



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 28, 2015

Administrator
Crystal Bay
2400 Crystal Cove Lane
Destin, FL 32541

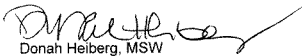
Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted via desk review on September 28, 2015 by representative(s) of this office. Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Should you have any questions please call me at 850-412-4540. Thanks you.

Sincerely,


Donah Heiberg, MSW
Field Office Manager

DH/dh
Enclosure

DT9D



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/28/2015
NAME OF PROVIDER OR SUPPLIER CRYSTAL BAY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CRYSTAL COVE LANE DESTIN, FL 32541		
(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) COMPLETE DATE
{A 000}	Initial Comments A revisit (desk review) was completed. The previously identified citation was found corrected.	{A 000}			

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

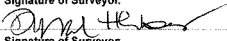
State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11953460	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/28/2015
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Name of Facility CRYSTAL BAY	Street Address, City, State, Zip Code 2400 CRYSTAL COVE LANE DESTIN, FL 32541
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix AE210 Reg. # 58A-5.0191(7) FAC LSC	Correction Completed 09/28/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: 	Date: 9/28/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:

8/31/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO