REPORTING Step #1 Corrective Action: On, 10/23/2020, upon notification of deficient practice, the DON observed/ checked (made copies of the notification and documentation of serious occurrence and placed in the client's clinical record) to ensure serious occurrence report is maintained in the clinical record for easy reference. No additional negative findings were found. Step #2 Identification of others with the potential of being affected: On, 11/09/2020, the DON's designee through reviewing the serious occurrence log for the past 90 days did not identfiy any additional residents who had the potential to be affected from the deficient practice. Administrative assistant to the DON observed/checked to ensure serious occurrence report was maintained in the clinical record and in the serious occurrence log. Any negative findings were corrected immediately.	11/09/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	2805 E ZION RD FAYETTEVILLE, AR 72703

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N 209	Continued From page 3 2. On 10/23/20 at 12:35 p.m., the Director of Nursing stated, "We have a copy of it, it just hasn't been put in the resident's chart yet."	N 209	Step #3 To ensure deficient practice does not reoccur: On 10/23/2020, the DON in-serviced the nursing administrative assistant to ensure serious occurrence report is maintained in the clinical record for easy reference. Step #4 Monitoring: Administrative assistant to DON will monitor to ensure serious occurrence report is maintained in the clinical record for easy reference by observation and documenting on serious occurrence checklist, each business day for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and DON notified. Completion Date: 11/09/2020	

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P O Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D C 20503

Provider/Supplier Number	Provider/Supplier Name
04L117	PINEY RIDGE TREATMENT CENTER, INC

Type of Survey (select all that apply): A

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

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. 30283	10/22/2020	10/23/2020	0.50	0.00	8.25	0.00	5.50	4.75
2. 21299	10/22/2020	10/23/2020	0.50	0.00	8.25	0.00	5.50	3.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.50

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

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

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

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
HUMANSERVICES.ARKANSAS.GOV

December 2, 2020

Bradley McDaris, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Mr. McDaris:

During the Follow-Up/revisit survey conducted on November 23, 2020, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. **A 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L117	A. BUILDING ______ B. WING ______	R-C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	**2805 E ZION RD** **FAYETTEVILLE, AR 72703**

(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. A revisit was conducted on November 23, 2020 for all deficiencies cited on October 23, 2020. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{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.

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P O Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D C 20503

Provider/Supplier Number	Provider/Supplier Name
04L117	PINEY RIDGE TREATMENT CENTER, INC

Type of Survey (select all that apply): A D

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

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. 30283	11/23/2020	11/23/2020	0.50	0.00	1.00	0.00	1.00	1.00
2.								
3.								
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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**

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
04L117	PINEY RIDGE TREATMENT CENTER, INC

Type of Survey (select all that apply): A D

A	Complaint Investigation	E	Initial Certification	I	Recertification		
B	Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing		
C	Federal Monitoring	G	Validation	K	State License		
D	Follow-up Visit	H	Life Safety Code	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. 30283	11/23/2020	11/23/2020	0.50	0.00	2.50	0.00	2.50	1.00
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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**