

Agency for Health Care Administration

|                                                             |                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                          |  |                                                        |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11943041</b>                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BAYTREE LAKESIDE</b> |                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>6411 46TH AVENUE NORTH<br/>SAINT PETERSBURG, FL 33709</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 000                                                       | Initial Comments<br><br>Assisted Living Facility<br><br>A Limited Nursing Services (LNS) Survey was<br>conducted on 07/19/12.<br><br>Baytree Lakeside assisted living facility had no<br>deficiencies found at the time of the visit. | A 000                                                                                                     |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE

RICK SCOTT  
GOVERNOR



ELIZABETH DUDEK  
SECRETARY

July 25, 2012

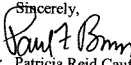
Administrator  
Baytree Lakeside  
6411 46th Avenue North  
Saint Petersburg, FL 33709

Dear Administrator:

This letter reports findings of a limited nursing services (LNS) state licensure survey that was conducted on July 19, 2012, by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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, at (727) 552-2000.

Sincerely,  
  
for Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

