STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105713	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Health and Rehabilitation Center	3456 21st Ave S Saint Petersburg, FL 33711

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and record review the facility did not ensure narcotic medications were provided in a timely manner for three (#5, 10, and 18) out of three residents reviewed.Findings included: On 01/05/2026 at 10:15 a.m., an observation and interview was conducted with Resident #18. Resident #18 had stated her pain was a 9 out of 10 and she had not received her pain medication this morning or throughout the night. Resident #18 stated she was told the nurses are waiting for a prescription. On 01/05/2026 at 10:40 a.m., an interview was conducted with Staff K, Licensed Practical Nurse (LPN) assigned to Resident #18. Staff K, LPN stated the physician will be coming in sometime today to write a new prescription. Staff K, LPN acknowledged Resident #18 had not had her pain medication since last night and stated she gave the resident two Tylenol tablets and a Flexeril tablet. Staff K, LPN stated there was nothing else she could do but wait until the doctor comes in sometime today to re-prescribe the pain medication. On 01/05/2026 at 11:00 a.m., an observation and interview was conducted with Resident #5. Resident #5 had an acquired tracheostomy; therefore, communication was limited to nodding of head or the resident could write on paper. Resident #5 wrote, need nurse pain. Through communication it was determined Resident #5 had requested pain medication earlier and her left arm and back were in pain. Resident #5 nodded yes when asked if her pain medication was a concern. Through yes/no questions, Resident #5 agreed to a lapse in time in her pain medication. Resident #5 hit her call button. On 01/05/2026 at 11:10 a.m., an interview was conducted with Staff K, LPN assigned to Resident #5. Staff K, LPN stated she gave the resident pain medication not too long ago and she is not due for more pain medication until 1:00 p.m. Staff K, LPN stated the facility had had a pain management nurse practitioner but as of January she no longer comes to the facility. Staff K, LPN stated pain management would be managed by the residents' primary physicians now. On 01/07/2026 at 8:39 a.m., an observation and interview was conducted with Staff L, LPN during medication administration for Resident #10. Staff L, LPN stated today she was able to administer the resident's order for Clonazepam but yesterday there was none to administer during her shift and she had to call the pharmacy to obtain a refill. Staff L, LPN stated if the narcotic prescription had refills all she has to do is call the pharmacy for a refill; however, if there were no further refills, she would call the primary physician for a new prescription. She stated the physician would either electronically fax over the prescription directly to the pharmacy or if a written prescription was made, the physician would fax over to the pharmacy. A record review of Resident #18's admission Record showed an admit date of 12/23/2024 with diagnoses to include but not limited to:Displaced bimalleolar fracture of right lower leg, sequela (primary) A record review of Resident #18's Minimum Data Set (MDS) annual dated 11/12/2025 showed a Brief Interview for Mental Status (BIMS) of 15, indicating cognitively intact. A record review of Resident #18's January 2026 physician orders showed the following:Monitor pain every shift and record pain number on a 0-10 scale every shift for pain monitoring, ordered 12/13/2024.Oxycodone-Acetaminophen oral tablet 10-325 milligrams (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(mg) to give one by mouth every 6 hours for pain, ordered 12/17/2025, discontinued 01/05/2026.Oxycodone-Acetaminophen oral tablet 7.5-325 mg to give one by mouth every 6 hours for pain, ordered 01/05/2026 at 14:42 (2:42 p.m.) A record review of Resident #18's Medication Administration Record (MAR) for the month of January 2026 showed the following entries for the order of Oxycodone-Acetaminophen oral tablet 10-325 mg to give one by mouth every 6 hours for pain:On 01/01/2026 at 12:00 p.m. and 18:00 (6:00 p.m.) medication was not administered with the chart code 9On 01/04/2026 at 18:00 (6:00 p.m.) .) medication was not administered with the chart code 9On 01/05/2026 at 00:00 (12:00 a.m.), 6:00 a.m., and 12:00 p.m., .) medication was not administered with the chart code 9The 9 as designated in the MAR for Chart Codes represents other/See Nurse Notes A record review of Resident #18's Medication Administration Record (MAR) for the month of January 2026 showed the following entries for the order Monitor pain every shift and record pain number on a 0-10 scale every shift for pain monitoring:On 01/01/2026 for the evening and night shift showed a pain of 0 and 8On 01/04/2026 for the night shift showed a pain of 8On 01/05/2026 for the day shift