RAT

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JOBT
Facility ID: 953441

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 345428

2. STATE VENDOR OR MEDICAID NO. (L2) 3405428

3. NAME AND ADDRESS OF FACILITY
(L3) THE LAURELS OF SALISBURY
(L4) 215 LASH DRIVE
(L5) SALISBURY, NC (L6) 28147

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 10/06/2011 (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) 12/30

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds 60 (L18)

13. Total Certified Beds 60 (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Transmit recertification survey of 10/06/2001. Event ID JOBT11.

17. SURVEYOR SIGNATURE — Date: 10/20/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: 1/3/12 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above : ___

22. ORIGINAL DATE OF PARTICIPATION 11/19/1992 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00310 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 10 03 11 To: F2 10 06 11
(MM DD YY) (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
(MM DD YY) (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5
The Laurels of Salisbury	345428/3405428	☐☐ ☐☐ ☐☐ (MM DD YY)

Street Address	City	County	State	Zip Code
215 Lash Drive	Salisbury	Rowan	NC	28147

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
(704) 637-1182	80	NC/C

A. F9 03
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☑

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐☐

Ownership: F12 03

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☑ No ☐

Name of Multi-Facility Organization: F14
Laurel Health Care Company

Dedicated Special Care Units (show number of beds for all that apply)

F15 0 AIDS
F16 0 Alzheimer's Disease
F17 0 Dialysis
F18 0 Disabled Children/Young Adults
F19 0 Head Trauma
F20 0 Hospice
F21 0 Huntington's Disease
F22 0 Ventilator/Respiratory Care
F23 0 Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☑	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☑
Does the facility conduct experimental research?	F26	Yes ☐	No ☑
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☑

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29________
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31________
(MM DD YY)

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☑

No paid feeding assistants.

FACILITY STAFFING

	Tag Number	A Services Provided 1	2	3	B Full-Time Staff (hours)	C Part-Time Staff (hours)	D Contract (hours)
Administration	F33				246		
Physician Services	F34	Y	N	N			
Medical Director	F35						10
Other Physician	F36						6
Physician Extender	F37	Y	N	N			
Nursing Services	F38	Y	N	N			
RN Director of Nurses	F39				80		
Nurses with Admin. Duties	F40				40		
Registered Nurses	F41				569		
Licensed Practical/ Licensed Vocational Nurses	F42				643		
Certified Nurse Aides	F43				1854		
Nurse Aides in Training	F44						
Medication Aides/Technicians	F45						
Pharmacists	F46	Y	N	N			32
Dietary Services	F47	Y	N	N			
Dietitian	F48						8
Food Service Workers	F49				463		
Therapeutic Services	F50						
Occupational Therapists	F51	Y	Y	N	80		
Occupational Therapy Assistants	F52				102		
Occupational Therapy Aides	F53						
Physical Therapists	F54	Y	Y	N			10
Physical Therapists Assistants	F55						140
Physical Therapy Aides	F56						
Speech/Language Pathologist	F57	Y	Y	N		25	
Therapeutic Recreation Specialist	F58	N	N	N			
Qualified Activities Professional	F59	Y	N	N	78		
Other Activities Staff	F60	N	N	N			
Qualified Social Workers	F61	Y	N	N	80		
Other Social Services	F62	Y	N	N	80		
Dentists	F63	Y	N	Y			1
Podiatrists	F64	Y	N	Y			
Mental Health Services	F65	Y	N	Y			
Vocational Services	F66	N	N	N			
Clinical Laboratory Services	F67	Y	N	N			
Diagnostic X-ray Services	F68	Y	N	N			
Administration & Storage of Blood	F69	Y	N	N			
Housekeeping Services	F70	Y	N	N	459		
Other	F71				203		

Name of Person Completing Form Casey Baucom	Time 10:50 AM
Signature	Date 10/4/2011

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
345428 K1	The Laurels of Salisbury	10/21/2011 * K4

K6 DATE OF PLAN APPROVAL

10/1/1997

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 01

NUMBER OF THIS BUILDING 0101

A

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

*K7 12 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVI

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE)

