STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105327	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Mora Rehabilitation and Extended Care	1902 59th St W Bradenton, FL 34209

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure Advance Directives were properly documented in the medical record for three residents (#2, #12, and #13) out of three residents reviewed for code status. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury or death to Residents #2, #12, and #13 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to an E.Findings included: 1)Review of the Emergency Medical Systems (EMS) run report for Resident #2, dated [DATE], showed: Dispatch to rehab facility for [Resident #2] reported to have pink fluid coming from his tracheostomy tube. Upon arrival facility staff were in the hallways and reported that the patient (pt) is not doing well and appeared visibly shaken. Staff were unable to provide a time of onset. Upon entering the room, the patient (pt) was found in a semi-Fowler's position in bed. He was responsive to pain the patient was on blow by humified oxygen. There were thick secretions coming from the pt's tracheostomy tube. Breathing was labored. Lung sounds revealed bilateral rhonchi. Rapid pulse was thready and regular. Skin was normal color, hot and dry. 50 milliliters (ml) of emesis was suctioned from the pt's tracheostomy. Vitals revealed hypoxia. A blood pressure was unable to be palpated or auscultated. The pt was moved on to the stretcher. Prior to moving the pt to the unit [ambulance] his breathing changed from labored to agonal and pulses were no longer present. Cardiopulmonary resuscitation (CPR) was initiated with pulseless electrical activity (PEA) noted as [unreadable]. The pt was moved to the unit. In the unit the pt had an additional 100 ml of emesis suctioned from his tracheostomy. The [NAME] device was used for continuous compressions. The tracheostomy tube (uncuffed) was removed and replaced with a 6.0 ET (endotracheal) tube. He was placed on the ventilator. At the next rhythm check the pt's rhythm was slow PEA that quickly became asystole. CPR was resumed. An Intraosseous Intravenous access (IO) was established and the pt was given 1 milligram (mg) of Epinephrine. Enroute to the hospital CPR was continued with no changes in rhythm. A blood glucose level of 138 milligrams (mg)/deciliter (dL) was obtained. The pt was given 1 mg of epinephrine prior to transferring the pt inside the ED. At the hospital pt care was transferred to the nurse where CPR continued. Review of admission Records showed Resident #2 was admitted on [DATE] and re-admitted on [DATE] with diagnoses including anoxic brain damage, persistent vegetative state, seizures, acute and chronic respiratory failure, tracheostomy status, gastrostomy status, and cardiac arrest due to underlying conditions Review of Resident #2's physician orders showed:-Do Not Resuscitate (DNR) Start: [DATE]. -Full Resuscitation Discontinued: [DATE] Start: [DATE]Review of Resident #2 Medical Certification for Medicaid Long-Term Care and Services and Patient Transfer Form (AHCA 5000-3008) from hospital discharge, dated [DATE], showed the resident had a Do Not Resuscitate order. Section H, Advanced Care Planning, listed the following: -Advanced Directives- indicated No with a checkmark-Living Will- indicated No with a checkmark-DO NOT Resuscitate (DNR)- indicated Yes with an X and No with a checkmark. The Yes was also circled and there was a line from the circle across the No and error written beside it. -DO NOT Intubate- indicated No with a checkmark-DO NOT Hospitalize- indicated No with a checkmark-No Artificial Feeding- indicated No with a checkmark-Hospice- indicated No with a checkmarkReview of Resident #2's medical record did not reveal a signed DNR Form DH1896. Review of Florida Statutes Chapter 401, Medical Telecommunications and transportation, section 401.45 (3)(a) regarding DNR Form DH1896 showed: Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician or physician assistant is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician or physician assistant and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient. (https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0401/Sections/0401.45.html#:~:text=(3)(a)%20Resuscitation%20may,by%20rule%20of%20the%20department. Accessed on [DATE])An interview was conducted on [DATE] at 2:34 p.m. with Staff N, Registered Nurse (RN)/Unit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to follow the established facility grievance policies and procedures related to investigation and follow-up for resident grievances for five residents (#16, #17, #18, #19, and #20) out of six residents sampled. Findings included:An interview was conducted on 09/09/2025 at 11:15 a.m. with Resident #18. The resident stated he had several grievances filed with the facility and the facility had not followed up with him on most of them. He stated a grievance where he had been awoken by a Certified Nursing Assistant (CNA) making noises in the hall was never addressed by the facility, as well as a grievance about some missing items. An interview was conducted 09/09/2025 at 2:30 p. m. with Residents #16 and #17. They stated there was a joint grievance regarding staff not passing out waters, and regarding the staff being on their personal phones during resident care. Both Resident #16 and #17 voiced no one has discussed their grievances with them and both of their complaints were still ongoing issues and had not been resolved. An interview was conducted on 09/10/2025 11:00 a.m. with Resident #20. The resident stated no one had ever resolved her grievances from July 2025 and no one had followed up on the grievances. The resident stated no staff had come to talk to her about the grievance or informed her of any plans to resolve it. An interview was conducted 09/10/2025 11:07 a.m. with Resident #19. The resident did not want to discuss the specifics of his grievance, however, he did voiced his issues had not been resolved and verified no one had followed up with him regarding his grievance. An interview was conducted with Staff L, Social Services, on 09/10/2025 at 11:34 a.m. Staff L explained the grievance process for the facility. Staff L stated it would depend on the specific situation as to who would follow up with residents and confirmed that no one specific person followed up with the residents to make sure they understood their grievances were either being worked on or completed and signed off. A review of the facility policy titled Grievance/Concern Management, dated May 2025, revealed the following: POLICY :Residents and their representative have the right to present concerns on behalf of themselves, and/ or others to the staff and/ or administrator of the facility, to governmental officials, or to any other person. The concern may be filed verbally or in writing, and the reporter may request to remain anonymous.Residents and their representative have the right to recommend changes in policies and services, and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal.These rights include access to the State of Florida Long-[NAME] Care Ombudsman and advocates and the right to be a member of, to be active in, and to associate with, advocacy or special interest groups.These rights also include the right to prompt efforts by the facility to resolve resident concerns, including concerns/grievances with respect to the behavior of other residents. PROCEDURE:1. At, during, or after admission, staff will provide:a. An explanation of the facility concern processb. A copy of the concern / grievance formc. An explanation of where concern forms are located, and that staff will provide a form should it be requestedd. Guidance on assistance available to residents or their representatives who are unable to complete the form unassistede. The names, job titles, and telephone numbers of employees responsible for implementing the facility's concern procedure. This information is found in the admission Booklet and includes the address and toll-free telephone numbers and email addresses for the Ombudsman and the Agency and other survey agencies.f. Outside resources available to the resident: -Ombudsman-Department of Health-Facility specific options such as a toll-free number for reporting concerns2. The facility will prominently display a poster that includes the following:a. The contact information of the Grievance Official to include his / her name, business address (mailing and email address), and business phone number,b. A reasonable expected time for completing a review of the concern, c. The right to obtain a written decision regarding the concern,d. Reference to independent entities with whom concerns may be filed.3. Residents and their representatives who are unable to complete a written concern will be assisted by staff to prepare and submit the form.4. The NH.A is responsible for oversight of the concern process.5. The Social Services representatives/ Grievance Official in collaboration with the NH.A will be responsible for assigning the concern to the appropriate department for investigation. Social Services will monitor and document resident / representative satisfaction upon completion of the investigation and the summary of findings / conclusion.6. Social Service Director in collaboration with the NH.A will be the Grievance Official at the facility7. The facility leadership team will review and discuss concerns and the progress of an investigation(s) and resolution(s). 