

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966315	(X3) DATE SURVEY COMPLETED 02/18/2015
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)		

Revisit Corrected Tags:

0081-Training - Staff In-Service-02/18/2015



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 18, 2015

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

Dear Administrator:

This letter reports the findings of a state licensure desk review conducted on February 18, 2015 by a representative 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 desk review.

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 call this office at (904) 798-4201.

Sincerely,

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

JM/sm
Enclosure

