

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969734</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/09/2024</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SUNFLOWER SPRINGS AT TRINITY**

**2300 WELBILT BLVD  
TRINITY, FL 34655**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A Biennial Re-licensure and Complaint Investigation (#2024005221) was conducted at Sunflower Springs at Trinity on . Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 000               |                                                                                                                          |                          |
| A 161<br>SS=D            | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275<br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.<br><br>59A-36.015<br>(2) STAFF RECORDS.<br>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable:<br>1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C.,<br>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,<br>3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., | A 161               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969734</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/09/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNFLOWER SPRINGS AT TRINITY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2300 WELBILT BLVD</b><br><b>TRINITY, FL 34655</b>                            |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 161                                                                   | <p>Continued From page 1</p> <p>4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C.,</p> <p>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.</p> <p>(b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C.</p> <p>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to have employee records available for review for two (Staff A and Staff C) of 3 sampled staff.</p> <p>Findings Included:</p> <p>Employee record review conducted on _____ revealed no training records or evidence that staff participated in elopement drills for Staff A and Staff C. Staff A was hired on _____ and Staff C was hired on _____.</p> <p>During an interview with the Administrator conducted on _____ at 1:37pm, confirmed that Staff A and Staff C required training had not been completed.</p> | A 161                                                                          |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNFLOWER SPRINGS AT TRINITY</b> |                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2300 WELBILT BLVD</b><br><b>TRINITY, FL 34655</b>                            |                          |                                                                    |
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| A 161                                                                   | Continued From page 2<br><br>During an interview conducted on _____ at<br>2:07pm, the Administrator confirmed the lack of<br>written documentation for the staff that<br>participated in elopement drills for Staff A and<br>Staff C.<br><br>Class III | A 161                                                                          |                                                                                                                          |                          |                                                                    |