8. The department involved will document the concern and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to report an incident of elopement related to lack of supervision for one Resident (#1) out of four residents reviewed for elopement. Findings included: A review of Resident #1's admission record revealed an admission date of 1/19/24 with diagnoses to include encephalopathy, unspecified, generalized anxiety disorder, mild cognitive impairment of uncertain or unknown etiology, syncope and collapse, and alcohol use, unspecified. A review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE], under section C-Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Section GG - Functional Abilities, revealed the resident used a walker for mobility and ambulated independently. Section P, Restraints and Alarms, revealed a wander/elopement alarm was used daily. A review of Resident #1's quarterly MDS, dated [DATE], revealed the same information was marked in sections C, GG, and P as in the assessment date of 7/26/25. A review of Resident #1's order summary report, to include completed and discontinued orders, revealed the following:- LOA [leave of absence] with escort for impaired cognition/elopement risk, with an order date of 1/29/24.- Electronic Wander Bracelet: Apply electronic wander bracelet to the L [left] ankle due to elopement risk, with a start date of 1/22/24 and discontinued 6/6/25.- Electronic Wander Bracelet: Check function with the transponder daily on night shift. Replace electronic wander bracelet if not working correctly. every night shift for poor safety awareness, with a start date of 1/22/24 and discontinued 9/3/25.- Electronic Wander Bracelet: Apply electronic wander bracelet to the L ankle due to elopement risk exp [expiration] 3/22/27 every day shift until 03/19/2027 23:59 change the wanderguard, with an order date of 6/6/25 and discontinued 9/3/25. - CBC [complete blood count] with diff [differential], CMP [comprehensive metabolic panel] and UA&PCR [urinalysis and polymerase chain reaction test] one time only for Behaviors for 1 Day. with a start date of 7/7/25 and end date of 7/8/25. A review of Resident #1's care plan revealed the following:- COGNITION: [resident name] has impaired cognitive function/dementia or impaired thought processes r/t [related to] Impaired decision making Date Initiated: 08/01/2025 Revision on: 08/01/2025, with interventions to include, Report to Nurse any changes in cognitive function, specifically changes in: . memory . confusion . Date Initiated: 08/01/2025.- FALL: [resident name] is at Risk for falls or fall related injury because of: Deconditioning, hx [history] of falls Date Initiated: 01/21/2024 Revision on: 01/29/2024 . - ELOPEMENT RISK: [resident name] is at risk for elopement The resident has cognitive impairment and is independently mobile Date Initiated: 01/23/2024 Revision on: 01/29/2024., with a goal to include the following, [resident name] will not exit the facility without staff knowledge, or appropriate supervision Date Initiated: 01/23/2024 Revision on: 07/29/2025., and with interventions to include the following, . Apply electronic wander bracelet due to elopement risk Date Initiated: 02/09/2024 . Obtain an order for LOA with escort Date Initiated: 02/09/2024 . A review of Resident #1's progress notes revealed the following: - 2/8/24 social services note, SW [Social Worker] was made aware that [resident name] continues to ambulate throughout the facility and has been noted to go to the door and look out the glass. He continues to have a wander guard to ankle. He told SW that he wanted to be discharged to [address] where he was going to reside with his [family member]. SW contacted [family member] at [phone number] . SW was told that [address] was an address where [resident] resided at in [state] and that resident's [family member] had passed away in [year]. She further explained that resident did not have a home in [state] and has been staying at a homeless shelter prior to being admitted to the hospital and subsequently [facility name]. She further stated that when talking to her [family member] he has told her that he has been staying at a motel and that he was wanting to leave to go to the bar and was planning on returning to the motel. SW met with resident following this conversation and conducted a BIMS [Brief Interview for Mental Status] assessment which indicated that [resident name] score was at this time an 11. During conversation it was also determined that he thought that he was in [state] at this time and had forgotten he was now in [state]. He asked why he could not just walk out the facility and stated that he would make his way there. It was discussed that in order to discharge from the facility it would have to be a safe and appropriate discharge and walking out of facility with no predetermined location would not be safe.- 7/7/25 general progress note, Resident observed with behaviors of going to other residents rooms and followed staff easy to redirect by staff.PA [Physician Assistant] made aware. New order received for labs. POA [power of attorney] notified.- 7/9/25 general progress note CBC CMP results reviewed by PA with no new order at this time UA result

