AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932639	R 11/17/2016
NAME OF PROVIDER OR SUPPLIER **DIVINE GALLO HOUSE ALF**	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

On / /, a revisit to complaint surveys, (CCR# 2016010301 & CCR# 2016008027) were conducted, in conjunction with a revisit to a Change of Ownership (CHOW) state licensure survey with Limited Mental Health (LMH) at Divine Gallo House ALF.
Divine Gallo House ALF had uncorrected deficiencies at the time of the survey.

(License # 6665)

0026 Resident Care - Social & Leisure Activities

Based on observation and interviews, the Assisted Living Facility failed to provide an ongoing activities program for 12 of 12 current in-house residents.

Findings included:

A review of the facility's activities calendar revealed that it was dated for and showed Leisure Time all day (reading, drawing, puzzles). While at the facility, no activities occurred. The residents were sitting in front of the television watching TV or outside smoking.
On / / at 10:00 am, per interviews with the residents who were watching TV, all stated there were no activities and nothing to do and they haven't been asked what they would like to do.
Per interview with the Administrator at 11:30 am on / , she stated that there were games and sometimes the residents play Wii.

Class III

0083 Training - First Aid and

Based on record review and interview, the facility failed to ensure that a staff member (Staff E), one of five employees who provide direct care services, had completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

courses, is in the facility at all times, places 12 current in-house residents at risk of improper response to emergencies and adverse medical consequences.

Findings included:

On / / a employee record review was conducted of Staff E's employee file. Staff E was hired on as a caregiver on the 3rd shift and is the only staff working in the facility from 11:00 pm - 7:00 am, 3 days per week and 3:00 pm - 7:00 am one day per week.

Staff E's employee file contained certificates for training & certification in First Aid and ( ) effective - / .

As of / record review, Staff E has not completed updated training and current certification as required.

Per interview with the Administrator at 11:30 am, the Administrator acknowledged that Staff E's record did not include evidence of current training & certification in First Aid and ( ) as required.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11932639 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE GALLO HOUSE ALF	9110 STAR TRAIL NEW PORT RICHEY, FL

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 A0079	Correction	ID Prefix A0081	Correction	ID Prefix A0090	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	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)	DATE	SIGNATURE OF SURVEYOR	DATE
	FWB	11/30/16		
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Divine Gallo House ALF
9110 Star Trail
New Port Richey, FL 34654

Dear Administrator:

This letter reports the findings of two revisit surveys conducted on , 2016, by representative(s) of this office. Enclosed are the provider's copies of the Statement of Deficiencies (State Forms 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit, and the Revisit Reports, which indicate the deficiencies that were corrected relative to the revisits.

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 30, 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 **Paul Brown**, HFES, of this office at (727) 552-2000.

Sincerely,

FOR Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 5000-3547 & Revisit Reports

BBT7

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