

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 11/10/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967546	(X3) DATE SURVEY COMPLETED 10/25/2016
NAME OF PROVIDER OR SUPPLIER SUNFLOWER SPRINGS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8733 WEST YULEE DRIVE HOMOSASSA, FL 34448	

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

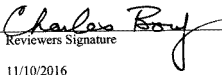
0000 Initial Comments

On 10/25/2016, an unannounced complaint survey (CCR#2016008861) was conducted at Sunflower Springs an Assisted Living Facility in Homosassa, Fl. Deficiencies were not identified as a result of this survey. The facility is in compliance at this time. License #11566

Agency for Health Care Administration State Facilities Only Tracking Sheet

Information in the attached documents may be confidential and subject to HIPPA regulations

Facility Name and Address: Sunflower Springs, LLC 8733 West Yulee Drive Homosassa, FL 34448		Facility Type: ☐ Abortion Clinic ☐ Adult Day Care Centers (ADCC) ☐ Adult Family Care Home (AFCH) ☒ Assisted Living Facility (ALF) ☐ Birth Center (BC) ☐ Crisis Stabilization Unit (CSU) ☐ Health Care Clinic (HCC) ☐ Organ and Tissue Procurement (O&T) ☐ Residential Treatment Center (RTC) ☐ Residential Treatment Facility (RTF) ☐ Short Term Residential Treatment Facility (SRT) ☐ Other:	Survey Type: ☐ Initial Licensure ☐ Relicensure ☐ Abbreviated ☐ Standard ☐ Life Safety ☐ LNS Monitoring ☐ ECC Monitoring ☐ Monitoring Visit ☐ Discharge ☒ Complaint ☐ Revisit ☐ Other:
ASPEN Event ID: QPRO11	Field Office: Alachua Area 3		
Survey Date(s): 10/25/2016	Surveyor: Allen-Beasley		
Kit Submitted By: Cb	CCR: 2016008861		

Initial, Renewals, Life Safety LNS/ECC Monitoring, and Discharge: ☐ Field Office Letter to Facility ☐ 3020 or 5000 Statement of Deficiencies Complaint: ☒ Field Office Letter to Facility ☒ Letter to Complainant (If Applicable) ☒ 3020 or 5000 Statement of Deficiencies ☒ Complaint Summary ☒ Complaint Investigation Form (CIF) Revisit: ☐ Field Office Letter to Facility ☐ 3020 or 5000 Statement of Deficiencies ☐ State Form: Revisit Report	Optional Information 1) Administrator: _____ 2) Phone Number: _____ 3) Fax Number: <u>352-621-8018</u> 4) Current Census: _____ 5) ECC Census: _____ 6) LNS Census: _____ 7) Number of Deficiencies: <u>0</u>  _____ Reviewers Signature 11/10/2016 _____ Approval Date
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