

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: 105563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Centre Pointe Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 Centerville Road 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, resident interview, staff interview, record review, and policy review, the facility failed to ensure the interdisciplinary team assessed and determined if a resident was capable of self-administration of medications prior to allowing the practice for 4 of 25 sampled residents. (Resident #43, #112, #67 and #7)The findings include:Observations:An observation of Resident #43's room was conducted on 1/5/26 at 11:30 AM, 1/6/26 at 9:46 AM and 2:10 PM, 1/7/26 at 9:30 AM and 12:30 PM, and 1/8/26 at 8:30 AM. A bottle of over-the-counter eye drops was observed to be sitting on the bedside table.An observation of Resident #112's room was conducted on 1/5/26 at 12:30 PM, 1/6/26 at 8:45 AM,1:45 PM and 3:00 PM, 1/7/26 at 9:00 AM and 12:45 PM, and 1/8/26 at 8:20 AM. A bottle of over-the-counter eye drops and a prescription bottle of Ipratropium Bromide 0.06% (nasal spray) were observed sitting on the bedside table.An observation of Resident #67's room was conducted on 1/5/26 at 12:39 PM, 1/6/26 at 9:00 AM and 1:00 PM, and 1/7/26 at 9:15 AM, 12:00 PM, and 4:30 PM. A bottle of throat antiseptic spray, aspirin, ibuprofen and eye drops were observed on the bedside table.An observation of Resident #7's room was conducted on 1/6/26 at 4:30 PM and revealed an inhaler on the bedside table. (Photographic Evidence Obtained of all observations)Record Review:A review of Residents #7, #43, #67 and #112's electronic medical records revealed no physician's order for self-medication administration and no assessments for self-medication.Interviews:An interview was conducted on 1/7/26 at approximately 9:45 AM with Staff A, Licensed Practical Nurse (LPN). LPN A confirmed that there were no residents that were permitted to self-administer medications.Policy review:A review of the facility policy for self-administration of medications by residents revealed each resident who desires to self-administer medications is permitted to do so if the healthcare center's Licensed Nurse and physician have determined that the practice would be safe for the resident.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the long term care ombudsman received a copy of the transfer notice for 1 of 2 residents reviewed for hospitalization. (Resident #156)The findings include:A review of Resident #156's medical record revealed the resident was transferred to the hospital on [DATE]. A review of the Nursing Home Transfer and Discharge Notice dated 11/8/25 revealed the that section the notice indicating the ombudsman received a copy of this transfer was blank. An interview was conducted with the Administrator on 1/7/26 at 4:45 PM. He stated the facility did not have evidence of transfers and discharges being reported to the ombudsman monthly. The former case manager that was working in the facility would not respond to the facility.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interviews, review of the electronic medical record (EMR), and review of the facilities policies and procedures, the facility failed to ensure each resident requiring a Preadmission Screening and Resident Review (PASARR) Level II screening had the evaluation completed for 1 of 1 residents sampled. (Resident #122)The findings include:On 1/7/26, a review of Resident #122's EMR revealed that the resident had multiple mental disorder diagnosis including Alzheimer's disease, depressive episodes, and cognitive communication deficit. The facility completed a PASARR Level I evaluation on 6/19/25, which recommended a PASARR Level II screening. However, the EMR contained no documentation that the facility completed the recommended PASARR Level II screening.On 1/8/26 at approximately 11:52 am, Staff C (Social Services Consultant) was interviewed. Staff C confirmed that the completed screening was not present in the EMR and had not been completed, Staff C stated that the facility faxed the request for a PASARR Level II screening that morning.A review of the facility's undated policy entitled PASARR Guidance stated: Referral for Level II resident review evaluation is required for individuals previously identified by PASRR to have a mental disorder or intellectual disability, or a related condition who experience a significant change.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based upon interviews, observations, and record review, the facility failed to provide activities of daily care who is dependent for care and services for 1 of 5 residents reviewed. (Resident #115)The findings include:An interview was conducted with Resident #115's representative on 1/5/2026 at 3:30 pm, who expressed concerns that her mother is not receiving the care and services she needs on a daily basis. She expressed concerns that her mother does not get her teeth brushed daily, she is often in the same clothes for days, she has matted hair to her scalp and is unable to get it untangled. During this interview, it was observed that Resident #115 was lying in bed with a grey t-shirt on, a brief and a sheet covering her lower extremities. Her hair was unkempt and matted to the back of her scalp.On 01/06/2026 at 09:30 am, an observation of Resident #115 revealed she was lying in bed, with her eyes closed and oxygen in use. She was in the same grey t-shirt from yesterday with a stain on the front of her shirt and her hair was unkempt and disheveled. Resident #115's teeth had food particles with a yellowish colored build up around her lower front bottom teeth.At 2:00 