showed a pain of 8A record review of Resident #18's progress notes showed the following entries: 01/04/2026 at 17:14 (5:14 p.m.) showed the following entry- oxycodone-acetaminophen oral tablet 10-325 mg give one mg by mouth every 6 hours for pain new script needed, MD notified01/05/2026 at 1:23 a.m. showed the following entry- oxycodone-acetaminophen oral tablet 10-325 mg give one mg by mouth every 6 hours for pain-Medication on order-provider aware.01/05/2026 at 5:36 a.m. showed the following entry- oxycodone-acetaminophen oral tablet 10-325 mg give one mg by mouth every 6 hours for pain- Medication is not on site-new order needed. Provider made aware.01/05/2026 at 12:10 p.m. Writer contacted MD this day shift regarding script needed for pain med. MD will f/u and contact pharmacy. Signed DON01/05/2026 at 12:11 p.m. showed the following entry- oxycodone-acetaminophen oral tablet 10-325 mg give, one mg by mouth every 6 hours for pain-Writer entered resident's room this day shift to discuss complain of pain. Resident observed sleeping (supine positions - respiratory even unlabored with no distress observed. Writer called resident's name 2 times and she did not wake, continued day napping. Writer will follow up to discuss meds and pain. MD notified of new script needed. Report given to assigned nurse. Signed DON01/05/2026 at 1:11 p.m. showed the following entry- - oxycodone-acetaminophen oral tablet 10-325 mg give, one mg by mouth every 6 hours for pain-pending new script MD aware. A record review of Resident 18's care plan showed a focus area of pain or potential for pain should with interventions to include but not limited to:Observe anticipate the residents need for pain relief and offer/ provide pain treatment intervention. A record review of Resident #5's admission Record showed an original admit date of 3/31/2023 with diagnoses to include but not limited to:Other sequelae of nontraumatic intracerebral hemorrhage (primary)Other lack of coordinationGastrostomy statusDysphagia, oropharyngeal phaseTracheostomy status A record review of Resident #5's MDS quarterly dated 12/05/2025 showed a BIMS of 13, indicating cognitively intact. A review of Resident #5's physician orders showed the following:Monitor pain every shift and record pain number on a 0-10 scale every shift for pain monitoring, ordered 10/17/2025Oxycodone-Acetaminophen oral tablet 10-325 mg to give one by mouth every 4 hours for pain, ordered on 10/21/2025 A record review of Resident #5's MAR for the month of January 2026 showed the following entries for the order of Oxycodone-Acetaminophen oral tablet 10-325 mg to give one by mouth every 4 hours for pain:On 01/01/2026 at 1:00 a.m., 5:00 a.m., 9:00 a.m., and 1:00 p.m. medication was not administered with the chart code 9A request was asked for nurses' progress notes from December 31- current but none were available for Resident #5. A record review of Resident #5's care plan showed a focus area for pain or a potential for pain with interventions to include but not limited to:Administer pain medication and observe for effectiveness (refer to orders for current order) A record (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alpine Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3456 21st Ave S Saint Petersburg, FL 33711	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #10's admission Record showed an initial admit date of 9/03/2021 with diagnoses to include but not limited to:Epileptic seizures related to external causes, not intractable, without status epilepticus (primary)Type 2 diabetes mellitus without complicationsAnxiety disorder, unspecifiedMajor depressive disorder, recurrent , unspecified. A record review of Resident #10's MDS Quarterly dated 9/25/2025, showed a BIMS of 15, indicating cognitively intact. A review of Resident 10's physician orders showed the following:Clonazepam oral tablet 0.5 mg, give one tablet by mouth after meals and at bedtime for anxiety hold for sedation three times a day and at bedtime=4 times a day, ordered 10/17/2024 A record review of Resident #10's MAR for the month of January 2026 showed the following entries for the order Clonazepam oral tablet 0.5 mg:On 01/06/2026 at 9:00 a.m., 1:00 p.m., 17:00 (5:00 p.m.) and 21:00 (9:00 p.m.) medication was not administered with the chart code 5The 5 as designated in the MAR for Chart Codes represents Hold/See Nurse Notes A record review of Resident #10's progress notes showed the following entries:On 01/06/2026 at 10:13 a.m. Clonazepam oral tablet 0.5 mg give one tablet by mouth after meals and at bedtime for anxiety hold for sedation three times a day and a bedtime=4 times a day - waiting on pharmacy to deliverOn 01/06/2026 at 14:02 (2:02 p.m.). Clonazepam oral tablet 0.5 mg give one tablet by mouth after meals and at bedtime for anxiety hold for sedation three times a day and a bedtime=4 times a day - awaiting from pharmacyOn 01/06/2026 at 17:38 (5:38 p.m.). Clonazepam oral tablet 0.5 mg give