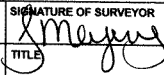


STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966315	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/11/2016
NAME OF FACILITY SMYRNA WEST ASSISTED LIVING FA	STREET ADDRESS, CITY, STATE, ZIP CODE 301 MILFORD PLACE NEW SMYRNA BEACH, FL 32168	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0053	Correction	ID Prefix A0056	Correction	ID Prefix A0058	Correction
Reg. # 58A-5.0185(4) FAC	Completed	Reg. # 58A-5.0185(7) FAC	Completed	Reg. # 429.42(1-2) FS; 58A-5.033(3)(a) FAC	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	07/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/18/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 26, 2016

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

Dear Administrator:

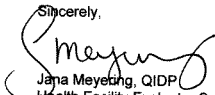
This letter reports the findings of a state licensure survey revisit conducted on July 11, 2016 by a representative of this office.

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 revisit.

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, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JM/sm
Enclosure

DT9D

