ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

May 18, 2022

Rob McDaniel, Administrator
Mentor Abi, Llc
15000 Highway 298
Benton, AR 72015

Dear Mr. McDaniel:

During the Validation survey conducted on May 16, 2022, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.**

If you have any questions, please contact your reviewer:**Sandra Broughton at 501-320-6182 or email to Sabdra.Broughton@dhs.arkansas.gov.**

Sincerely,

Sandra Broughton
Administrative Services Manager
DPSQA/Office of Long Term Care
Survey and Certification Section

sgb

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 04L105 | A. BUILDING _____ B. WING _____ | 05/16/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MENTOR ABI, LLC | 15000 HIGHWAY 298 BENTON, AR 72015 |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>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.<br><br>The findings on this statement of deficiencies demonstrate compliance with §483.73 - Emergency Preparedness Requirements for Psychiatric Residential Treatment Facilities. | E 000 | | |
| N 000 | Initial Comments<br><br>A Validation survey was conducted on 5/9/22 through 5/16/22.<br><br>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.