

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11932639	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/26/2016
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 A0025	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/26/2016	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
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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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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

5/26/16

SIGNATURE OF SURVEYOR

DATE

REVIEWED BY
CMS RO



REVIEWED BY
(INITIALS)

DATE

TITLE

DATE

FOLLOWUP TO SURVEY COMPLETED ON
4/25/2016

☐ 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

May 26, 2016

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

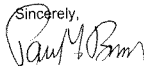
Dear Administrator:

This letter reports the findings of a state licensure survey desk review conducted on May 26, 2016 by representative(s) 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 desk review.

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,


for Patricia Reid Cauffman
Field Office Manager

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

DT9D

