



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

March 11, 2022

David Napier, Administrator Youth Home Inc 20400 Colonel Glenn Road Little Rock, AR 72210-5323

Dear Mr. Napier:

A Complaint survey was conducted on March 8, 2022. 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 8, 2022 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 email to Sandra Broughton@dhs.arkansas.gov.

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

Sincerely,

Dandre Brandton Administrative Services Manager

DPSQA/Office of Long Term Care Survey and Certification Section

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cc: DRA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		S FOR MEDICARE &	MEDICAID SERVICES					M APPROVED D. 0938-0391	
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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 referrant to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/suppler, the State Survey Agency (SA) should be notified immediately. A complaint survey was conducted on 3/7/22 through 3/8/22. AR00027902 was substantiated, all or in part, without deficiency. AR00027918 was unsubstantiated.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE		
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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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES