

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 10/12/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966315	(X3) DATE SURVEY COMPLETED 10/05/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On October 5, 2015 a Limited Nursing Services survey was conducted at Smyrna West Assisted Living. Deficient practice was not identified during the survey.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 12, 2015

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

Dear Administrator:

This letter reports findings of a state licensure Limited Nursing Services survey that was conducted on October 5, 2015 by a representative of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the 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 call this office at (904) 798-4201.

Sincerely,

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

JS/JM/sm
Enclosure

1GGN