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure Advance Directives were honored and properly documented in the medical record for three residents (#2, #12, and #13) out of three residents reviewed for code status. Resident #2 received cardiopulmonary resuscitation (CPR), despite his preference to be a Do Not Resuscitate (DNR) code status, after he was found unresponsive by staff on [DATE]. Staff failed to inform the Emergency Response Team (EMT) of the DNR code status and CPR was begun at the facility and conducted during transport and care in the emergency room (ER). This failure created a situation that resulted in a worsened condition and the likelihood for serious injury or death to Residents #2 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to an E.Findings included: 1)Review of the Emergency Medical Systems (EMS) run report for Resident #2, dated [DATE], showed:Dispatch to rehab facility for [Resident #2] reported to have pink fluid coming from his tracheostomy tube. Upon arrival facility staff were in the hallways and reported that the patient (pt) is not doing well and appeared visibly shaken. Staff were unable to provide a time of onset.Upon entering the room, the patient (pt) was found in a semi-Fowler's position in bed. He was responsive to pain the patient was on blow by humified oxygen. There were thick secretions coming from the pt's tracheostomy tube. Breathing was labored. Lung sounds revealed bilateral rhonchi. Rapid pulse was thready and regular. Skin was normal color, hot and dry. 50 milliliters (ml) of emesis was suctioned from the pt's tracheostomy. Vitals revealed hypoxia. A blood pressure was unable to be palpated or auscultated. The pt was moved on to the stretcher. Prior to moving the pt to the unit [ambulance] his breathing changed from labored to agonal and pulses were no longer present. Cardiopulmonary resuscitation (CPR) was initiated with pulseless electrical activity (PEA) noted as [unreadable]. The pt was moved to the unit.In the unit the pt had an additional 100 ml of emesis suctioned from his tracheostomy. The [NAME] device was used for continuous compressions. The tracheostomy tube (uncuffed) was removed and replaced with a 6.0 ET (endotracheal) tube. He was placed on the ventilator. At the next rhythm check the pt's rhythm was slow PEA that quickly became asystole. CPR was resumed. An Intraosseous Intravenous access (IO) was established and the pt was given 1 milligram (mg) of Epinephrine.Enroute to the hospital CPR was continued with no changes in rhythm. A blood glucose level of 138 milligrams (mg)/deciliter (dL) was obtained. The pt was given 1 mg of epinephrine prior to transferring the pt inside the ED.At the hospital pt care was transferred to the nurse where CPR continued. Review of Resident #2's hospital record, dated [DATE], showed: History of Present Illness (HPI)[Age and gender] with history of anoxic brain injury from prior stroke, tracheal tube, PEG (percutaneous endoscopic gastrostomy) tube, BIBEMS (brought in by emergency medical service) after being found pulseless at this facility. Upon EMS arrival they found him/her in PEA with pink frothy sputum coming out of his/her tracheal tube, they switched out for endotracheal tube. Patient has some point was found to be asystole. Compression were continued until he arrived to the emergency department. He received several rounds of epinephrine and was coded for 30 minutes prior to arrival and transfer to emergency department care. Patient presented from local nursing facility as a pre-hospital cardiac arrest. Report from medics was that they were called because the patient was hypoxic and having significant drainage from his trach. When they arrived, the patient was saturating [oxygen saturation] in the 70s, They said that they suctioned the trach and were getting significant output. They report that it was pink and thick in color. Because of the amount of suctioning they were having to do they were concerned that the trach may have been clogged. Shortly after their arrival the patient went to a cardiac arrest, PEA was the initial rhythm. ACLS (Advanced Cardiac Life Support) protocol was followed. They opted to remove the trach, place a 6-0 endotracheal Lube within the Tracheostomy and then bag the patient. They were able to get improvement in his oxygenation to the 90s with bagging the patient but patient remained between PEA and asystole on pulse checks during transport. ACLS have been ongoing for least 30 minutes on patient arrival. Paramedics report that the patient's blood sugar was in the 130s. He had received 2 rounds of epinephrine prior to arrival. Patient arrived here with a [NAME] device providing chest compressions. Endotracheal tube was within the tracheostomy, and the patient had equal bilateral breath sounds. Additional intraosseous access was obtained and ACLS was continued. He received additional doses of epinephrine including a dirty epi drip and Levophed infusion. He also received bicarb, calcium and magnesium. We did obtain ROSC (return of spontaneous circulation) twice

