

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A PLACE TO GROW LLC

**109 VALLEY DR
BRANDON, FL 33510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint with complaint # 2022006296 in conjunction with a generator monitoring survey was conducted at A Place to Grow on Deficiencies were identified at the time of survey.	A 000		
A 181 SS=D	59A-36.019(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised. (b) A new facility as described in Rule 59A-36.014, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.	A 181		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A PLACE TO GROW LLC

**109 VALLEY DR
BRANDON, FL 33510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 181	Continued From page 1 (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by: Based on a record review and interview the facility failed to provide proof that their comprehensive emergency management plan (CEMP) was submitted for approval or approved by the local emergency management agency. Findings included: A review of the facility's most recent CEMP approval conducted on revealed that the facility's CEMP was last approved on There was no evidence provided that the facility had submitted their CEMP prior to expiration date. During an interview with the Interim Administrator, conducted on at 11:25am, the Interim Administrator confirmed that he was unable to provide evidence for the submission of the facility's CEMP to the local emergency management agency. Class III	A 181		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/12/2022
NAME OF PROVIDER OR SUPPLIER A PLACE TO GROW LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 109 VALLEY DR BRANDON, FL 33510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the employment status of staff members within the employee roster listed on the background screening clearinghouse within 10 business days of starting employment for 3 (Interim Administrator, Staff A and Staff B) of 3 employees sampled.	CZ814			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/12/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A PLACE TO GROW LLC

**109 VALLEY DR
BRANDON, FL 33510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814	Continued From page 1 Findings included: On a record review of the employee roster listed on the background screening clearinghouse, did not list the Interim Administrator, Staff A or Staff B as active on the employee roster. During an interview with the Interim Administrator conducted on at 11:09 AM, he stated, himself, Staff A and Staff B became employed at the facility on as direct caregivers. The interim Administrator, confirmed himself, Staff A and Staff B were not listed on the employee roster. Unclassified	CZ814		