



Division of Provider Services
& Quality Assurance
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HUMANSERVICES.ARKANSAS.GOV

February 25, 2021

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

Dear Ms. Radebaugh:

A Complaint Investigation survey was conducted on November 19, 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 November 19, 2020 Complaint Investigation 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 Amanda M Smith at (501) 682-6159 or email at amanda.m.smith@dhs.arkansas.gov as soon as possible.**

If you have any questions please contact your reviewer at 501-320-3963.

Sincerely,

A handwritten signature in cursive script that reads "Amanda M Smith".

RN Manager
DPSQA/Office of Long Term Care
Survey and Certification Section

ams

cc: DRA

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

PRINTED: 02/25/2021
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 C 11/19/2020
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	
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 #AR00025835 was substantiated without deficiencies cited.</p> <p>The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.</p>	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.

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P O Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D C 20503

Provider/Supplier Number 04L114	Provider/Supplier Name WOODRIDGE BEHAVIORAL CARE NORTHEAST
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Type of Survey (select all that apply)

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

Extent of Survey (select all that apply)

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- 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	11/19/2020	11/19/2020	0.50	0.00	2.25	0.00	5.00	1.50
2. 21299	11/19/2020	11/19/2020	0.50	0.00	2.25	0.00	5.00	1.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00 Total RO Supervisory Review Hours..... 0.00

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

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