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide supervision to prevent elopement for one resident (#1) out of four residents reviewed for elopement risk. On 7/26/25 Resident #1 exited the facility at 6:30 p.m., unnoticed by staff. Resident #1 was mildly impaired, confused, and had an electronic monitoring device in place. Resident #1 followed another resident out the door which was remotely opened by staff. The door alarm was disabled by a resident who was aware of the code after Resident #1 triggered the alarm upon exit. Resident #1 walked approximately 0.2 miles to a hospital near the facility and was returned with assistance of law enforcement to the facility at 9:00 p.m. This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #1 and resulted in the determination of Immediate Jeopardy on 9/10/2025. The findings of Immediate Jeopardy were determined to be removed on 9/11/2025 and the severity and scope was reduced to a D after verification of removal of immediacy of harm.Findings included: A review of Resident #1's admission record revealed an admission date of 1/19/24 with diagnoses to include encephalopathy, unspecified, generalized anxiety disorder, mild cognitive impairment of uncertain or unknown etiology, syncope and collapse, and alcohol use, unspecified. A review of Resident #1‘s quarterly Minimum Data Set (MDS), dated [DATE], under section C-Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Section GG - Functional Abilities, revealed the resident used a walker for mobility and ambulated independently. Section P, Restraints and Alarms, revealed a wander/elopement alarm was used daily. A review of Resident #1's quarterly MDS, dated [DATE], revealed the same information was marked in sections C, GG, and P as in the assessment date of 7/26/25. A review of Resident #1's order summary report, to include completed and discontinued orders, revealed the following:- LOA [leave of absence] with escort for impaired cognition/elopement risk, with an order date of 1/29/24.- Electronic Wander Bracelet: Apply electronic wander bracelet to the L [left] ankle due to elopement risk, with a start date of 1/22/24 and discontinued 6/6/25.- Electronic Wander Bracelet: Check function with the transponder daily on night shift. Replace electronic wander bracelet if not working correctly. every night shift for poor safety awareness, with a start date of 1/22/24 and discontinued 9/3/25.- Electronic Wander Bracelet: Apply electronic wander bracelet to the L ankle due to elopement risk exp [expiration] 3/22/27 every day shift until 03/19/2027 23:59 change the wanderguard, with an order date of 6/6/25 and discontinued 9/3/25. - CBC [complete blood count] with diff [differential], CMP [comprehensive metabolic panel] and UA&PCR [urinalysis and polymerase chain reaction test] one time only for Behaviors for 1 Day. with a start date of 7/7/25 and end date of 7/8/25. A review of Resident #1's care plan revealed the following:- COGNITION: [resident name] has impaired cognitive function/dementia or impaired thought processes r/t [related to] Impaired decision making Date Initiated: 08/01/2025 Revision on: 08/01/2025, with interventions to include, Report to Nurse any changes in cognitive function, specifically changes in: . memory . confusion . Date Initiated: 08/01/2025.- FALL: [resident name] is at Risk for falls or fall related injury because of: Deconditioning, hx [history] of falls Date Initiated: 01/21/2024 Revision on: 01/29/2024 . - ELOPEMENT RISK: [NAME] is at risk for elopement The resident has cognitive impairment and is independently mobile Date Initiated: 01/23/2024 Revision on: 01/29/2024., with a goal to include the following, [resident name] will not exit the facility without staff knowledge, or appropriate supervision Date Initiated: 01/23/2024 Revision on: 07/29/2025., and with interventions to include the following, . Apply electronic wander bracelet due to elopement risk Date Initiated: 02/09/2024 . Obtain an order for LOA with escort Date Initiated: 02/09/2024 . A review of Resident #1's progress notes revealed the following: - 2/8/24 social services note, SW [Social Worker] was made aware that [resident name] continues to ambulate throughout the facility and has been noted to go to the door and look out the glass. He continues to have a wander guard to ankle. He told SW that he wanted to be discharged to [address] where he was going to reside with his [family member]. SW contacted [family member] at [phone number] . SW was told that [address] was an address where [resident] resided at in [state] and that resident's [family member] had passed away in [year]. She further explained that resident did not have a home in [state] and has been staying at a homeless shelter prior to being admitted to the hospital and subsequently [facility name]. She further stated that when talking to her [family member] he has told her that he has been staying at a motel and that he was wanting to leave to go to the bar and was planning on returning to the motel. SW met with resident following this conversation and conducted a BIMS [Brief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105327	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Mora Rehabilitation and Extended Care	1902 59th St W Bradenton, FL 34209

