STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345170	A. BUILDING _____ B. WING _____	C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL BLUFFS REHABILITATION AND HEALTH CARE CENT	**4010 BRIDGES STREET EXTENSION MOREHEAD CITY, NC 28557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/16/2024 through 09/18/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KUF111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/16/2024 through 09/18/2024. Event ID#KUF111. The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). The following intakes were investigated NC00211338, NC00212689, NC00213655 and NC00218753. 11 of the 11 complaint allegations did not result in deficiency.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/23/2024