STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105364	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Hills Health & Rehabilitation Center	3333 Capital Medical Blvd Tallahassee, FL 32308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to meet professional standards of care for 3 of 4 residents sampled for wound care. (Resident #1, #3 and #8)The findings include:Resident #1On 9/8/25, a review of Resident #1's medical record was conducted. Resident #1 was admitted on [DATE] with diagnoses that included a pressure ulcer of sacral - stage 4 and non-pressure ulcer left third toe full thickness. The physician's documentation dated 9/5/25 stated the treatment plan for the non-pressure wound of the left, third toe was primary dressing alginate calcium with silver once daily and as needed if saturated, soiled or dislodged for 25 days and a secondary dressing gauze island with border once daily and as needed if saturated, soiled, or dislodged. The treatment plan for the Stage 4 pressure wound on the coccyx full thickness included a primary dressing apply Dankins (sodium hypochlorite solution) twice daily and as needed and a secondary dressing of gauze Island with border twice daily. The documentation was electronically signed on 9/5/25 at 3:32 PM. Documentation stated the patient's plan of care was discussed with a Nursing Staff Member, but no name was provided.A review of the physician's orders was conducted. Physician's orders entered into the medical record included Wound Care: Coccyx: Cleanse with normal saline or wound cleaner. Pat dry. Apply Dakin's wet to dry dressing and cover with silicone super absorbent dressing, every day and evening shift and as needed if soiled, saturated, or not intact. This order was dated 8/29/25. There are no active orders for the non-pressure ulcer on left third toe.A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) was conducted for September 2025. On 9/2/25, there was no wound care documented, the entry was left blank. MAR and TAR documentation did not include left third toe wound care.A review of progress notes was conducted. There was a progress note dated 9/1/25 indicating Resident #1 refused wound care. There were no progress notes for 9/2/25.On 9/9/25 at 11:20 AM an interview was conducted with Registered Nurse and Wound care nurse. She reviewed Resident #1's TAR documentation and stated wound care treatment on 9/2/25 was done but not documented. She stated it was an oversight. On 9/9/25 at 3:02 PM, a follow-up interview was conducted with the Director of Nursing (DON). The DON was made aware that TAR documentation for Resident #1 did not include the left third toe wound care under physician's order, yet the wound physician had noted it under the treatment plan on 9/5/25. She was also made aware that TAR was not documented on 9/2/25 for wound care on Coccyx for Resident #1. She stated she will fix this issue immediately. Resident #3On 9/8/25, a review of Resident #3's medical record was conducted. Resident #3 was admitted on [DATE] with diagnoses that included dementia and anxiety. The physician's active orders included, Cleanse coccyx wound with normal saline, dry with 4x4 gauze, cover with foam bordered dressing, every day shift for wound management dated 5/19/25.MAR and TAR documentation did not include an order for wound care to the coccyx. The most recent weekly skin assessment documentation dated 8/29/25 stated generalized pruritus/ dry skin; order in progress.On 9/9/25 at 10:29 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked the reason the order for wound care on the coccyx placed on 5/19/25 for Resident #3 did not show onto the TAR. She reviewed Resident #3's medical record and stated that order was placed under other and the nurse that placed the order should have checked MAR or TAR for the order to show onto the administration record, but the nurse did not enter the order correctly. She further reviewed the medical record and concluded the order should have been discontinued as Resident #3 currently did not have a wound on coccyx. Resident #8On 9/9/25 at 12:45 PM, an interview was conducted with Resident #8. She stated the facility was performing wound care on both sites every other day but the facility was very inconsistent doing her wound care. She further stated she could not recall having her wound treatment since last Wednesday (9/3/25) when the wound care physician assessed the wounds. A review of physician orders was conducted. Orders stated, Wound care: right breast dated 8/10/25: cleanse area to right breast with Dankins pat dry and apply xeroform, then dry 4x4 and cover with dry border gauze every day shift and as needed if soiled or not intact. Another physician order dated 8/16/25 stated wound care: sacrum-cleanse sacrum wound, apply collagen filler and calcium ag w/silver to wound bed and cover with silicone superabsorbent dressing until resolved, every day shift every 2 day(s) for Wound Management.A wound care assessment dated [DATE] stated, wound chest full thickness treatment plan: xeroform gauze apply every two days and as needed. Stage 4 pressure wound sacrum full thickness, treatment plan: alginate calcium w silver to apply once daily and as needed A review of Resident #8's TAR stated Wound Care: Right Breast: