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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PGMB11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 923320

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 345177
2.STATE VENDOR OR MEDICAID NO.
(L2) 3415177

3. NAME AND ADDRESS OF FACILITY
(L3) MANOR CARE HEALTH SVCS PINEHURST
(L4) 205 RATTLESNAKE TRAIL
(L5) PINEHURST, NC (L6) 28374

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 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	

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 of 12/13/11. Event ID# PGMB11 and intake # NC00077041.

17. SURVEYOR SIGNATURE Date: 12/14/11 (L19)

18. STATE SURVEY AGENCY APPROVAL Denise Rogers-Murray Date: 12/21/11 (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: PGMB11 (NC00077041)

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

1. Medicare/Medicaid Identification Number: 3 4 5 1 7 7

Facility Name and Address
MANOR CARE HEALTH SVCS PINEHURST
205 RATTLESNAKE TRAIL
PINEHURST, NC 28374

3. Date Complaint Received: 1 1 3 0 1 1 (M M D D Y Y)

4. Receiving Component
1 State Survey Agy.
[1] 2 RO

5. Date Acknowledged: 1 2 0 1 1 1 (M M D D Y Y)

6A. Source of Complaint
1: [1]
2: [ ]
3: [ ]
1 Resident/Patient Family
2 Ombudsman
3 Facility Employee/Ex-Employ
4 Anonymous
5 Other

6B. Total Number of Complainants: 0 1

7. Allegations
1: 0 6
2:
3:
4:
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) _____
19 Life Safety Code
20 State Monitoring

7.B. Findings (To be completed following investigation)
1: 0 2
2:
3:
4:
5:
01 Substantiated
02 Unsubstantiated/ Unable to Verify

7.C. Number of Complainants per Allegation
1: 0 1
2:
3:
4:
5:

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: 1 2 1 3 1 1 (M M D D Y Y)

11. Findings (Under 7B Above)

12. Proposed Actions Taken by SA or RO
1: 2 1
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: 1 2 1 3 1 1 (M M D D Y Y)

14. Parties Notified and Dates

	Party	Date
1 Facility	1. [1]	1 2 2 0 1 1
2 Complainant	2. [2]	1 2 2 2 1 1
3 Representative	3. [ ]	
4 Other (Specify) _____		(M M D D Y Y)

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

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

16. Date of CMS/MSA Receipt: (M M D D Y Y)

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: (M M D D Y Y)