



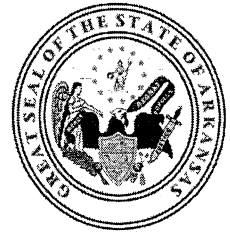
**Division of Provider Services and Quality Assurance**

**Office of Long Term Care**

PO Box 8059, Slot S404

Little Rock, AR 72203-8059

Fax: 501-682-6159



Certified Mail # 7017 0190 0000 3768 2454

April 18, 2019

Tony Mobley, Administrator  
Woodridge Behavioral Care Of Forrest City  
1521 Albert St  
Forrest City, AR 72335


Dear Mr. Mobley:

A Complaint survey was conducted on April 10, 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 April 10, 2019 Complaint Investig. 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 Sandra Broughton at (501) 682-6159 as soon as possible.**

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

Sincerely,

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

sgb

cc: DRC  
file

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

PRINTED: 04/18/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04L115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/10/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODRIDGE BEHAVIORAL CARE OF FORREST CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1521 ALBERT ST FORREST CITY, AR 72335</b>
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(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 000	<p>Initial Comments</p> <p>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.</p> <p>Complaint #AR00022834 was unsubstantiated.</p> <p>The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center</p>	N 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.