STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williston Care Center and Rehab	300 NW 1st Ave Williston, FL 32696

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. Based on interview and record review, the facility failed to ensure each resident received an accurate assessment reflective of the resident status for 2 of 7 residents, Residents #1 and #3 reviewed for Minimum Data Set (MD) assessments. 1)Review of Resident #1 Minimum Data Set (MDS) titled Quarterly dated 9/18/2025 in Section J Bladder and Bowel documented no indwelling catheter.Review of Resident #1 physician order dated 1/24/2025 read, Cath [Catheter] Change urinary catheter bag and tubing once monthly and as needed.Review of Resident #1 physician order dated 9/9/2025 read, Suprapubic Catheter Dx [Diagnosis]: Neurogenic bladder.Review of Resident #1 physician order dated 9/9/2025 read, Cath: Catheter care with soap and water every shift pat dry, apply T-drain per resident request and as needed.During an interview on 12/05/2025 at 12:40 with the MDS Coordinator stated, [Residnet #1's name] does have a catheter, not sure why it was coded no. We will have do submit a modification and correct it.Review of the facility policy and procedure titled MDS Assessment with an issue date of 4/1/2022 read, Policy: It will be the policy of this facility to complete MDS assessment in accordance with the RAI [Resident Assessment Manual] manual guidelines. Procedures: 1. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts time and appropriate resident assessments.2) During an interview on 12/05/25 at 12:05 PM, Staff A, Certified Nursing Assistant [CNA], identified Resident #3 as a resident who requires assistance with eating who resides on her assigned hallway.During an interview on 12/05/25 at 12:15 PM, Staff B, CNA, identified Resident #3 as a resident who requires assistance with eating who resides on her assigned hallway.Review of Resident #3's Minimum Data Set [MDS], under Section GG, dated 11/02/25 read: A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident - independent.Review of Resident #3's progress notes documented a Dietary Note dated 10/03/25 that read, Intake 75-100% - dependent with meals.Review of Resident #3's progress notes documented a Dietary Note dated 11/04/25 that read, Intake 75-100% - dependent with meals.During an interview on 12/15/25 at 3:34 PM, the MDS Coordinator stated, We looked into the MDS [for Resident #3], it was a coding error.

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

FORM CMS-2567 (02/99)
Previous Versions Obsolete

Event ID:

Facility ID: 105467

If continuation sheet
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