

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 03/05/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations and record reviews, the facility failed to inform and obtain consent of psychotropic medication for 1 out 5 residents reviewed. (Resident #13)The findings include:An observation of Resident #13 was conducted on 03/03/2026 at 09:15 AM. Resident #13 was in a wheelchair in the common area next to the nurse's station. An interview with Resident #13 was attempted but the resident was unable to answer questions at this time. Resident #13 was dressed and groomed appropriately for the day. Resident #13 was able to move about the facility using a wheelchair without difficulty. A record review on 3/4/26 at 09:00 AM revealed Resident #13 was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease, Unspecified dementia, Major depressive disorder, anxiety disorder, and Pseudobulbar affect. The resident had orders for the following medications: Zoloft, Trazadone, Depakote and Melatonin. A review of the Minimum Data set assessment dated [DATE] reveals a BIMS score of 3, indicating Resident #13 rarely understands others and is rarely understood. Resident #13's plan of care demonstrates that Resident #13 is resistive to care by refusing to bathe, change clothes, and take medications. She has impaired cognitive function and impaired thought processes and is care planned for behaviors related to becoming aggressive towards staff during care. A psychotropic consent form was signed by Resident #13's representative for Ativan 0.5 mg on 09/24/2025 and a consent form was signed for Melatonin 3 mg on 06/14/2024. However, no psychotropic medication consent form was observed in electronic medical record for the psychotropic medications Trazadone, Zoloft, and Depakote.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, and staff interviews, the facility failed to store resident care equipment in a sanitary manner in 1 of 22 sampled resident restrooms (room [ROOM NUMBER]). The facility also failed to maintain restroom plumbing in good working order for 1 of 22 sampled resident restrooms. (room [ROOM NUMBER]) The findings include:room [ROOM NUMBER]Observations of room [ROOM NUMBER] shared restroom was conducted on 3/3/26 at 10:12 AM. One bedpan and 4 basins were on the floor under the sink. The items were not labeled or bagged. An additional observation of room [ROOM NUMBER]'s shared restroom was conducted on 3/5/26 at 11:42 AM with the Director of Nursing (DON). The bedpan and 4 basins remained on the floor under the sink. The items were not labeled or bagged. The DON stated the bedpan, and basins should be labeled for each resident and bagged separately. (Photographic evidence obtained.) room [ROOM NUMBER]Observations of room [ROOM NUMBER] restroom was conducted on 3/2/26 at 3:53 PM. At this time, the Resident in room [ROOM NUMBER] stated the toilet did not flush well and was clogged at times. He indicated the staff were aware because they empty his bedside commode to the toilet in the restroom. The toilet was then observed not flushing completely. An additional observation of room [ROOM NUMBER]'s restroom was conducted with the facility Administrator on 3/5/26 at 11:32 AM. The toilet seat was observed to be loose, and feces were present in the toilet. The Administrator attempted to flush the toilet, but it did not flush properly. The Administrator stated he would have a plumbing company come and check the toilet today.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review, and interview, the facility failed to assess and obtain consent prior to implementing the use of abdominal binders as restraints for 2 of 3 residents sampled for restraints. (Resident #3 and #149)The findings include:Resident #3Observations of Resident #3 on 3/3/26 at approximately 9:05 AM, 11:35 AM, and 3:25 PM and on 3/4/26 at approximately 9:00 AM and 12:25 PM revealed an abdominal binder covering the gastrostomy tube to the resident's abdomen. (A gastrostomy tube is a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication, typically used when a person cannot eat enough by mouth.)A review of Resident #3's clinical record revealed a physician's order dated 10/24/25 for an abdominal binder and for staff to make sure the binder is on every shift for safety and placement. The resident's care plan included the resident using an abdominal binder to keep her from pulling out her gastrostomy tube.Resident #149Observations of Resident #149 on 3/3/26 at approximately 8:45 AM, 11:48 AM, and 3:30 PM and on 3/4/26 at approximately 9:40 AM, 1:20 PM, and 4:00 PM revealed an abdominal binder covering the gastrostomy tube inserted into the resident's abdomen.A review of Resident #149's clinical record revealed a physician order for staff to verify placement of abdominal binder every shift for gastrostomy tube protection. The resident's care plan included, abdominal binder as indicated.A review of Resident #3 and #149's minimum data set documentation showed no restraint use. There were no signed consents for the use of the restraints.On 3/4/2026 at approximately 9:07 