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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UUD411

Facility ID: 923173

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 345389
2. STATE VENDOR OR MEDICAID NO.
(L2) 3415389

3. NAME AND ADDRESS OF FACILITY
(L3) THE LAURELS OF FOREST GLENN
(L4) 1101 HARTWELL STREET
(L5) GARNER, NC (L6) 27529

4. TYPE OF ACTION: 6 (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 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 IHA	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	

FISCAL YEAR ENDING DATE: (L35)

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

12. Total Facility Beds (L18)

13. Total Certified Beds (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(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 CI survey of 6/23/12. Event ID#UUD411 and intake #s NC00081485, NC00081404, NC00081368, NC00081336 and NC00081789.

17. SURVEYOR SIGNATURE Kristine Mosley Date: 6/23/12 (L19)

18. STATE SURVEY AGENCY APPROVAL Tammy Hall Date: 7/17/12 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Department of Health and Human Services
Medicare/Medicaid/CLIA Complaint Form

Control Number: UUD411 (NC00081336 NC00081368 NC00081404 NC00081485 NC00081789)

Part I - To Be Completed by Component First Receiving Complaint (SA or RO)

1. Medicare/Medicaid Identification Number

345389

Facility Name and Address

THE LAURELS OF FOREST GLENN
1101 HARTWELL STREET
GARNER, NC 27529

3. Date Complaint Received

06 13 12
MM DD YY

4. Receiving Component

1 State Survey Agy.
[1] 2 RO

5. Date Acknowledged

06 14 12
MM DD YY

6A. Source of Complaint

1: [1]
2: [4]
3: [ ]

1 Resident/Patient Family
2 Ombudsman
3 Facility Employee/Ex-Employ
4 Anonymous
5 Other

6B. Total Number of Complainants

05

7. Allegations

	7.A. Category	7.B. Findings (To be completed following investigation)	7.C. Number of Complainants per Allegation
1	18	02	03
2	06	02	03
3	03	02	02
4	07	02	01
5			

7.A. Category:
1 Resident Abuse; 2 Resident Neglect; 3 Resident Rights; 4 Patient Dumping; 5 Environment; 6 Care or Services; 7 Dietary; 8 Misuse of Funds/ Property; 9 Certification/Un- authorized Testing; 10 Proficiency Test; 11 Falsification of Records / Reports; 12 Unqualified Personnel; 13 Quality Control; 14 Specimen Handling; 15 Diagnostic Erroneous Test Results; 16 Fraud/False Billing; 17 Fatality/Transfusion Fatality; 18 Other (Specify) Quality of Life; 19 Life Safety Code; 20 State Monitoring

7.B. Findings (To be completed following investigation):
01 Substantiated
02 Unsubstantiated/ Unable to Verify

8. Action (if multiple actions, indicate earliest action)

[2]

1 Investigate within 2 working days
2 Investigate within 10 working days
3 Investigate within 45 working days
4 Investigate during next onsite
5 Referral (Specify) _____
6 Other Action (Specify) _____
7 None

Part II - To Be Completed By Component Investigating Complaint (SA or RO)

9. Investigated by

[1]
1 State Survey Agency
2 RO
3 Other (Specify) _____

10. Complaint Survey Date

06 23 12
MM DD YY

11. Findings (Under 7B Above)

12. Proposed Actions Taken by SA or RO

1: 21
2:
3:

1 Recommend Termination (23-day)
2 Recommend Termination (90-day)
3 Recommend Intermediate Sanction
4 POC (No Sanction)
5 Fine
6 Denial of Payment for New Admissions
7 License Revocation
8 Receivership
9 Provisional License
10 Special Monitor
11 Directed POC
12 Limitation of Certificate
13 Suspension of Certificate
14 Revocation of Certificate
15 Injunction
16 Civil Monetary Penalty
17 TA & Training for Unsuccessful PT
18 State Onsite Monitoring
19 Suspension of Part of Medicare Payments
20 Suspension of All Medicare Payments
21 None
22 Other (Specify) _____
23 Enforcement Action

13. Date of Proposed Action

07 03 12
MM DD YY

14. Parties Notified and Dates

1 Facility
2 Complainant
3 Representative
4 Other (Specify) _____

Party	Date
1. 1	07 05 12
2. 2	07 16 12
3.	

MM DD YY

15. Date Forwarded to CMS RO or Medicaid SA (MSA) (Attach HCFA-2567)

MM DD YY

Part III - To Be Completed By Component Taking Final Close-Out Action (RO/MSA)

16. Date of CMS/MSA Receipt

MM DD YY

17. CMS RO/MSA Action

[ ]

1 None
2 Termination (23-day)
3 Termination (90-day)
4 Intermediate Sanction
5 Move Routine Survey Date Forward
6 Limitation of Certificate
7 Suspension of Certification
8 Revocation of Certificate
9 Injunction
10 Civil Monetary Penalty
11 TA & Training For Unsuccessful PT
12 Cancellation of Medicare Approval
13 Other (Specify) _____
14 Enforcement Action

18. Date of Final Action Sign-off

MM DD YY