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	02/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility policy, the facility failed to thoroughly investigate allegations of abuse, neglect and misappropriation of property for one resident (#1) of two residents reviewed.Findings included: On 2/7/2026 at 12.03 p.m., an interview was conducted with Resident #1. Resident #1 stated sometime last year, Staff H, Certified Nursing Assistant (CNA) befriended her and started taking money from her. The resident stated she was giving Staff H money to buy visa gift cards. Resident #1 stated Staff H was using the cards to buy adult gummies for both of them. The resident stated the adult gummies contained THC (Tetrahydrocannabinol, the main psychoactive compound in cannabis). Resident #1 stated she gave Staff H, CNA approximately $5,000 or more. She stated she did not remember the exact amount. Resident #1 said the staff member still owes her $1000 for prepaid money card Staff H, CNA never bought. Resident #1stated she reported this information to the previous Nursing Home Administrator (NHA) and the previous Social Services Director (SSD). Resident #1 stated she reported to the police the missing money, and her Power of Attorney (POA) was handling the investigation. Resident #1 stated she did not tell the police about the drug use, because I was afraid I would get in trouble. I told the NHA and SSD though. The resident stated she was getting the THC gummies to ease her pain. She stated every morning, Staff H would come to her room, and they would split a gummy. She stated the staff member would advise her on the potency and would recommend if she would take a half or a full one. Resident #1 stated Staff H had her bank card pin number and would go to the bank and withdraw the money. The resident said, She did not have to steal from me. She stated the staff member was no longer working at this facility. A review of the admission record revealed: Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, chronic pain syndrome and opioid abuse with intoxication. Review of a quarterly minimum data set (MDS) dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. On 2/7/2026 at 1:01 p.m., an interview was conducted with the NHA and the Risk Manager (RM). The NHA stated he was new to this facility and had not participated in the investigation. The RM stated on 10/05/2025 the resident had reported she gave Staff H, CNA, her bank card to shop for her. She stated during their investigation, they requested bank statements from Resident #1's POA and confirmed the resident had sent money to Staff H, CNA, through a mobile money app. The RM stated the Staff H agreed she had received money from the resident to buy [prepaid money card]. The RM stated when speaking with Resident #1's POA, the POA said [Resident #1] probably did not want me to see the purchases, and that was why Resident #1 did not use the debit card. The RM said they obtained a statement from Staff H, CNA which the RM read, I purchased [prepaid money card] for [Resident #1] totaling $4570. The RM stated the Staff H denied knowing why the resident needed the prepaid money cards. During this interview, the NHA and the RM stated they could not speculate why the resident needed the prepaid money cards. The RM said, I never (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

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	02/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked her [Resident #1], but it would make sense now with the allegation of drug use. The NHA stated the previous NHA did not document any notifications to outside agencies. On 2/7/2026 at 4:03 p.m. an interview was conducted with Staff H, CNA. She said, I was buying her stuff and the [prepaid money cards], I don't know why she needed the cards. They were worth hundreds of dollars. She was telling me she would want to buy gifts, I would get her the cards because I have a kind heart, she taught me a lesson. Staff H denied having bought THC gummies. She stated she spent way over $2000 on Resident #1 because she did not mind helping her. Staff H restated the resident never said what she needed the cards for. Staff H said, There was money exchanged between us. She [Resident #1] tried to pay me back. [Resident #1] wrote me a check for $500, more than one time. She [Resident #1] did not give me the money for drugs; it was for the gift cards [prepaid money cards]. Staff H stated as a staff member, she should not have taken money from the resident. She stated, it was not right, I was wrong, I got messed up in the end. I know I am not supposed to do it. Staff H stated the investigation was ongoing. On 2/7/2026 at 2:35 p.m. an interview with the facility's medical director revealed, staff should not provide a resident with THC, it can impact their health due to other medications. He stated if a patient wanted the drug to relieve pain, they should be evaluated and monitored by a provider. In an interview with the NHA on 2/7/2026 at 2:48 p.m., the NHA confirmed the resident gave the staff member money knowingly. He stated the staff member should not have been taking the resident's money for whatever reason. He said, It is against our policy. We did not know she was supplying the resident with THC, until today. We will investigate. The NHA stated the allegation of THC was not documented in their previous investigation. Review of a facility policy titled, Abuse Prevention Program, reviewed September 2025, revealed the following:Exploitation/Misappropriation of Resident Property: Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident belongings or money without the resident's consent. Taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.Investigation: An Event Report is initiated. NHA or designee is notified and will initiate and conclude a complete and thorough investigation within the specified timeframe.Investigation may include, but may not be limited to: Resident statements/interviews; Employee statements/interviews; Visitor statements/interviews; Observation of resident(s), staff, environment; Document review i.e., chart reviews, policy review, education programs, appropriate resource review (such as medical literature); and Re-enactment of event.

