

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER Suwannee Valley Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 427 15th Avenue Northwest Jasper, FL 32052	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were complete and accurate for 1 of 3 residents, Resident #11, reviewed for Minimum Data Set assessments. Findings include: Review of Resident #11's Minimum Data Set (MDS) titled Significant Change dated 05/20/26 documented under Section N, High-Risk Drug Classes, antipsychotics was coded as yes. Review of Resident #11's Medication Administration Record for May 2026 revealed no antipsychotic medications administered during the look-back period for the MDS dated [DATE]. During an interview on 08/12/26 12:48 PM, the Director of Nursing stated that Resident #11 has not taken an antipsychotic medication during her stay at the facility. During an interview on 08/12/26 at 01:25 PM, the Corporate MDS Coordinator stated that the MDS for Resident #11 had antipsychotic medication clicked yes instead of no for her lamotrigine. She stated that the MDS was incorrect. Review of the facility's policy titled, MDS 3.0 Completion, dated 09/19/22 read, According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument] specified by the State.		

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure residents with newly evident or known diagnosis of serious mental disorders have a coordinated Preadmission Screening and Resident Review (PASRR) for 1 of 3 residents, Resident #31, reviewed for PASRR. Findings include: Review of Resident #31's PASRR dated 07/24/26 revealed no related conditions, including traumatic brain injury, checked off. Review of Resident #31's Minimum Data Set (MDS) titled Admission dated 07/02/26 documented under Section I, Active Diagnoses, personal history of traumatic brain injury. Review of Resident #31's physician progress notes revealed a Nursing Home Progress Note dated 07/14/26 read, [Name and age of Resident #31] with a PMH [personal medical history] of Atrial fibrillation, Vascular dementia, TBI [traumatic brain injury], Anemia, HTN [hypertension], HLD [hyperlipidemia], Pulmonary fibrosis, speech and language deficits, Cerebrovascular disease and Parkinson's. During an interview on 08/12/26 at 12:48 PM, the Director of Nursing confirmed that the resident has a history of traumatic brain injury and that this diagnosis should be reflected on his PASRR. She stated that the PASRR needs to be updated. Review of the facility's policy titled, Resident Assessment - Coordination with PASARR Program, dated 01/2026 read, Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.		