pm, an observation was conducted with Resident #115, who was observed lying in bed, continues to be in grey t-shirt with a stain on the front, and only an incontinence brief on her lower half. Resident #115 hair was still unkempt and disheveled.At 4:00 pm Resident #115 was lying in bed eyes with her daughter at her bedside. The daughter stated she had a bath just a few minutes ago. Resident #115's hair was brushed but it was still matted at the scalp on the back of her head. She is wearing a new blue t-shirt and has a new incontinence brief on.On 01/07/2026 at 09:15 AM, Resident #115 was lying in her wearing the same navy-blue shirt from yesterday afternoon and an incontinence brief on and her hair was disheveled and appears unkempt. Further observations at 12:30 pm and 4:30 pm revealed no change in the situation. An additional observation on 1/8/26 at 8:15 AM revealed no changes.On 1/8/2026 at 09:00 AM an interview was conducted with Staff Member E (Certified Nursing Assistant), who stated that Resident #115 is totally dependent on staff assistance for eating, bathing, changing, and dressing and that she is incontinent of bowel and bladder. Staff E stated that there are times she will become combative when providing care for her. When asked if she has any training with residents who are combative with care, Staff Member E stated that they have not had any training or in-services on how to deal with combative residents during care. On 1/6/2026 at 10:00 am, a record review was conducted for activities of daily living for Resident #115. Her shower days are scheduled for every Tuesday, Thursday, and Saturday. A thirty-day look back period for showers noted Resident #115 only received 5 showers and 1 bed bath.Resident #115's plan of care reveals she has an activities of daily living self-care deficit related to impaired functional mobility, generalized weakness, and decreased endurance with the goal that she will have needs met and that she will be clean, and well groomed. Interventions include assist as needed to reposition, face her when speaking, provide diet as ordered, encourage her to participate to the fullest extent possible, encourage the use of call light, and explain all procedures.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, record, and policy review, the facility failed to ensure that residents received wound care and treatment in accordance with professional standards of practice in 1 of 1 resident sampled for wound care. (Resident #122)The findings include:On 1/5/26 at approximately 2:45 PM, Resident #122 was observed seated in a wheelchair in the hallway. There was an undated dressing on the resident's left shin which had lifted along the bottom edge and was dripping a dark red fluid. The dark red fluid drained from beneath the dressing, ran in a thin stream down the resident's leg, and dripped onto the floor. An approximate silver dollar sized pool, with several smaller drops of the dark red fluid, had formed on the floor beneath the resident's feet. At 3:45 PM, an additional observation of Resident #122 noted that staff had applied a new bandage dated with the current date.On 1/6/26, Resident #122's electronic medical record (EMR) was reviewed. The EMR contained no documentation regarding the dressing on the resident's left shin and no skin care orders for treatment to the area.On 1/6/26 at approximately 4:45 PM, Staff D, Licensed Practical Nurse (LPN), was interviewed. Staff D confirmed that she was Resident #122's nurse. She was asked why Resident #122 had a dressing on her lower left leg and whether it was related to a wound or a skin condition. Staff D stated that she was not aware of any dressing on the resident's left leg. Staff D was asked to show documentation in the EMR explaining why the resident's leg was draining and required a dressing. Staff D stated that the EMR contained no documentation regarding the dressing.On 1/6/26 at approximately 5:00PM the facility's Director of Nursing (DON) was asked whether the EMR contained documentation of a draining wound or skin condition requiring a dressing on Resident #122's left shin. The DON stated that the resident had a pressure ulcer to her coccyx with treatment orders; however, the DON found no documentation in the EMR of a draining skin condition or wound on the left shin requiring dressing. The DON stated that skin assessments for long term care residents were documented on paper and may not have been scanned into the EMR.On 1/7/26, a skin sweep (an assessment used to document areas of compromised skin integrity) was completed for Resident #122. The skin sweep contained no documentation of a skin condition or wound to Resident #122's left leg. The resident's most recent quarterly Care Plan included interventions for skin inspection, including observing for redness, open areas, scratches, cuts, bruises and report changes to the nurse.On 1/8/26 at approximately 9:30 AM, the DON confirmed that the facility had no documentation of any skin condition or wound to Resident #122's left shin.The facility's undated policy entitled Weekly & (as needed) PRN Skin Check. The policy stated: 1. The skin check should be documented on the Weekly & PRN Skin Check. If a new area is identified the appropriate Change in Condition should be initiated. 4. If there are any new areas identified: a. Complete a Change in Condition 5. Maintain in resident Electronic Medical Record.