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	02/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement and maintain an infection prevention and control program to mitigate and prevent the spread of infection related to: failing to provide an anti-parasitic medication to one (#2) of three residents being treated for scabies, failed to ensure staff were accurately educated on the implementation of transmission-based precautions, and ensure personal protective equipment (PPE) was readily available for one (#380) of three sampled rooms posted with transmission-based precautions.Findings included: On 2/7/26 at 1:06 p.m. an observation revealed Resident #2s room was posted with a sign for Enhanced Barrier Precautions directing staff and providers to wear gloves and gowns for high-contact resident care activities. Review of Resident #2's admission Record revealed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified psoriasis, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, type 2 diabetes mellitus with foot ulcer, and muscle wasting and atrophy not elsewhere classified multiple sites. Review of Resident #2's paper chart revealed handwritten instructions, dated 2/4/26, from a dermatologist which included but not limited to: Treat for scabies - See handout, this will be repeated in one week (wk), treat all linens, laundry appropriately. Permethrin prescription (rx) today - begin treatment tonight, Isolation from other nursing home residents until second treatment is completed. The prescription for Permethrin, written on 2/4/26, instructed: Permethrin 5% topical cream. Apply neck down to feet overnight x 8 hours. Wash off in a.m. Repeat in 1 week. Review of Resident #2's physician orders revealed an order dated 2/4/26 at 9:54 p.m. for Ivermectin oral tablet 3 milligram (mg) - Give 3 tablets by mouth one time a day, everyday for 5 days for dermatitis- crusted, for 5 administrations. The order was to start on 2/5/26 (day after dermatology appointment) and to continue for 5 administrations. Review of Resident #2's Medication Administration Record (MAR) showed the resident's first dose of Ivermectin scheduled at 9:00 a.m. on 2/5/26, with sequential doses to be given on 2/10, 2/15, 2/20, and 2/25/26. The March MAR did not reveal any scheduled doses. The February MAR showed staff had documented 9 regarding the administration of the first dose of anti-parasitic, Ivermectin on 2/5/26. The documentation legend revealed, 9 see other/nurse's notes. An interview was conducted on 2/7/26 at 3:01 p.m. with Staff B, Licensed Practical Nurse (LPN)/Unit Manager (UM). Staff B, LPN/UM reported being told the facility did have Ivermectin in the emergency drug kit (edk). Staff B reviewed the documentation 9 for Resident #2's Ivermectin dose and the related medication administration progress note stating the note was awaiting RX for delivery, notified MD, no adverse reactions noted. Staff B stated if a medication was not available staff were to notify the MD, to see if there were new orders, or to get out of edk. Staff B, LPN/UM said the expectation was the missed dose would be added to the end of the schedule so the resident would receive the ordered 5 treatments. The staff member recognized the resident would have received 4 of the 5 ordered doses of ivermectin.Review of the pharmacy delivery times memo revealed: new order cut-off times and delivery windows included cut-off times of 9:00 p.m., with a delivery window of 12:00 a.m. - 3 a.m. and 12:00 a.m. cut-off time, with a 4:30 a.m. - 7:30 a.m. delivery time. Resident #2's ivermectin was ordered at 9:54 p.m. on Wednesday 2/4/26 allowing for a 4:30 a.m. - 7:30 a.m. delivery window. An interview was conducted on 2/7/26 at 12:11 p.m. with Staff A, LPN. Staff A, LPN stated the resident had a (dermatology) appointment, because she had a rash and the roommate was also being treated for rashes. Review of the facility policy titled Scabies Management, effective August 2025, revealed: The Facility will strive to identify the early stages of potential resident infestation with scabies during daily personal care in weekly skin assessments. It is important to (continued on next page)

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	02/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remember that the first time a person gets scabies they usually have no symptoms. Symptoms typically take 4-8 weeks to develop after they are infested; However, they can still spread scabies during this time. The procedure showed:3. Implement contact precautions (due to communicability of scabies) until a diagnosis is confirmed by physician or nurse practitioner.A private room is indicated but if this is not possible, obtain a physician's order to treat the roommate.Utilize a private room for the residents who cannot use good hygiene.May cohort residents during an outbreak. 4. Wear long-sleeved gowns during close contact with the residents, their clothing or bed linens. Cover wrist area with the gown and pull the gloves over the cuff. 5. Obtain an order for the treatment of scabies and apply as directed. 10. Place resident in contact precautions and encourage resident to remain in room for 24 hours post treatment, if possible. 11. Discontinue steps 3-4 24 hours after treatment. 