

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 03/03/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966315	(X3) DATE SURVEY COMPLETED 02/25/2014
NAME OF PROVIDER OR SUPPLIER Smyrna West Assisted Living Fa	STREET ADDRESS, CITY, STATE, ZIP CODE 301 Milford Place New Smyrna Beach, FL 32168	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments

Specific Tag Findings:

0000-Initial Comments

An unannounced complaint survey, CCR #2014001005, was conducted on February 25, 2014. Smyrna West Assisted Living Facility had no deficiencies found at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 5, 2014

Administrator
Smyrna West Assisted Living Facility
301 Milford Place
New Smyrna Beach, FL 32168

Re: CCR #2014001005

Dear Administrator:

This letter reports the findings of a complaint survey completed on February 25, 2014 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey.

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.

Thank you for the assistance provided to the surveyor. Should you have any questions, please contact this office at (904) 798-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

NH/JM/sm
Enclosure

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