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)
A2. ☒ (ACCEPTABLE POC)
A3. ☒ (WAIVERS)
A4. ☐ (FSES)
A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☒ FULLY SPRINKLERED (All required areas are sprinklered)
B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
C. ☐ NONE (No sprinkler system)

* MANDATORY

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Nursing Home Licensure and Certification Section
2711 Mail Service Center, Raleigh, North Carolina 27699-2711
http://www.ncdhhs.gov/dhsr/
Drexdal Pratt, Director

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Beverly Speroff, Section Chief
Phone (919) 855-4520
Fax (919) 733-8274

MEMORANDUM

TO: Facility File
SUBJECT: Civil Rights (Title VI) Compliance

DATE OF VISIT: 10/6/11

FACILITY NAME: The Laurels of Salisbury

PROVIDER NUMBER: 34-5438

ADDRESS: 215 Lash Lane Salisbury
(Street/RFD) (Town)

CHECK ONE

YES	NO	N/A	MATERIAL REVIEWED	EXPLANATORY COLUMN
(✓)	( )	( )	1. The facility's policies and procedures are consistent with Title VI requirements.	
(✓)	( )	( )	2. Room assignments are made on a random basis.	
(✓)	( )	( )	3. All areas appear to be used by all races in the same manner.	
(✓)	( )	( )	4. On the day of the visit, the above referenced facility was found to be in compliance with Title VI.	

Signature: [signature] Date: 10/10/2011

cc: Division of Medical Assistance

DHSR-4146 (Rev. 01//09)

...OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: The Laurels of Salisbury

TOWN: Salisbury, NC 28147

PROVIDER NUMBER: 345428

If change in beds or room numbers the effective date of the change:

		CHECK ONLY ONE							CHECK ONLY ONE			
Room Number	# of Bed's within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only		Room Number	# of Bed's within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only
101	2	X					310	2	X			
102	2	X					401	2	X			
103	2	X					402	2	X			
104	2	X					403	2	X			
105	2	X					404	2	X			
106	2	X					405	2				X
107	2	X					406	2				X
201	1	X					407	2				X
202	1	X					408	2				X
203	2	X					409	2				X
204	2	X					410	2				X
205	2	X					411	2				X
206	2	X					412	2				X
207	2	X					413	2				X
208	2	X					414	2				X
209	2	X										
210	2	X										
301	2	X										
302	2	X										
303	2	X										
304	2	X										
305	2	X										
306	2	X										
307	2	X										
308	2	X										
309	2	X										

INSTRUCTIONS: Complete and mail to appropriate Regional Office of the Division of Facility Services, North Carolina Department of Human Resources.

Total the beds for the different classifications (Medicare, Medicaid, etc.) at the bottom of the continuation sheet. The administrator must sign and date the form on the back since copies of these forms are sent to the appropriate certifying agency(ies) for reimbursement purposes.

***Identify type of beds (Nursing or Home for the Aged)**

DHSR-Form 4504 (03/97) - Formerly 4103

BREAKDOWN OF ROOM NUMBERS AND BEDS WITHIN THOSE ROOMS

NAME OF FACILITY: **The Laurels of Salisbury** | TOWN: Salisbury, NC 28147 | PROVIDER NUMBER: 345428

If change in beds or room numbers the effective date of the change:

		CHECK ONLY ONE							CHECK ONLY ONE			
Room Number	# of Bed's within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only		Room Number	# of Bed's within Room	Medicare Medicaid	Medicaid Only	Medicare Only	*Licensed Only

TOTAL

Medicare/Medicaid = 60 (Beds)
Medicare Only = ______ (Beds)
Medicaid Only = ______ (Beds)
Licensed Only = 20 (Beds)

FOR YOUR INFORMATION: Home for the Aged beds cannot be certified in Medicare nor Medicaid

***Identify type of beds (Nursing or Home for the Aged)**

Administrator's Signature: [signature] Date: 10/3/11

DHSR-Form 4504 (03/97) - Formerly 4103

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

10/3/11
Date

[signature], Administrator
Signature and Title of Authorized Official

The Laurels of Salisbury
Name of Applicant or Recipient

215 Lash Drive
Street

Salisbury, NC 28147
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

* U.S.GPO : 2004 - 310 - 244 / 80713

CONSTRUCTION SECTION TRANSMITTAL FORM

Division of Health Service Regulation

cc ____________
cc ____________
cc ____________

To: Acute & HC ☐ Adult Care .. ☐ LTC Lic. & Certification ☒ DSS Child Care .... ☐ MH Lic. & Certification ☐ Certificate of Need ...... ☐ ICF/MR ☐ Other: ____________ ☐ Jails & Detention ☐

Facility Name: *The Laurels of Salisbury*

Facility Location: *215 Lash Drive; Salisbury, NC 28147* County: *Rowan*

Construction Section Project No. ____________ FID No.: ____________ CON No.: ____________

Type of Facility: (Check all applicable boxes)

HL	Acute Care Hospital (131E) ☐	HL	Rehab Hospital (131E) ☐	MHH	Psy Hospital (122C) ☐	ESRD	Dialysis Treat. ☐
HP	Hospice (Inpatient) ☐	HP	Hospice (Residential) ☐	AS	Ambulatory Surgery ☐	AB	Abortion Clinic ☐
ICF/MR	Intermediate Care/MR ☐	J	Jails ☐	CC	Child Care ☐	OTHER	____________ ☐
MHL	Mental Health Prog. No. ________ ☐	NH	Nursing Home ☒	HA	Adult Care ☐	FC	Family Care ☐

Project Description: *345428*

Archive Drawings: Yes ☐ No ☐ NA ☐

Facility Licensed Capacity: (specify) ____________

All residents must be able to respond and evacuate the building without physical or verbal assistance: Yes ☐ No ☐ NA ☐

Construction Section – Licensure:

Existing Facility DHSR Licensure Survey By: ____________ Survey Date: ____________

Local Building Official's Approval By: ____________ Approval Date: ____________

Local Fire Official's Approval By: ____________ **Combined With Bldg. Official Approval:** YES ☐ Approval Date: ____________

Local Sanitarian's Approval By: ____________ Approval Date: ____________

DHSR Inspection By: ____________ Inspection Date: ____________

DHSR Approval By: ____________ **By Documentation Only:** YES ☐ Approval Date: ____________

Remarks: ____________

Signed: ____________ Date: ____________

Construction Section - Medicare/Medicaid Certification:

Has HCFA 855 Cleared? Yes ☐ No ☐ NA ☐

Certification Survey By: *Jeff Waddell* Date Conducted: *10/21/2011*

Attachments: Crucial Data ☒ Physical Environment ☐ Life Safety Code Survey ☒ HCFA-2567(s) ☒ Workload ☒ Request for Waiver ☒ FSES ☐

Follow-up Needed: Yes ☒ No ☐ Date: *11/4/2011* FSES: Yes ☐ No ☐ Waiver(s) Recommended: Yes ☐ No ☐

Follow-up Visit by: ____________ Date Conducted: ____________

Attachments: HCFA-2567(s) ☐ HCFA-2567B(s) ☐ Workload Report Form ☐

Remarks: *temporary waiver or poc extension until 2/3/12 - see letter from administrator* Approval Date: ____________

Signed: *[signature]* Date: *11/28/2011*

Building Data Input Into Data Base:

Input By: ____________ Date: ____________ **Final Const. Section Approval Date:** Yes ☐ No ☐

Occupancy Type: Group I-1 ☐ Res. Bldg. Code ☐ Group I-2 ☐ Res. Care Hm. ☐ Group I-3 ☐ Small Res. Care ☐ Group R ☐ Small Non-Am. ☐ Group B ☐ Large Res. Care ☐ Other: ... ☐ ____________

Sprinklered: Yes ☐ No ☐ Sp. Type: ____ Wet ☐ Dry ☐ Generator: Yes ☐ No ☐ NCSBC Const. Type: ____ Bldg. Code Ed. ____________