

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 12/15/2015
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 A 000 ASSISTED LIVING FACILITY An extended congregate care (ECC) monitoring visit was conducted on 12/15/15 at the Baytree Lakeside assisted living facility. The Baytree Lakeside assisted living facility had no deficiencies at the time of the visit.			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 12/23/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943041	(X3) DATE SURVEY COMPLETED 12/15/2015
NAME OF PROVIDER OR SUPPLIER BAYTREE LAKESIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 6411 46TH AVENUE NORTH SAINT PETERSBURG, FL 33709	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

An extended congregate care (ECC) monitoring visit was conducted on 12/15/15 at the Baytree Lakeside assisted living facility. The Baytree Lakeside assisted living facility had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUKE
SECRETARY

December 23, 2015

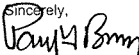
Administrator
Baytree Lakeside
6411 46th Avenue North
Saint Petersburg, FL 33709

Dear Administrator:

This letter reports findings of a extended congregate care (ECC) survey that was conducted on December 15, 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) 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(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

For Patricia Reid Cauffman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form,

1GGN

