

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/08/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966315	(X3) DATE SURVEY COMPLETED R 11/07/2017
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 The deficiencies were found corrected at the time of the desk review.		