ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance
Office of Long Term Care
PO Box 8059, Slot S404
Little Rock, AR 72203-8059
Fax: 501-682-6159

January 6, 2020

Megan Wedgworth, Administrator
Piney Ridge Treatment Center, Inc
2805 E Zion Rd
Fayetteville, AR 72703

Dear Ms. Wedgworth:

A Complaint survey was conducted on December 30, 2019. 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 December 30, 2019 Complaint 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 e-mail to** Sandra Broughton@dhs.arkansas.gov **as soon as possible.**

If you have any questions please contact your reviewer at 501-**320-6182**.

Sincerely,

Sandra Broughton

Sandra Broughton, DHS Program Administrator
Office of Long Term Care
Survey and Certification Section

sgb

cc: DRA
file

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 12/30/2019

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 #AR00024019, unsubstantiated. The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	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.