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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. Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 5 residents, Resident #11, reviewed for unnecessary medications. Findings include: Review of Resident #11's psychiatry note dated 04/29/26 read, Diagnoses Rationale and Justifications Bipolar Disorder: The patient's history suggests that the patient has chronic episodes of depression and manic-like symptoms. These symptoms cause significant distress and functional impairment to the patient. There is no consistent substance use or organic brain disorder to explain these consistent mood symptoms. As bipolar disorder is a lifelong disorder, mood stabilizer medicine needs to be continued on a long-term basis; Other anxiety disorder: Patient has vague symptoms of anxiety, but they are causing distress. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. Review of Resident #11's psychiatry note dated 07/29/26 read, This is a [age of Resident #11] patient with a past psychiatric history of bipolar disorder, depression, anxiety and dementia; Dementia is persisting, but no other behaviors noted. The patient reports benefiting from medication regimen. Trazodone along with Prozac are managing with depression, Donepezil is helping dementia, Lamotrigine is assisting with bipolar disorder and Clonazepam is assisting with anxiety. Review of Resident #11's care plan did not document a focus area for bipolar disorder or anxiety disorder. During an interview on 08/12/26 01:25 PM, the Corporate Minimum Data Set Coordinator-Corporate stated that anxiety disorder and bipolar disorder were not included in Resident #11's care plan and will be added to the care plan. Review of the facility's policy titled, Care Plans, Development Baseline and Comprehensive, dated 01/2026 read, The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure a resident assessed as being at high risk for falls received the physician-ordered fall prevention intervention of a fall mat positioned on the right side of the bed. This failure was identified for 1 of 3 residents reviewed for fall prevention (Resident #50). Findings Include : Review of Resident #50's clinical record documented Resident #50 was admitted [DATE] with the diagnosis that included ortho-static hypo-tension (sudden drop in blood pressure when standing up), lack of coordination, reduced mobility and communication deficit. During an observation on 8/10/2026 at 10:45 AM, Resident #50 was observed up in a wheelchair at the bedside. The resident was dressed in personalized clothing and appeared clean and groomed. The bed was observed locked and in the lowest position. A Certified Nursing Assistant (CNA) was present at the bedside assisting the resident in the wheelchair to activities. No fall mat was observed on the floor on the right side of the bed and was not located in the room. During an observation on 8/11/2026 at 8:18 AM, Resident #50 was observed sitting on the right side of the bed with both feet dangling off the bed. No fall mat was observed on the floor on the right side of the bed. Review of the fall risk assessment dated [DATE] revealed a score of 50, indicating high risk for falling. Review of Resident #50's physician orders dated 6/7/2026 read, mat right side of bed. Review of Resident #50's care plan dated 5/20/2026 documented a focus identifying the resident as being at risk for falls and fall-related injury due to a history of falls with fracture, cognitive impairment, and decreased safety awareness. Interventions included assisting with toileting and transfers with a stand aide, completing fall-risk screening as indicated, cueing for safety awareness, encouraging the bed to remain in the lowest position as appropriate, encouraging use of non-skid socks, ensuring the call light was within reach, keeping frequently used items within reach, observing for medication side effects that could contribute to falls, orienting the resident to the environment, and obtaining a therapy screen as needed. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed medications and treatments were documented as administered as ordered; however, the physician order for the fall mat on the right side of the bed was not reflected on the TAR as an implemented intervention. During an observation on 8/11/2026 at 12:46 PM, Resident #50 was observed sitting in a wheelchair at the bedside on the right side of the bed. No fall mat was observed on the floor beside the bed or located in the room. During an interview on 8/11/2026 at 12:46 PM, Resident #50 stated, I use to have a fall mat here but I got a new bed and they took the fall mat away. That was a long time ago. During an interview on 8/11/2026 at 1:18 PM, Staff A, Registered Nurse (RN) stated Resident #50 was a fall risk and became somewhat confused when she woke up. Staff A, RN stated the resident required sit-to-stand assistance. Staff A, RN further stated, I reviewed the orders and there is an order for a fall mat on the right side of the bed we should follow that order or have it cancelled if she no longer needs the fall mat. During an interview on 8/11/2026 at 1:30 PM, the Director of Nursing (DON) stated, I do remember her bed being changed out and the mat would get in the way, we should have got the order for fall mat on the right side of the bed cancelled. Review of the facility policy titled Fall Prevention Program, dated 1/6/2026, revealed, in part, that each resident would be assessed for fall risk and receive care and services in accordance with the resident's individualized level of risk to minimize the likelihood of falls. The policy further identified high-risk protocols requiring patient-centered interventions addressing unique risk factors and additional interventions as directed by the resident's assessment, including ix. Fall mat.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to ensure medications were securely stored when unattended for 1 of 5 hallways. Findings include: Review of Resident #41's physicians order dated 07/06/26 read, May self administer medications. Review of Resident #41' Self Administration of Medication Evaluation dated 07/06/26 read, The resident can demonstrate secure storage of medications kept in room. Completely Capable. During an observation on 08/10/26 at 10:19 AM, an inhaler was observed to be unsecured on top of a small dresser under Resident #41's television. Lubricant eye drops were observed to be unsecured on Resident #41's bedside table. During an interview on 08/10/26 at 10:19 AM, Resident #41 stated that her bedroom does not lock. She explained that she would prefer that her room had a lock so other residents could not enter her room. During an observation on 08/11/26 at 02:06 PM, Resident #41 was observed retrieving nasal sprays from an unlocked drawer in her bathroom. Observed an inhaler in a wicker box on a dresser and nebulizer vials on her nightstand. During an interview on 08/11/26 at 02:06 PM, Resident #41 stated that she does not have a lockbox but would like to have one. Resident #41 said, I didn't know we could get a lockbox. I don't have one, can I ask? During an interview on 08/12/26 at 09:55 AM, Staff B, LPN, stated that Resident #41 is able to manage her own medications, but the nursing staff keep her oral medications locked in the medication cart. The resident keeps her breathing treatments in her room. She has no concerns about the resident's ability to manage her medications. She stated that she was unsure if the resident's medications need to be locked up when kept in her room. During an observation on 08/12/26 at 10:08 AM Staff B, Licensed Practical Nurse (LPN), confirmed that medications were unsecured in Resident #41's bedroom. During an interview on 08/12/26 at 10:18 AM, Staff B, LPN stated that she was unsure if Resident #41's medications needed to be locked up, but that makes sense, she probably leaves them out to reminder herself to take them. During an interview on 08/12/26 12:36 PM, the Director of Nursing stated that Resident #41 has been assessed for self-administration of medications and as part of that, has to be able to administer the medications correctly and keep them secure. She stated that the resident keeps her inhalers and artificial tears in her room, but nursing staff keep her oral medications locked in the medication cart. She stated that Resident #41 likes to keep her medications within sight on her table. She stated that Resident #41 has a private room and was not offered a lockbox for her medications. She explained that when Resident #41 leaves her room, she keeps the medications in an unlocked drawer. She stated that Resident #41's bedroom does not lock from the outside. Review of the facility's Resident Self-Administration of Medication policy dated 01/2026 read, when determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: The resident's ability to ensure that medications is stored safely and securely; Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required on if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.		