

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 06/18/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11932639	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER GALLO HOUSE I, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 9110 STAR TRAIL NEW PORT RICHEY, FL 34654	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments Assisted Living Facility A Complaint survey (CCR#2015005328) was conducted on 6/10/15, in conjunction with a Biennial licensure survey with Limited Mental Health services (Aspen # IGF911). The Gallo House I, Assisted Living Facility, had no deficiencies at the time of this visit.		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 18, 2015

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

RE: CCR #2015005328

Dear Administrator:

This letter reports the findings of a complaint survey completed on June 10, 2015 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this 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 contact **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

for

Patricia Reid Cauffman
Field Office Manager

PRC/src

Enclosure: State (5000-3547) Form

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