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 OR SURVEY OPERATIONS GROUP

1. MEDICARE/MEDICAID PROVIDER NO. (L1)
345317

2. STATE VENDOR OR MEDICAID NO. (L2)
3426550

3. NAME AND ADDRESS OF FACILITY
CLAYTON REHABILITATION AND (L3)
HEALTHCARE CENTER (L4)
204 DAIRY ROAD (L5)
CLAYTON, NC 27520

4. TYPE OF ACTION (L8)
Other

5. EFFECTIVE DATE FOR CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)
07/23/2025

7. PROVIDER/SUPPLIER CATEGORY (L7)
SNF/NF Distinct Part

8. ACCREDITATION STATUS (L10)

9. FISCAL YEAR ENDING DATE (L35)

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

12. Total Facility Beds (L18)
90

13. Total Certified Beds (L17)
90

10. THE FACILITY IS CERTIFIED AS

☑ A. In Compliance with Program Requirements

COMPLIANCE BASED ON:

☑ 1- Acceptable POC

☐ B. Not in Compliance with Program Requirements and/or Applied Waivers

☐ NOT IN COMPLIANCE

A/B (IF APPLICABLE CODES 1-9)

AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS

☐ 2 - TECHNICAL PERSONNEL
☐ 3 - 24 HR RN
☐ 4 - 7-DAY RN (Rural SNF)
☐ 5 - LIFE SAFETY CODE
☐ 6 - SCOPE OF SERVICE LIMITED
☐ 7 - MEDICAL DIRECTOR
☐ 8 - PATIENT ROOM
☐ 9 - BEDS PER ROOM

14. LTC CERTIFIED BED BREAKDOWN

18-SNF	18/19- SNF	19-SNF	20- ICF/IID
19	71		
(L37)	(L38)	(L39)	(L42)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Transmit paper revisit survey of 07/23/25. Facility in compliance effective 07/21/25. Event ID# R4V0-H2. Administrator: Katrina Stevens (kstevens@claytonrehabcenter.com)

17. SURVEYOR SIGNATURE — DATE
Susan Kelly — 07/24/2025 (L19)

18. STATE SURVEY AGENCY APPROVAL — DATE
Tracie Strickland — 07/24/2025 (L20)

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

19. DETERMINATION OF ELIGIBILITY (L21)

☑ 1-FACILITY IS ELIGIBLE TO PARTICIPATE

☐ 2-FACILITY IS NOT ELIGIBLE TO PARTICPATE

20. INITIAL SURVEY DETERMINATION

SURVEY #1 ☐ SURVEY #2 ☐ SURVEY #3 (FINAL ATTEMPT) ☐

22. EFFECTIVE DATE
04/16/1990 (L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE
(L27)

27. ALTERNATIVE SANCTIONS

A. SUSPENSION OF ADMISSION
(L44)

B. RESCIND SUSPENSION DATE
(L45)

26. TERMINATION ACTION

VOLUNTARY

☐ 1- MERGER, CLOSURE
☐ 2- DISSATISFACTION WITH REIMBURSEMENT
☐ 3- RISK OF INVOLUNTARY TERMINATION
☐ 4- OTHER REASON FOR WITHDRAWAL

INVOLUNTARY

☐ 5- FAILURE TO MEET HEALTH/SAFETY
☐ 6- FAILURE TO MEET AGREEMENT

OTHER

☐ 7- PROVIDER STATUS CHANGE
☐ 00- ACTIVE

(L30)

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