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	07/01/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, staff interviews, and a review of resident records, the facility failed to ensure the accurate administration and also failed to ensure reconciliation of narcotic medications for 2 of 6 medication carts observed.The findings include:1. On 7/1/2026 at approximately 9:26 AM, Staff A, a Licensed Practical Nurse (LPN), spilled approximately 1/3 of a crushed Percocet 5/325 mg tablet (a narcotic pain medication) onto the medication cart #2 located in the building's B wing, while attempting to pour it into a medication cup for administration with applesauce. When asked whether the resident would be receiving the full prescribed dose, the LPN stated, It was just a little bit, and proceeded to administer the partial dose to Resident #3.A review of the electronic medical record (EMR) revealed that Resident #3 had an order for Percocet 5/325 mg to be administered twice daily for pain associated with a sacral wound. At approximately 9:27 AM on 7/1/2026, Resident #3 was observed moaning with facial grimacing. When asked if they were experiencing pain, the resident responded yes. On 7/1/2026 at approximately 1:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the LPN should have disposed of the Percocet and obtained a new dose to ensure Resident #3 received the complete prescribed amount.2. On 6/30/2026 a reconciliation of the narcotic medication cards and the narcotic logbook was conducted from approximately 4:55 PM-5:25 PM for medication cart #1 located in the building's A wing. Four discrepancies were observed. - The medication card of Morphine Sulfate ER 15 mg with directions to give twice daily for pain for Resident # 6 had 11 tablets remaining at 4:56 PM. The Medication logbook indicated 12 tablets were remaining. Staff B stated that the 9:00 AM dose was given and not signed out on the logbook. A review of the EMR revealed the dose was signed out at 9:12 AM on 6/30/2026.-The medication card of Lacosamide 150 mg with directions to give twice daily for seizure control for Resident #7 had 19 tablets remaining at 4:59 PM. The medication logbook indicated 20 tablets were remaining. Staff B stated that the 9:00 AM dose was given and not signed out on the logbook. A review of the EMR revealed the dose was signed out at 8:43 AM on 6/30/2026.- The medication card of Hydrocodone/acetaminophen 5/325 mg, given as needed for pain for Resident #8 had 8 tablets remaining at 5:04 PM. The medication logbook indicated 9 tablets were remaining. Staff B stated that the 2:00 PM dose was given and not signed out on the logbook. A review of the EMR revealed the dose was signed out at 3:50 PM on 6/30/2026.-The medication card of Oxycodone/acetaminophen 5/325mg with directions to give every 8 hours as needed for pain for Resident #9 had 9 tablets remaining at 5:05 PM. The medication logbook indicated that 10 tablets were remaining. Staff B stated that the 9:00 AM dose was given and not signed out on the logbook. A review of the EMR revealed the dose was given at 9:46 AM on 6/30/26.On 6/30/2026 at approximately 5:20 PM an interview was conducted with Staff B, a registered nurse (RN) assigned to medication cart #1, on 6/30/2026. The RN explained that she had worked a double shift and forgot to document the administration of narcotic medications in the logbook during the previous shift. When asked when the logbook should be updated and signed, Staff B stated it should be signed at the time the medication is pulled and given.On 6/30/2026 at approximately 6:30 PM, an interview was conducted with the DON. The DON confirmed that the facility's expectation is for nurses to document medication administration in both the logbook and EMR at the time the medication is given.

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