

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11932639	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY GALLO HOUSE I, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 9110 STAR TRAIL NEW PORT RICHEY, FL 34654

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 A0026	Correction	ID Prefix A0030	Correction	ID Prefix	Correction
Reg. # 58A-5.0182(2) FAC	Completed	Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	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) PFB	DATE 3/3/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO	☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/20/2016			☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 03/03/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932639	(X3) DATE SURVEY COMPLETED R 02/26/2016
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 revisit to CCR #2015011772 was conducted on 2/26/16. Gallo House I had uncorrected an uncorrected deficiency at the time of the survey 0025 Resident Care - Supervision Based on record review and interview, the facility still had not necessarily contacted the health care provider for two of two residents sampled (#1; #2) who had experienced a significant or potentially significant change. Findings include: A review of resident files during the 2/26/16 revisit revealed that the record for Resident #1 had no new information documented since the 1/16 investigation; this individual had lost approximately 28 lbs. during the period from 1/16 to 2/16, gaining back 2 lbs. No documented evidence could be found verifying staff had notified Resident #1's health care provider regarding this weight issue, and what action he/she was going to take. Review of Resident #2's file revealed that between 1/16 and 2/16, he weighed 150 lbs. and ended up at 130 lbs.--a net loss of over 13%. Although not officially significant, further review of the file found no pertinent documentation whatsoever--either in a communication to the resident's health care provider, a progress note, or other type of notification indicating that such a weight loss might be worth tracking. Interview with facility staff at 1:15pm provided no clarification. (Please note: This is an uncorrected deficiency from the 1/16 survey.) Class III		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2016

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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 (727) 552-2000.

Sincerely,

Patricia Reid Cauffman
Field Office Manager

PRC/ct
Enclosure

BBT7

