

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Seven Hills Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations, interviews, and record review, the facility failed to provide a well-kept and comfortable wheelchair for 1 of 2 residents sampled for assistive devices. (Resident #4)The findings include:On 1/26/26 at 12:33 PM, Resident #4 was observed in bed with eyes closed. Resident #4's wheelchair was observed with tears on back, the seat cushion being smaller than the full depth of seat which exposed metal rods on the right and left side of front of the seat's structure, and screws were exposed bilaterally. (Photographic evidence obtained) On 1/27/26 at 10:40 AM, an interview was conducted with Resident #4. He stated that the therapist had placed a cushion on his chair because he was not comfortable, but the cushion was small and his legs would hurt because he could feel the metal against his thighs. A review of Resident #4's care plan was conducted. The care plan revealed that the resident was independent with wheelchair positioning, however at times he will not position himself appropriately. Resident # 4 was independent with locomotion via wheelchair. A review of the Occupational Therapy (OT) documentation was conducted. The OT's dates of services were from 10/28/25 to 11/9/25. The OT discharge notes stated that the patient's wheelchair was fitted with a cushion in a good upright position with a goal achieved of no complaint of discomfort for 2+ hours.On 1/27/26 at 11:11 AM, an interview was conducted with Staff A, Occupational Therapist. Staff A reviewed Resident #4's most recent OT documentation and later reviewed the resident's the wheelchair's cushion and the wheelchair's torn back. He stated that Resident #4's wheelchair seat was probably 18 inches in depth and when the cushion was replaced, an 18 inch cushion was not available, but the resident did not complain about the cushion provided. Staff A acknowledged the cushion should be replaced with the proper 18 inch cushion.</p>

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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