12. Retreat with ordered medication one (1) week later. a. Itching may last for one (1) week or more after treatment has killed the mites. b. The risk of transmission between treatments is possible. On 2/7/26 at 10:03 a.m. an observation was made of signs posted outside of Resident #6 and Resident #7's room. The signs posted showed both Contact precautions and Enhanced Barrier precautions for the residents. The area outside of the resident's room did not reveal any Personal Protective Equipment was stored at the entrance. The sign for contact precautions revealed Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Put on gloves Before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. An interview was conducted on 2/7/26 at 10:03 a.m. with Staff D, LPN. Staff D, LPN stated the precautions were per protocol as Resident #6 had a wound on back. Staff D reviewed the signs posted outside of the room and stated the resident was on enhanced barrier and would have to look for the contact precautions, as she was a floater and this wasn't her cart. The staff member was unable to locate orders for Contact precautions. An interview was conducted on 2/7/26 at 10:12 a.m. with Staff E, Certified Nursing Assistant (CNA). Staff E, CAN stated being the CNA for Resident #6 and Resident #7 and did not know why the residents were on contact precautions. An observation was made on 2/7/26 at 10:56 a.m. of the Activity Director (AD) in Resident #4's room with no PPE on and in direct contact with Resident #4. A sign for contact precautions was posted on the wall outside of Resident #4's room door. No PPE was available outside of the room. The AD exited the room and reported just having a conversation with the resident and wasn't providing care so PPE did not have to be worn, just hand hygiene. The AD referred to the posted sign for Contact precautions and reported only having to do the top part of related to hand hygiene as she was just having a conversation. The AD read the sign again and stated the sign did not say PPE was to be worn if only doing care and should confirmed she should have been wearing PPE, gown and gloves, before entering the room. An interview was conducted on 2/7/26 at 10:57 a.m. with Staff B, LPN/UM and Staff C, Registered Nurse (RN). The staff members stated staff should be wearing PPE when entering Resident #4 and #5's room. Staff B, LPN/UM agreed with the door open the sign for contact precautions was hard to see. Staff C moved the PPE which was hanging inside the room to outside of the room. Staff C stated staff should know why the residents were on precautions. During an interview on 2/7/26 at 1:27 p.m. Staff G, CNA said staff should gown up before entering an Enhanced Barrier Precautions (EBP) room and the same for Contact precautions. The difference between them is goggles, and gloves is needed for contact precautions. An interview was conducted on 2/7/26 at 3:39 p.m. with the Director of Nursing (DON). The DON said believes the pharmacy delivers once in the afternoon and once late (evening), two deliveries every day and if the (continued on next page)

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	02/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was ordered at 9:00 p.m. it would come the next day. The expectation if a medication was not at the facility, reach out to the physician and get an order to start when available from pharmacy. Staff should reach out to pharmacy and ask where the medication is and reach out to the physician to ask what they wanted to do. The DON stated the policy for scabies was for 24-hour contact precautions from treatment. The DON described the use of PPE for contact precautions as dress in gown and gloves if staff go into the room, usually they stand at doorway and gather PPE, get dressed in the hallway for contact precautions and PPE should be outside the room. The facility places PPE on the door, so it doesn't look like something crazy is going on. For EBP, PPE is kept behind the door and should be available in all EBP rooms. The DON stated nurses should know what precautions the resident was on, look it up if they have any questions. The DON stated PPE should be worn inside the contact precaution rooms and if the room is posted for contact precautions staff should honor the sign. Review of the facility's policy and procedure for Isolation Precautions - Categories of Transmission-based infections, effective October 2021, revealed: Standard precautions shall be used when caring for residents regardless of their suspected or confirmed infection status. Transmission- based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. The policy instructed for Contact Precautions: In addition to standard precautions, implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with Information Services our resident-care items in the residence environment. The policy included examples of infections requiring Contact Precautions, (9) Scabies. Further review instructed the use of gloves and handwashing after having contact with infective material and gown for interactions that may involve contact with the resident or potentially contaminated items in the resident's environment removing the gown and performing hand hygiene before leaving the resident's environment. The policy instructed (1) For individuals with skin lesions, excretions, secretions, or drainage that is difficult to contain, maintain precautions to minimize the risk of transmission to other residents in contamination of environmental services or equipment.