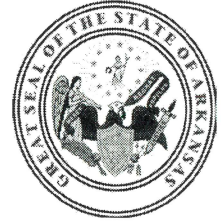




Division of Provider Services and Quality Assurance
Office of Long Term Care
PO Box 8059, Slot S404
Little Rock, AR 72203-8059
Fax: 501-682-6159



October 31, 2019

Barbara Radebaugh, Administrator
Woodridge Behavioral Care Northeast
600 North 7th Street
West Memphis, AR 72301

Dear Ms. Radebaugh,:

A Validation survey was conducted on October 25, 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.

We have enclosed form CMS 2567, "Statement of Deficiencies and Plan of Correction" for the October 25, 2019 Recertification 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,

A handwritten signature in cursive script, appearing to read "Sandra Broughton".

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

sgb

cc: DRA
file

A large, stylized handwritten mark in blue ink, resembling the number "3" or a similar symbol.

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

PRINTED: 10/31/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04L114 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/25/2019 |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE NORTHEAST | | | STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH 7TH STREET WEST MEMPHIS, AR 72301 | | |
| (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 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. | E 000 | | | |
| N 000 | Initial Comments The facility was in compliance with Emergency Preparedness of Psychiatric Residential Treatment Center.. A 5 year recertification survey was conducted on 10/24/19 through 10/25/19. 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.