KAT

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: YJIK
Facility ID: 923330

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 345093

2. STATE VENDOR OR MEDICAID NO. (L2) 3405093

3. NAME AND ADDRESS OF FACILITY
(L3) MARYFIELD NURSING HOME
(L4) 1315 GREENSBORO ROAD
(L5) HIGH POINT, NC (L6) 27260

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 08/15/2013 (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 ICF/IID, 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) 09/03

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A* (L12)

12. Total Facility Beds 115 (L18)

13. Total Certified Beds 115 (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	115			
(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):
To transmit a recertification survey was conducted on 8/12/13-8/15/13. Event ID#YIJK11.

17. SURVEYOR SIGNATURE [signature] Date: ~~08/23/2013~~ 11/4/13 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 08/23/2013 (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 07/01/1973 (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 08 (MM) 12 (DD) 13 (YY) To: F2 08 (MM) 15 (DD) 13 (YY)

Extended Survey

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

Name of Facility		Provider Number	Fiscal Year Ending: F5
Pennybyrn at Maryfield		3405093	☐☐ ☐☐ ☐☐ (MM DD YY)
Street Address	City	County	State	Zip Code
1315 Greensboro Rd	High Point	Guilford	NC	27260
Telephone Number: F6	State/County Code: F7	State/Region Code: F8		
336-821-4000				

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 ☐☐

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

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

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ 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 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31________

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

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				442	120	
Physician Services	F34	Y	N	Y			
Medical Director	F35						32
Other Physician	F36						2
Physician Extender	F37	Y	N	Y			42
Nursing Services	F38	Y	N	N			
RN Director of Nurses	F39				80		
Nurses with Admin. Duties	F40				408	12	
Registered Nurses	F41				417	72	
Licensed Practical/ Licensed Vocational Nurses	F42				1035	32.6	0
Certified Nurse Aides	F43				3050	1822	
Nurse Aides in Training	F44						0
Medication Aides/Technicians	F45					60	
Pharmacists	F46	Y	N	N			19
Dietary Services	F47	Y	N	N			
Dietitian	F48						8
Food Service Workers	F49				1020	347	
Therapeutic Services	F50						
Occupational Therapists	F51	Y	N	N			18
Occupational Therapy Assistants	F52						160
Occupational Therapy Aides	F53						0
Physical Therapists	F54	Y	N	N			100
Physical Therapists Assistants	F55						85
Physical Therapy Aides	F56						10
Speech/Language Pathologist	F57	Y	N	N			30
Therapeutic Recreation Specialist	F58	Y	N	N			0
Qualified Activities Professional	F59	Y	N	N	80	96	
Other Activities Staff	F60	Y	N	N		32	
Qualified Social Workers	F61	Y	N	N	240		
Other Social Services	F62	Y	N	N			0
Dentists	F63	Y	N	N			8
Podiatrists	F64	Y	N	N			0
Mental Health Services	F65	Y	N	N			6
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	N	N	N			
Housekeeping Services	F70	Y	N	N	398	212	
Other	F71				710	295	

Name of Person Completing Form	Vonda Hollingsworth	Time	2:15 pm
Signature	Vonda Hollingsworth	Date	8-13-13

Form CMS-671 (12/02)

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
345093 K1	**Maryfield Nursing Home**	**9/4/2013** * K4

K6 DATE OF PLAN APPROVAL

7/1/1973

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 SURV

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

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

PROVIDER NUMBER

345093

K1

FACILITY NAME

Maryfield Nursing Home

SURVEY DATE

9/4/2013

* K4

K6 DATE OF PLAN APPROVAL

7/1/1973

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS *02*

NUMBER OF THIS BUILDING *0202*

[*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 SURV

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

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: *Maryfield Nursing Home*

Facility Location: *1315 Greensboro Road, High Point NC 27260* County: *Guilford*

Construction Section Project No. ______ FID No.: *923330* 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: *345093*

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: *Marcus C. Staley II* Date Conducted: *9/4/2013*

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

Follow-up Needed: Yes ☒ No ☐ Date: *9/16/2013* 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: ______ Approval Date: ______

Signed: *Marcus C. Staley II* [signature] Date: *9/30/2013*

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. ______