AM, an interview was conducted with Employee F, LPN (Licensed Practical Nurse). Employee F, LPN confirmed placement of the abdominal binders on Resident #3 and #149. LPN F stated the abdominal binder is worn to prevent the residents from pulling out their feeding tubes and neither can remove the abdominal binders.On 3/4/2026 at approximately 9:40 AM, an interview was conducted with the UM (unit manager). The UM stated, Residents with abdominal binders do not need consent, when we put the order in the computer from the doctor, we notify the family and that is considered a consent.Review of the facility policy for physical restraints revealed the resident and/or responsible party will be provided with information necessary to make an informed choice about the use of the restraint. The restraint risk/benefit consent form must also be completed and signed by the resident and/or responsible party indicating either acceptance or refusal of the restraint device.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interviews, and record reviews, the facility failed to develop a plan of care for 1 out 1 resident for activities of daily living (Resident #135) and failed to implement care plan interventions for 1 out of 1 residents reviewed (Resident #9). The findings include:Resident #135An observation and interview were conducted with Resident #135 on 03/03/2026 at 11:41 AM. He stated, I have not been getting my showers due to not enough staff on the evening shift. A record review was conducted on 03/04/2026 at 01:30 PM. Resident #135 was admitted to the facility on [DATE] with the following diagnoses: Cerebral palsy, Acute respiratory failure, Left below knee amputation, Contracture of right lower leg, and Systemic Lupus. Resident #135 had no plan of care developed for activities of daily living. A minimum data set assessment was completed on 12/26/25, which revealed that Resident #135 has impairment to both upper and lower bilateral extremities and he requires assistance with set up assistance for eating, maximal assistance for oral hygiene, bathing, dressing, and personal hygiene, and he is dependent on staff for toileting. The MDS (Minimum Data Set) Coordinator was interviewed on 3/4/2026. She reviewed the plan of care for Resident #135. She confirmed that the resident does not have a plan of care in place for activities of daily living. Resident #9An observation was conducted on 03/03/2026 at 10:43 AM for Resident #9. The resident was lying in his bed awake and alert and denied having any concerns or discomfort. A sign posted on his wall by the window stated NO STRAWS and instructions underneath revealed head positioning for swallowing when eating or drinking. A cup of nectar thick juice was sitting on the bedside table with a straw noted inside of the juice cup.On 03/04/2026 at 08:00 AM, Resident #9 was out of the room attending an appointment. However, a white Styrofoam cup dated 3/4/26 was sitting on the bedside table next to Resident #9's bed, filled with thin water and a straw inside of the cup. An interview was conducted with the Speech Therapist on 03/05/2026 at 11:00 AM. She stated that there are some residents who are able to drink thickened liquids through a straw, but thickened liquids are ordered for residents with swallowing difficulties. Thickened liquids are for residents who have failed a swallow study and after being evaluated for safe swallowing. After the Speech Therapist reviewed her documentation of Resident #9, she stated that she did recommend that Resident #9 should not use any straws when drinking due to Resident #9 being a high risk for aspiration. A record review was completed on 03/04/2026 at 10:00 AM for Resident #9's plan of care. The plan stated that he is on a restorative nursing program for swallowing, with the goal that he will safely consume thin liquids with trained caregiver assistance. Interventions listed does not list NO STRAWS and no physician order is noted on the medication record. (photographic evidence obtained)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure that the tube feeding product has not exceeded the expiration date for enteral nutrition in 1 of 2 residents sampled. (Resident #149)The findings include:Observations of Resident #149 on [DATE] at approximately 12:33 PM revealed that Jevity 1.5 was observed infusing at 60 milliliters per hour through the gastrostomy tube to the resident. The bottle of tube feeding had the date of [DATE] and the resident's name written on the bottle. The expiration date of the Jevity 1.5 used was dated [DATE]. (Photographic evidence obtained)On [DATE] at approximately 2:43 PM, an interview was conducted with Employee D, Licensed Practical Nurse (LPN). Employee D, LPN confirmed the tube feeding connected to the resident was expired as of [DATE].On [DATE] at approximately 10:40 AM, an interview was conducted with the Unit Manager (UM). The UM indicated that, after observing the expired tube feeding of Jevity 1.5 infusing on [DATE] to resident #149 that she checked all tube feeding in the building and no other expired tube feedings were observed.		