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

February 18, 2020

Matthew Doyle, Administrator
Woodridge Behavioral Care Of Forrest City
1521 Albert St
Forrest City, AR 72335

Dear Mr. Doyle:

A Complaint survey was conducted on February 12, 2020. 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 February 12, 2020 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: DRA
file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE BEHAVIORAL CARE OF FORREST CITY	1521 ALBERT ST FORREST CITY, AR 72335

(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 #AR00024201 was substantiated without deficiencies 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.

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L115	WOODRIDGE BEHAVIORAL CARE OF FORREST CITY

Type of Survey (select all that apply)

A				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 30283	02/12/2020	02/12/2020	0.50	0.00	4.25	0.00	4.00	2.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 1.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**