

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/08/2013
NAME OF PROVIDER OR SUPPLIER BAYTREE LAKESIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 6411 46TH AVENUE NORTH SAINT PETERSBURG, FL 33709		
(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 Assisted Living Facility A complaint survey, CCR# 2013003786, was completed on 05/08/13 in conjunction with a change of ownership survey with limited nursing services (LNS), (see Aspen Event 5YN711). The Baytree Lakeside, assisted living facility, had no deficiencies cited relative to the complaint survey. Deficiencies were cited relative to the change of ownership survey with limited nursing services (LNS), (see Aspen Event 5YN711).	A 000			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0500

RM6D11

If continuation sheet 1 of 1

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

May 17, 2013

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

Dear Administrator:

Re: CCR# 2013003786 & CHOW with LNS

This letter reports the findings of a complaint survey and a change of ownership (CHOW) state licensure survey with limited nursing services (LNS) that was conducted on May 8, 201, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit relative to the CHOW survey. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your 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,

Patricia Reid Kaufman
Field Office Manager

for

PRC/kpr

Enclosures: State Forms 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161