CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

MITTAL ID: QHHV11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY							Facility ID: 923072		
1. MEDICARE/MEDICAID PROV (L1) 345279 2.STATE VENDOR OR MEDICAI (L2) 3435279	3. NAME AND ADDRESS OF FACILITY (L3) THE CARROLTON OF NASH (L4) 7369 HUNTER HILL ROAD (L5) ROCKY MOUNT, NC			(L6) 27804		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	 6 (L8) 2. Recertification 4. CHOW 6. Complaint 		
5. EFFECTIVE DATE CHANGE (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint			
	(L34) (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)	
11LTC PERIOD OF CERTIFICAT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	(L18) (L17)	B. Not in Com	nce With quirements		And/Or Approved Waiv 2. Technical Per 3. 24 Hour RN 4. 7-Day RN (R 5. Life Safety C	rsonnel tural SNF)	Collowing Requirements: 6. Scope of Serv 7. Medical Direct 8. Patient Room 9. Beds/Room (L12)	vices Limit	
14. LTC CERTIFIED BED BREAK	DOWN	requirements	ши от гррпои типт		15. FACILITY MEETS		(2.2)		
	9 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j)	(1):	(L15)		
(L37) (L	38) (L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY RI Transmt CI 11/03/2021.	EMARKS (IF APPLICABLE S	SHOW LTC CANCELL	LATION DATE):						
17. SURVEYOR SIGNATURE Date :					18. STATE SURVEY AGENCY APPROVAL Date:				
				(L20)					
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGL	E STATE	EAGENCY		
DETERMINATION OF ELIGI 1. Facility is Eligib 2. Facility is not Eligib	e to Participate	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	23. LTC AGREEM	ENT 2	24. LTC AGREEME	NT	26. TERMINATION AC	TION:		(L30)	
OF PARTICIPATION	BEGINNING		ENDING DATE		VOLUNTARY 01-Merger, Closure	00	INVOLUN' 05-Fail to M		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Rei		06-Fail to M	leet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:					03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active			Status Change	
(L44) B. Rescind Suspension Date: (L45)							00.126.110		
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.					30. REMARKS				
00000									
(L28) (L31)									
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE									
(L32) (L33)					DETERMINATION APPROVAL				