

POST-CERTIFICATION REVISIT REPORT

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|------------------------------------------------------------------------|----|-------------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------|----|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 345170 | Y1 | MULTIPLE CONSTRUCTION A. Building B. Wing | Y2 | DATE OF REVISIT 9/24/2019 | Y3 |
| NAME OF FACILITY CRYSTAL BLUFFS REHABILITATION AND HEALTH CARE CENT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC 28557 | | |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|------------------------|------------|-----------------|------------|-----------------|------------|
| ID Prefix F0644 | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # 483.20(e)(1)(2) | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | 09/05/2019 | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | | LSC _____ | | LSC _____ | |
| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
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| ID Prefix _____ | Correction | ID Prefix _____ | Correction | ID Prefix _____ | Correction |
| Reg. # _____ | Completed | Reg. # _____ | Completed | Reg. # _____ | Completed |
| LSC _____ | | LSC _____ | | LSC _____ | |

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|---------------------------------------------------|------------------------|------|-----------------------|------|
| REVIEWED BY STATE AGENCY <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
| REVIEWED BY CMS RO <input type="checkbox"/> | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| | | |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| FOLLOWUP TO SURVEY COMPLETED ON 8/23/2019 | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|