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

A revisit to a Change of Ownership (CHOW) with Limited Mental Health (LMH) survey, in conjunction with a revisit to two complaint surveys, (CCR# 2016008027 & CCR# 2016010301) was conducted on 11/ at Divine Gallo House ALF.

Divine Gallo House ALF had uncorrected deficiencies and a new deficiency identified at the time of the revisit.

(License # 6665)

0054 Medication - Records

Based on record review and interview, the facility failed to ensure correct and complete maintenance of a Medication Observation Record (MOR) for 11 of 11 residents who receive assistance with self-administration of medications, recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.

Findings included:

At 9:15 am on / /, a review of the resident Medication Observation Record (MOR) revealed that 11 of 12 residents' MORs had holes where medications were not signed off that they had been given. There were no explanations written on the backside of the MOR for leaving the spaces blank, as regulations require. A recap of the MOR signature omissions follows, and photos were taken of the MOR pages as back-up evidence.

1. Resident #1 - 3 medications not signed off on /, no explanation for omission notated on backside of MOR.
2. Resident #2 - all medications not signed off on / / & /, no explanation for omission notated on backside of MOR.

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3. Resident #3 - all medications not signed off on / , no explanation for omission notated on backside of MOR.
4. Resident #4 - all medications not signed off on / , no explanation for omission notated on backside of MOR.
5. Resident #5 - all medications not signed off on / , no explanation for omission notated on backside of MOR.
6. Resident #6 - 2 medications not signed off on / ,1 medication not signed off on / & 1 medication not signed off on / / , no explanation for omission notated on backside of MOR.
7. Resident #7 - all medications not signed off on / , no explanation for omission notated on backside of MOR.
8. Resident #8 - all medications not signed off on / & / , no explanation for omission notated on backside of MOR.
9. Resident #9 - all medications not signed off on / and / , no explanation for omission notated on backside of MOR.
10. Resident #10 - MOR was complete and up to date (the only one)
11. Resident #11 - 1 medication not signed off on / / , no explanation for omission notated on backside of MOR.
12. Resident #12 - all medications not signed off on / / & / , no explanation for omission notated on backside of MOR.

In an interview with the Administrator, she stated that she was unaware that the MORs had not been signed off. She explained that they did not have the funds to pay a registered nurse or a pharmacist to come to the facility to help them with their medication administration process. She stated that she had not reviewed the MORs to verify if her staff was signing off after medications were passed. She did acknowledge that she knew this had been a problem in the recent past, but so far she had not addressed the issue.

Class III

0058 Pharmacy & Dietary: Uncorrected Deficiencies

Based on interview and records review, the facility failed to correct Tag #0054 Medication Records, a Class III deficiency.

Findings included:

A revisit to deficiencies from an unannounced Change of Ownership survey with Limited Mental Health services (CHOW Provisional License issued for the period / to) was conducted on 11/ . Tag #0054 was previously cited due to the facility failing to record in the Medication

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)

Observation Records (MOR) for 12 of 12 residents, on numerous occasions over the month of 2016, and no explanations for this failure to record was written on the back of the MOR. At 9:15 on I/ , the MORs for the month of 2016 were reviewed. This review revealed that for 11 of the 12 residents, there were omissions (holes) in the MOR where it was unclear whether the residents had received their medications or not.

There were no explanations on the back of the MOR for any of the 11 residents with incomplete MORs. In an interview with the Administrator, she stated that she was not aware that there were omissions in the MORs because she had not reviewed the MORs to verify if medications were being given as ordered. She stated that she did not know if the residents had received the medications and if not, why not. She stated that since the last survey when this deficient practice was pointed out to her, she had not addressed the issue with staff.

Class III

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to ensure annual documentation of freedom of for 1 of 5 staff (Staff A) providing 12 residents with direct personal care services.

Findings included:

On I/ an employee record review of Staff A ' s employee file revealed Staff A was hired as a caregiver on . Staff A ' s employee record contained evidence of a testing negative on I/ . There was no documentation of an annual testing having been conducted by I/ .
In an interview with the Administrator on I/ / at 11:30 am, the Administrator acknowledged that Staff A ' s record did not include evidence of an annual testing.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on observation, record review and interviews, the facility failed to ensure that all unlicensed staff providing residents assistance with self-administration of medication complete an initial 4 hour training and a minimum of 2 hours training annually on providing assistance with self-administered medications

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

and safe medication practices in an Assisted Living Facility.

Findings included:

Per record review on / / of Staff A, Staff B, Staff C and Staff E ' s employee files, it was revealed that Staff A had no documentation of having completed an annual 2 hour update by . The last 2 hour update was / .
Staff B ' s employee file revealed that there was a certificate dated for completion of assistance with self- administration of medication, however the certificate did not specify length of training (no hours).
Staff C ' s employee file revealed that there was a certificate dated / for assistance with self-administration of medication lecture and training, signed by a registered nurse, however the certificate did not specify length of training (number of hours) and there is no indication that the training was specific to providing assistance with self-administered medications and safe medication practices in an Assisted Living Facility.
Staff E ' s employee file revealed completion of the initial 4 hours of training in providing assistance with self-administration of medications on and an annual 2 hour update on . There was no documentation of Staff E having completed an annual 2 hour update due by .
In an interview with the Administrator on / at 11:30 am, the Administrator acknowledged that employee records did not contain medication training certificates 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 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 AZ814 Reg. # 435.12(2)(b-d), FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) 11/30/16	DATE [signature]	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/29/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: VUSH12

STATE FORM: REVISIT REPORT ( )

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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