

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY OR SURVEY OPERATIONS GROUP

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 345215 2. STATE VENDOR OR MEDICAID NO. (L2) 3415215	3. NAME AND ADDRESS OF FACILITY (L3) River Trace Nursing and Rehabilitation Center (L3) 250 Lovers Lane (L4) Washington, NC 27889 (L5)	4. TYPE OF ACTION (L8) Complaint												
5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY (L34) 04/08/2026	7. PROVIDER/SUPPLIER CATEGORY (L7) SNF/NF Dual Certification	9. FISCAL YEAR ENDING DATE (L35)												
8. ACCREDITATION STATUS (L10)														
11. LTC PERIOD OF CERTIFICATION From (a): To (b):														
12. Total Facility Beds (L18) 150	10. THE FACILITY IS CERTIFIED AS AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS <input checked="" type="checkbox"/> A. In Compliance with Program Requirements COMPLIANCE BASED ON: <input type="checkbox"/> 1- Acceptable POC <input type="checkbox"/> 2 - TECHNICAL PERSONNEL <input type="checkbox"/> 6 - SCOPE OF SERVICE LIMITED <input type="checkbox"/> 3 - 24 HR RN <input type="checkbox"/> 7 - MEDICAL DIRECTOR <input type="checkbox"/> 4 - 7-DAY RN (Rural SNF) <input type="checkbox"/> 8 - PATIENT ROOM <input type="checkbox"/> 5 - LIFE SAFETY CODE <input type="checkbox"/> 9 - BEDS PER ROOM <input type="checkbox"/> B. Not in Compliance with Program Requirements and/or Applied Waivers NOT IN COMPLIANCE A/B (IF APPLICABLE CODES 1-9)													
13. Total Certified Beds (L17) 140														
14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">18-SNF</td> <td style="width:25%;">18/19- SNF</td> <td style="width:25%;">19-SNF</td> <td style="width:25%;">20- ICF/IID</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">140</td> <td style="text-align: center;">0</td> <td style="text-align: center;">0</td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">(L39)</td> <td style="text-align: center;">(L42)</td> </tr> </table>			18-SNF	18/19- SNF	19-SNF	20- ICF/IID	0	140	0	0	(L37)	(L38)	(L39)	(L42)
18-SNF	18/19- SNF	19-SNF	20- ICF/IID											
0	140	0	0											
(L37)	(L38)	(L39)	(L42)											
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Transmit CI survey of 04/08/26. Event ID# 22D3D8-H1. Intakes: 2960729, 2669468 Administrator: Caroline Flythe (rvt21-admin@rivertracecare.com)														
17. SURVEYOR SIGNATURE Marjorie Feely	DATE 04/13/2026 (L19)	18. STATE SURVEY AGENCY APPROVAL Tracie Strickland												
		DATE 04/13/2026 (L20)												

PART II - TO BE COMPLETED BY THE CMS SURVEY AND OPERATIONS GROUP LOCATION OR STATE AGENCY

19. DETERMINATION OF ELIGIBILITY (L21) <input checked="" type="checkbox"/> 1-FACILITY IS ELIGIBLE TO PARTICIPATE <input type="checkbox"/> 2-FACILITY IS NOT ELIGIBLE TO PARTICIPATE		20. INITIAL SURVEY DETERMINATION SURVEY #1 SURVEY #2 SURVEY #3 (FINAL ATTEMPT) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
22. EFFECTIVE DATE (L24) 10/01/1981	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION VOLUNTARY <input type="checkbox"/> 1- MERGER, CLOSURE <input type="checkbox"/> 2- DISSATISFACTION WITH REIMBURSEMENT <input type="checkbox"/> 3- RISK OF INVOLUNTARY TERMINATION <input type="checkbox"/> 4- OTHER REASON FOR WITHDRAWAL INVOLUNTARY <input type="checkbox"/> 5- FAILURE TO MEET HEALTH/SAFETY <input type="checkbox"/> 6- FAILURE TO MEET AGREEMENT OTHER <input type="checkbox"/> 7- PROVIDER STATUS CHANGE <input type="checkbox"/> 00- ACTIVE (L30)	
25. LTC EXTENSION DATE (L27)	27. ALTERNATIVE SANCTIONS A. SUSPENSION OF ADMISSION (L44) B. RESCIND SUSPENSION DATE (L45)			
28. TERMINATION DATE (L28)	29. MAC ID NUMBER (L31)	30. REMARKS		
31. CMS LOCATION OR MAC RECEIPT OF 1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	33. INITIAL CERTIFICATION DETERMINATION REMARKS		