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based upon observation, record review, and interviews the facility failed to demonstrate an infection prevention and control program that identifies, investigates and monitors all infections at the facility. Additionally, the facility failed to follow hand hygiene procedures when initiating intravenous medication administration for 1 of 1 residents reviewed. (Resident #7) The findings include: Infection tracking program: Upon review of the facility's infection control tracking and monitoring logs for 2025, there was no data of infections available for the months of July, August, and September 2025, only two infections were documented for the month of October 2025, and zero infections were documented for the months of November and December 2025. No facility mapping of infections to monitor for patterns is available for any of the months in 2025. An interview was conducted with Director of Nurses / Infection Control Preventionist on 1/8/2026 at 10:30 AM. She revealed that she and the clinical management team review all orders and clinical reports in a daily clinical meeting. They review for clinical summaries for each resident and look for any abnormal labs, abnormal vital signs, changes in condition status, symptoms that may be indicative of an infection, and any new antibiotic physician orders received. She further states that she tracks the infections through the electronic records portal for infection control and the system tracks and flags for an active infection when new antibiotic orders are noted. She reviews the data, cultures, labs, and symptoms, and monitor the time out for 3 days. Once the symptoms are resolved and / or antibiotic is completed, they close the active infection out. She also completes a mapping of infections and looks for any patterns that may occur. If a culture or lab is received and requires a change in an antibiotic, she contacts the physician and updates them on the sensitivity report. She stated she communicates with the clinical team every day in the morning or at evening team meetings and reports to the team every month in their Quality Assurance meetings. If there is an outbreak of an infection, they monitor all residents for symptoms. If they have the same infection, we cohort them together in the same room. If the infection requires a resident to be isolated, then we isolate them, manage their symptoms, track and map the infections to control the outbreak. She also reports to the Department of Health any outbreaks of infections such as influenza, Norovirus, and Covid. She stated that she provides education to staff on hand hygiene, perform spot checks with the blue light and the glow germ, donning and doffing protective equipment correctly, and types of infections that requires contact and droplet isolation. When asked to explain why there was no tracking or monitoring available to review for the months of July, August, September 2025, she explained that the facility went to electronic tracking but that she still writes out her line listing by hand, and the Administrator has her copies in the QAPI binder. Upon asking for clarification of the October 2025 tracking report revealing only two infections for the month of October and zero infections for November and December 2025 she did not offer any clarification or explanation and could not demonstrate the infection control line listing data from the QAPI binder prior to exit conference. The facility's infection control policy states the facility will use a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determining factors of a given (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease, complication, or event above the background rate. The procedure includes: gather information from each unit at least once per week, initiate a resident specific infection surveillance worksheet if infection appears likely, summarize information from the infection surveillance worksheet on the monthly line listing report, Tabulate infection data according to the following and document on the appropriate month on the annual infection rate summary, calculate incidence rates and compare to previous rates within the facility, present information at the next scheduled infection control prevention tea meeting, develop conclusions, recommendations, actions, and follow ups, report to risk manager / quality improvement committee as needed, provide staff training, and review and revise action plan as needed. Resident #7 On 1/7/26 at approximately 2:05 PM, Staff B, Licensed Practical Nurse (LPN), was observed administering Resident #7's scheduled intravenous (IV) antibiotics. Staff B was observed performing all steps in the administration of Resident #7's IV medication. At no time after entering the resident's room did Staff D remove her gloves, perform hand hygiene, and don a new pair of gloves, even though she was observed touching the resident's waste basket and bedside table. At approximately 2:10 PM, Staff B was asked about the facility's infection control policy and asked whether she should perform hand hygiene after touching the resident's bedside table and waste basket. Staff B stated that she should have washed her hands and put on a new pair of gloves after touching those things. At approximately 2:20 PM, the facility's Director of Nursing (DON) was asked about the expectations when nurses administer IV medications to the residents. The DON stated that she expects all nurses to follow the infection control policy and use aseptic [clean] technique when administering IV medications. The facility's undated policy entitled Infection Prevention - Hand Hygiene stated: The facility requires personnel to wash hands thoroughly to remove dirt, organic material, and transient microorganisms. Hand hygiene to occur including but not limited to the following activities: Contact with contaminated items or surfaces. Initiating/completing a clean [aseptic] procedure.		