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: 25LT11
Facility ID: NH7236

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 37G035
2. STATE VENDOR OR MEDICAID NO (L2) 100771540A

3. NAME AND ADDRESS OF FACILITY
(L3) Gateway Foundation, Inc 11
(L4) 1217 East College
(L5) Broken Arrow, OK 74012 (L6)

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 5-30-18 (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 11 (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	

FISCAL YEAR ENDING DATE: (L35)

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

12 Total Facility Beds 8 (L18)
13. Total Certified Beds 8 (L17)

10 THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On
___1. Acceptable POC
X 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 (L12)

14 LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
				8
(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).
See Attached Remarks Based on 5-30-18 complaint investigation, facility has not met conditions of participation. Termination of agreement is effective August 13, 2018.

17. SURVEYOR SIGNATURE [signature] Date: 6-8-18 (L19)

18. STATE SURVEY AGENCY APPROVAL [signature] Date 6-8-18 (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 10-14-1986 (L24)
23 LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION. (L30)

VOLUNTARY
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

25. LTC EXTENSION DATE (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B Rescind Suspension Date (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30 REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

C&T REMARKS - CMS 1539 FORM **REGIONAL OFFICE REMARKS**