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews, the facility failed 1) to properly store and secure medications for two residents (#8 and #9) out of twenty resident sampled, and 2) to properly secure medications out of reach of residents in one nursing station (200) out of four nursing stations. Findings included: An observation and interview was conducted on 9/8/25 at 07:30 a.m. with Resident #8. There was a tube of zinc oxide paste skin cream on the bedside table. Resident #8 stated, “This was brought with me from the hospital and has been in my room since arrival, however it has since been discontinued.” (Photographic evidence obtained) An observation and interview was conducted on 9/8/25 at 07:40 a.m. with Resident #9. There was a tube of Betamethasone Valerate cream on the windowsill. Resident #9 was asked if the medication belong to the resident and the resident replied, “I think so.” (Photographic evidence obtained) During an interview on 9/8/25 at 1:53 p.m. with the Director of Nursing (DON), the DON stated, “All employees are given training regarding misplaced medications in the resident's room. As it pertains to self-administered medication (SAM) residents, we do have a policy, however as of this date, we do not have any SAM residents in the facility and if we find medications in the resident's room, we send them back to the pharmacy. The facility also discourages residents and visitors from bringing in any medications to the facility. During an interview on 9/8/25 at 12:35 p.m. with Staff A, Registered Nurse (RN), Staff A stated, “I adhere to the six patient rights when administering medications, so I would never administer a medication that does not belong to the resident. After I administer a medication, I document the administration in the electronic health record. If there is a medication that is left in the room after administration, I would follow policy and report it to the DON and secure the medication. We do not currently have any SAM residents in this facility. During an interview on 9/8/25 at 10:55 a.m. with Staff B, RN, Staff B stated, “If a resident has a discontinued medication that is left in the resident's room, we return the medication to the pharmacy and we do not have any SAM residents in the facility. During an interview on 9/8/25 at 11:05 a.m. with Staff C, RN, Staff C stated, “Before administration of medications, I confirm the order in the electronic health record and ensure the six resident rights for medication administration, then if after administration, if the medication is not fully used, it is either wasted or returned to the pharmacy depending on the medication. The facility does not currently have any SAM residents. During an interview on 9/8/25 at 11:10 a.m. with Staff D, Licensed Practical Nurse (LPN), Staff D stated, “If I have a discontinued medication, I will return it to the pharmacy and if I find a medication left in the resident's room, I will take it out and return it to the pharmacy. The facility does not currently have any SAM residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/8/25 at 11:15 a.m. with Staff E, CNA, Staff E stated, “If I find a medication in the resident's room, I will report it to the on-duty nurse. I am not aware of any SAM residents in the facility. A review of discontinued medications in the electronic health record revealed Resident #8 was prescribed Zinc Oxide and the medication had been discontinued. A review of current and active medications in the electronic health record revealed Resident #9 was prescribed Betamethasone Valerate cream, which was active on 7/22/23 to be used for dermatitis. An observation was conducted on 9/8/25 at 6:27 a.m. of a prescription medication sitting at the 200 hall nurses' station and there was an unlocked treatment cart containing prescription medication sitting outside the nurses' station. There were no staff in sight of the treatment cart of nurses' station. An observation was conducted on 9/8/25 at 3:14 p.m. of two full medication bubble packs, two bottles of liquid medication, and one bag of nebulizer treatments were sitting at the 200 hall nurses' station with no staff in sight and residents sitting nearby. Review of the facility policy titled Self-Administration by resident, dated 11/17, revealed the following: Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Review of the facility policy titled Storage of medication, dated 9/18, revealed the following: Policy: Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories. 2. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (Refer to Section 5-Disposal of Medications, Syringes and Needles), and reordered from the pharmacy (Refer to Section 3.2-Ordering and Receiving Non-Controlled Medications), if a current order exists. Review of the facility policy titled Medication administration general guidelines, dated 9/18, revealed the following: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only be persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked.