

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  11/07/2024
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45951</p> <p>Based upon observation and interview, the facility failed to provide a clean and homelike environment for 6 of 91 rooms observed.</p> <p>The findings include:</p> <p>During tours of the C-wing conducted from 11/04/24 through 11/07/24, numerous chairs and wheelchairs were observed lining the hallways, easements, and egresses of the C-wing, which could cause a tripping or entrapment hazard for staff members, residents, and visitors (photographic evidence obtained).</p> <p>During a tour of the facility conducted on 11/04/24, the floor in room [ROOM NUMBER] was visibly dirty (photographic evidence obtained). The resident living in this room stated she was bothered by the dirty floor in the room.</p> <p>During a tour of the facility conducted on 11/04/24 at 11:40 AM, it was observed in room [ROOM NUMBER] that one of the two bedside tables was missing a wheel. Also the corner of the wall in this room by the bathroom was noted to be heavily scraped and in disrepair (photographic evidence obtained).</p> <p>On 11/4/24 at 11:30 AM, Resident #17 stated the wheelchair in her room was not her wheelchair and that her wheelchair was a bigger size. Nursing staff on the wing was asked if they was aware that Resident #17 was missing her wheelchair. They stated they knew that Resident #17's wheelchair was in another resident's room. The staff said they would return Resident #17's wheelchair. Upon returning to Resident #17 on 11/04/24 at 3:19 PM, it was found that her wheelchair had not been returned to her. The surveyor returned to the nursing station and asked about the wheelchair. The staff member stated she would look for Resident #17's wheelchair. Upon returning on 11/05/24 at 9:09 AM, it was found that her wheelchair had been returned to her.</p> <p>48176</p> <p>During initial tour on 11/4/2024, the following rooms were observed to have environmental concerns (Photographic evidence obtained):</p> <p>room [ROOM NUMBER] had some broken tiles, peeling baseboard, peeling paint, and brown rust like substance on the bathroom doorframe at the entrance to the room.</p> <p>(continued on next page)</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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>room [ROOM NUMBER] had some peeling paint and a black substance on the door frame.</p> <p>Room # 69 had some debris around the tile and some other debris accumulating in a hole in the tile. The door frame had some peeling paint.</p> <p>51236</p> <p>During a tour of the facility conducted on 11/04/2024 at 10:45 AM, the persistent odor of feces was present in Resident #27's room and in the hallway outside the resident's room. In an interview conducted with Resident #27, he stated his toilet has been repeatedly clogging and not flushing properly for at least 2 weeks. Resident #27 further stated he had attempted to unclog the toilet himself with the plunger that was located in the bathroom and that he was embarrassed to repeatedly request help from the maintenance staff to unclog the toilet.</p> <p>During this observation and interview, Resident #27 also stated the air conditioning unit did not properly cool his room. When asked how long this had been a concern, he stated that it had been like that for a while. Closer observation revealed the temperature on the air conditioning Unit in Resident #27's room was set at 60 degrees Fahrenheit, but the air coming out was not cold. Using a hygrometer, the temperature in the room was reading at 77 degrees Fahrenheit. (Photographic evidence obtained.)</p> <p>Review of Resident #27's most recent Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview of Mental status score of 15, indicating he had no cognitive impairment. Further review of his MDS revealed he was independent for his toileting needs.</p> <p>An interview was conducted with the facility's Maintenance Director. The Maintenance Director stated he was aware of the issue with Resident #27's room toilet. Staff M stated that the resident's bowel movements constantly clog the toilet. He stated, I even told the nurse the resident may need medication or something, but his toilet has to be plunged every other day. During further interviews, the Maintenance Director stated he was not aware that the air conditioning unit not working in Resident #27's room. He stated that he would get the air conditioner fixed that day.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45951</p> <p>Based on observations, interviews, and record review, the facility failed to properly follow physician's orders for central line care for 1 of 1 resident reviewed for central line care (Resident #41).</p> <p>The findings include:</p> <p>During a tour of the facility conducted on 11/04/24 at 11:52 AM, Resident #41 was observed with a PICC line (which is a central intravenous line used for long term intravenous medication therapy) present in her right upper arm. Further observation revealed the dressing covering Resident #41's PICC line was dated 10/21/24. This dressing appeared to be loose fitting and there was a 2x2 gauze present under the transparent dressing which was saturated with dried blood (photographic evidence obtained). Resident #41 was asked when the dressing was last changed. She stated she did not remember.</p> <p>Review of Resident #41's medical record revealed she had been admitted to the facility on [DATE] for Orthopedic Surgery Aftercare. Resident #41 has a medical history significant for Diabetes, Paraplegia, Left Leg Amputation, Anemia, and Depression.</p> <p>A review of Resident #41's physician orders revealed an order was written on 10/23/24 for PICC line change transparent dressing every day shift every 7 days for Preventative Care AND as needed for soiling or dislodgement along with orders for two separate intravenous antibiotics to be given multiple times per day.</p> <p>An interview was conducted with Staff G, Licensed Practical Nurse, on 11/07/24 at 11:15 AM. Staff G stated that the central line dressings were supposed to be changed weekly and that the dressing change should be charted in the resident's medical record on the Treatment Administration Record. She verified the current dressings were overdue based upon the physician's order.</p> <p>Review of the facility's policy titled Infusion Devices Ongoing Assessment, Site Care, and Dressing Change, dated March 2019 revealed the Central vascular access device and midline catheter site care and dressing changes are performed at established intervals and immediately when the integrity of the dressing is compromised, if moisture, drainage, or blood is present. Gauze dressings are changed every 2 days. Transparent membrane dressings are changed every 5-7 days.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>42756</p> <p>Based on Interview and record review, the facility failed to ensure that physician orders for catheter care was provided in accordance with the care plan for 1 of 1 sampled residents for catheter care. (Resident #68)</p> <p>The findings include:</p> <p>On 11/4/24 at 12:45 PM, Resident #68 was observed to have an indwelling catheter drainage bag attached to his wheelchair.</p> <p>On 11/5/24 at approximately 10:30 AM, a review of the care plan for Resident #68 was conducted. The care plan indicated that Resident #68 had an indwelling catheter placed due to obstructive uropathy on 8/10/2023. The care plan indicated that catheter care should be provided as ordered. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #68 revealed no orders for catheter care to be performed.</p> <p>On 11/5/24 at approximately 10:40 AM, a review of physician's orders for Resident #68 was conducted. There were no orders in place for catheter care for Resident #68. There was no active order found to perform catheter care for Resident #68. A review of discontinued orders for the resident was conducted. There was an order to provide urinary catheter care using soap and water every shift that ended on 7/8/2024. There was another order to change the catheter that also ended on 7/8/24.</p> <p>On 11/5/24 at approximately 12:00 PM, an interview was conducted with Nurse B, a Licensed Practical Nurse (LPN). She was asked about the frequency of catheter care for Resident #68. Nurse B looked and could not locate an order. Nurse B stated Nurse G, another LPN, is working with that resident today and might be able to provide more information.</p> <p>On 11/5/24 at approximately 12:10 PM, an interview was conducted with Nurse G. She was asked about the frequency of catheter care for Resident #68. Nurse G looked and could not locate an order. Nurse G indicated that Resident #68 had been discharged from hospice services and the order might not have been rewritten when he was discharged. She indicated that she was sure staff was providing catheter care every shift and would get the issue corrected.</p> <p>On 11/6/24 at approximately 9:00 AM, a review of the current physician orders for Resident #68 was conducted. The orders had been updated on 11/6/24 at 7:00 AM to include orders to perform catheter care every shift.</p> <p>On 11/6/24 at approximately 4:00 PM, an interview was conducted with the Director of Nursing (DON). The DON was notified about concerns with Resident #68 not having physician orders to perform catheter care. She acknowledged the oversight.</p> <p>On 11/6/24, a review of the facility policy for catheters was conducted. The policy directed nurses to verify physician's orders for catheter care prior to performing the procedure.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45951</p> <p>Based on observations, interviews, and record review, the facility failed to ensure proper storage of medications for 2 of 5 residents observed (Resident #386 and Resident #57) and in 3 of 3 medication carts reviewed for medication storage.</p> <p>The findings include:</p> <p>Resident #386</p> <p>During a tour of the facility conducted on 11/04/24 at 11:27 AM, a medication cup was observed on the bedside table of Resident #386. The cup contained 4 medication tablets (photographic evidence obtained). During this observation, Resident #386 was asked how long the medication cup had been sitting on her bedside table. She stated, a little while. When asked if the staff often left her medications for her to take herself, she said I don't know.</p> <p>A review of Resident #386's medical record revealed she was admitted to the facility on [DATE]. She has a medical history significant for Falls, Diabetes, Hypertension, Anxiety, Bipolar Disorder, and Depression. A review of Resident #386's physician orders and medication administration record revealed she was ordered to receive 7 medications on 11/04/24 at 9:00 AM. Further review of Resident #386's medical record did not reveal documentation of her being evaluated for medication self-administration safety.</p> <p>An interview was conducted with Staff G, Licensed Practical Nurse (LPN), on 11/05/24 at 11:15 AM. She stated Resident #386 was not safe to take her own medications. Staff G further stated she did not give Resident #386 medications on 11/04/24 and she would not leave medications at the bedside.</p> <p>Resident #57</p> <p>During a tour of the facility conducted on 11/04/24 at 4:00 PM, the surveyor observed a bottle of Pepto Bismol and a tube of Hydrocortisone cream present on the dresser of Resident #57 (photographic evidence obtained). Resident #57 was not present in the room at the time of this observation.</p> <p>A review of Resident #57's medical record revealed she was admitted to the facility on [DATE]. She has a medical history significant for Falls, Muscle Weakness, Hypertension, and Chronic Obstructive Pulmonary Disease. A review of Resident #57's physician orders revealed she did not have orders for either Pepto Bismol or Hydrocortisone Cream. Further review of Resident #57's medical record did not reveal documentation of her being evaluated for medication self-administration safety.</p> <p>An interview was conducted with Resident #57 on 11/05/24 at 9:05 AM. She said she did not know she was not supposed to have medications in her room.</p> <p>Medication carts</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a tour of the facility conducted on 11/07/24 at 9:17 AM, the surveyors observed an unlocked medication cart on the B-hallway. Further observation found Staff D, a Registered Nurse, was in room [ROOM NUMBER] administering medications. While waiting for Staff D to return to the cart, another staff member walked past the unlocked cart. When Staff D returned to the hallway, she was asked about the medication cart being unlocked. She stated this was her second day working and promptly locked the cart.</p> <p>A medication cart observation was conducted on 11/07/24 at 9:28 AM with Staff E, LPN, on the B-hallway. The surveyors found 1 loose tablet in this medication cart. Staff E properly disposed of this tablet into the pill buster solution (a chemical solution used to dissolve medications for quick and safe disposal). Staff E told the surveyors the pharmacist comes each month to audit medication carts and rooms.</p> <p>A medication cart observation was conducted on 11/07/24 at 9:40 AM with Staff F, LPN, on the C-hallway. The surveyors found 13 loose tablets in this medication cart. Staff F properly disposed of the tablets into the pill buster solution.</p> <p>A medication cart observation was conducted on 11/07/24 at 9:56 AM with Staff G, LPN on the A-hallway. The surveyors found 30 loose tablets in this medication cart. Staff G properly disposed of the tablets into the pill buster solution.</p> <p>An interview was conducted with the facility's Director of Nursing on 11/07/24 at 10:48 AM. During this interview, the above medication storage concerns were discussed. She confirmed the pharmacy did monthly audits. She further stated she would educate the staff about medication safety and conduct her own audits of rooms and medication carts.</p> <p>Review of the facility's policy titled Storage of Drugs, Biologicals, Syringes, and Needles, dated July 2020 revealed the following:</p> <p>Drugs are stored under proper conditions</p> <p>Only facility staff have possession of the keys which open drug storage areas</p> <p>Drugs are stored in an orderly manner</p> <p>All drugs are securely stored in a locked cabinet/cart, inaccessible by residents and visitors</p> <p>Bedside drugs require a physician order and approval by the facility</p> <p>Bedside drugs must be stored in a secured area within the resident's room.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42756</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure nurses followed facility policy for handwashing, cleaning, and disinfecting glucometer machines for 3 of 4 sampled observations during medication pass. (Residents #337, #40, and #187).</p> <p>The findings included:</p> <p>On 11/5/24 at approximately 4:09 PM, an observation of Nurse A, a Registered Nurse (RN), was conducted as she prepared a glucose meter to obtain a capillary blood sampling via finger stick for Resident #337. Nurse A removed the glucometer machine from the top drawer of the medication cart. She proceeded directly to the bedside to collect a capillary sample from Resident #337's finger. She did not clean or disinfect the glucometer before use, set the disinfected glucometer on a clean field, or wash/ sanitize her hands before performing the procedure. Nurse A did not clean and disinfect the glucometer or wash or sanitize her hands after performing the procedure on Resident #337.</p> <p>On 11/5/24 at approximately 4:15 PM, Nurse A immediately prepared to obtain a obtain a capillary blood sampling via finger stick for Resident #40. Nurse A utilized the same glucometer that she used to collect a capillary sample from Resident #337 to collect the capillary sample from Resident #40's finger. She did not clean or disinfect the glucometer before use, did not set the disinfected glucometer on a clean field, and did not wash/sanitize her hands before performing the procedure. Nurse A did not clean and disinfect the glucometer or wash her hands after performing the procedure on Resident #40.</p> <p>On 11/5/24 at approximately 4:20 PM, Nurse A immediately prepared to obtain a obtain a capillary blood sampling via finger stick for Resident #187. Nurse A utilized the same glucometer that she used to collect a capillary sample from Resident #337 and Resident #40 to obtain the sample from Resident #187. She did not clean or disinfect the glucometer before use, did not set the disinfected glucometer on a clean field, and did not wash/sanitize her hands before performing the procedure. Nurse A RN did not clean and disinfect the glucometer or wash her hands after performing the procedure on Resident #187.</p> <p>On 11/5/24 at approximately 4:30 PM, an interview was conducted with Nurse A. She was asked how many glucometer machines are on each medication cart. Nurse A explained that normally there are 1-2 on each cart and that the glucometers are used for several residents.</p> <p>On 11/6/24 at approximately 3:30 PM, a second interview was conducted with Nurse A. She was asked to describe the process for cleaning the glucometer machines. Nurse A indicated that her supervisor and the risk manager conducted training regarding the process for cleaning and sanitizing the glucometer yesterday afternoon. She indicated that she had implemented the process of cleaning glucometer both before and after use and is also ensuring that she sanitizes or washes her hands.</p> <p>On 11/6/24 at approximately 4:00 PM, an interview was conducted with the Director of Nursing (DON). The DON was notified about the infection concerns with observations of collection of capillary finger stick glucometer readings. The DON indicated that she was aware and training has already been conducted with Nurse A regarding the process.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy for Capillary Blood Sampling (Finger Sticks) (dated 2001) was conducted. The General Guidelines section of the policy stated that glucose meters intended for reuse should always be cleaned and disinfected between each resident use. The Steps to the Procedure portion of the policy directed nurses to 1. Wash hands, 2. [NAME] Gloves. 3. Place the blood glucose monitor on a clean field 8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts and/or devices after each use. 9. remove gloves. 10. Wash hands.</p> <p>A review of the Handwashing policy (dated 2001) was also conducted. The policy indicated hand hygiene is indicated immediately before touching a resident. Before performing an aseptic task, after contact with blood, body fluids or contaminated surfaces and after touching a resident.</p>