| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11932639 | 02/05/2015 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Gallo House I, Inc. | 9110 Star Trail<br>New Port Richey, FL 34654 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**

St - A - 0000 - - Initial Comments
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

**Specific Tag Findings:**

Assisted Living Facility

A Complaint survey, CCR# 2014011888, was conducted on [redacted].

Gallo House I, Inc., Assisted Living Facility, had a deficiency found at the time of the visit.

**0025-Resident Care - Supervision 429.26(7) FS; 58A-5.0182(1) FAC**

Based on interview and record review the facility failed to provide proof of notification to residents, families, guardians or other responsible parties of a change in in-house physician services and failed to document changes in resident condition that required hospitalization as well as notification of the hospitalization to families, guardians or other responsible parties..

Findings Include:

An interview was conducted with the facility administrator on [redacted] at 10:00 a.m. in conjunction with resident record reviews. A concern was identified in follow-up to a complaint related to notification of a change in in-house physician services that took place in [redacted] 2014. The administrator stated that residents, families, guardians and other responsible parties had been notified that the facility had a change in the physician services providing in-house care to the residents. She was unable to provide any documentation that indicated the nitrifications had been provided. "The new doctor had the residents sign a release to allow her to provide care but I don't have any of the signed consents." The administrator confirmed that she did not maintain any progress or facility notes that would verify the notifications had been provided to the residents and all concerned parties.

A review of 2 resident records (#2 and #3) revealed that both of these residents had hospitalizations within the last 4 months. There was no documentation of the date of transfer to the hospital, reason for transfer, resident condition requiring hospitalization or notification of the residents' transfers made to the families, guardians and other responsible parties. The administrator verified that she did not maintain any progress or facility notes that would detail the reason for the transfers as well as document that notification was provided to the families, guardians or other responsible parties that the resident was sent to the hospital.. "I haven't been doing that but I understand why I need to start documenting more. I just hadn't thought about doing notes like that, but will start now."

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Gallo House I, Inc.
9110 Star Trail
New Port Richey, FL 34654

**RE: CCR #2014011888**

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on . 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your 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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

FOI Patricia Reid Caufman
Field Office Manager

PRC/src
Enclosure: State (5000-3547) Form

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