

Agency for Health Care Administration

|                                                          |                                                                                                                                                                                         |                                                                                |                                                                                                |                                                                                                                          |                                                        |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968337</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                               |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/07/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SELA ALF, INC</b> |                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4080 NORTH 35TH AVENUE<br/>HOLLYWOOD, FL 33021</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>An Assisted Living Facility initial licensure survey was conducted on 08/07/2012. Sela ALF, Inc., had no licensure deficiencies found at the time of the visit. |                                                                                | A 000                                                                                          |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6000

VPMR11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

August 13, 2012

Administrator  
Sela Alf, Inc  
4080 North 35th Avenue  
Hollywood, FL 33021

Dear Administrator:

This letter reports findings of an Initial state licensure survey that was conducted on August 7, 2012 by representative from 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

*Arlene Mayo-Davis*  
for **Arlene Mayo-Davis**  
Field Office Manager

AMD/lis  
Enclosure