one tablet by mouth after meals and at bedtime for anxiety hold for sedation three times a day and a bedtime=4 times a day - awaiting from pharmacy. Pharmacy notified and informed nurse that it will be delivered on next run.On 01/06/2026 at 21:50 (9:50 p.m.). Clonazepam oral tablet 0.5 mg give one tablet by mouth after meals and at bedtime for anxiety hold for sedation three times a day and a bedtime=4 times a day - awaiting from pharmacy On 01/05/2026 at 11:25 an interview was conducted with the pharmacy consultant. The pharmacist stated narcotic prescriptions can be electronically faxed to the pharmacy by the physician or a paper form could be faxed over from the facility. The pharmacist stated if there were refills available, the nurse could call the pharmacy for an authorization code to access the emergency supply kit to obtain the medication if available. The pharmacist stated on the medication cards there is a low caution count usually when 10 pills are left to alarm the nurse the medication is low. The pharmacist stated this is the time the medication should be requested for a refill or to notify the ordering physician. The pharmacist returned at 11:36 a.m., and stated he was able to determine the timeline of Resident #18's order for Oxycodone-Acetaminophen oral tablet 10-325 mg. The pharmacist stated the resident's physician telephoned an order on 01/01/2026 for 12 pills. The pharmacist stated because it was a telephone call only the prescription can only be filled in for 3 days. The pharmacist stated he does not see any current orders for the resident. [Photographic evidence obtained] On 01/07/2026 at 12:57 a.m., an interview was conducted with a pharmaceutical representative (PR) from the pharmacy. The PR confirmed the pharmacist interview and stated the pharmacy received an order on 01/01/2026 for a three-day supply for Resident #18's oxycodone-acetaminophen 10-325 mg. The PR stated a call was placed by the physician for another 3-day supply today but there was an electronic order placed for a month supply but stated, we would only send a three-day supply until order is clarified. The PR stated the pharmacy has two deliveries times during the day 1:00-1:30 pm and 11:00-11:30 pm On 01/08/2025 at 8:49 a.m., an interview was conducted with a customer service technician. She stated Resident #5 had a prescription dated December 16th from (pain management provider) but was faxed over from the facility on 01/01/2026. Stated she was not sure why Resident #5 missed medications on 01/01/2026 when she had a prescription. On 01/08/2026 at 3:51 p.m., an interview was conducted with Resident #18's primary physician. The primary physician stated, missing narcotics should not happen. The primary (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician stated the on-call physician can take care of the issue as well during off hours. The primary physician stated his usual practice is to electronically order the prescription over to the pharmacy or if his office is closed, he will telephone an order to the pharmacy for a 3 day supply followed by an electronic prescription. On 01/08/2026 at 1:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated narcotic medications can be requested by the nurse only if there are available refills. The nurse should call the pharmacy. If there are not any refills available for refill the nurse should call the physician or the physician on call. The physician should call a new prescription to the pharmacist. The physician can either e-fax the prescription, call the prescription or write a prescription in which the nurse will fax to the pharmacy. The DON stated the medication blister packs the nurses have during medication administration will inform the nurse the number of available refills. The DON stated she was not aware of a red warning column on the medication blister packs to notify the nurses the medication should be refilled to avoid a delay. A review of the facility's policy titled, Medication Orders Controlled Substance Medication Orders, dated 5/16 showed the following policy statement:Before a controlled substance medication can be dispensed, the pharmacy must be in receipt of a clear, complete, valid prescription from a person lawfully authorized to prescribe them.The pharmacy can dispense a Schedule II controlled substance medication only after the receipt of a practitioner signed valid Schedule II prescription (original and/ or fax) OR in the case of an emergency, the practitioner may speak directly to the pharmacist providing an emergency authorization for the pharmacy to supply a small quantity of the Schedule II medication until the practitioner can provide a valid signed prescription.The pharmacy can dispense a Schedule III through V controlled substance medication after the receipt of a practitioner signed valid Schedule III through V prescription (original and/ or fax) or the practitioner (or his agent) speaks directly to the pharmacist providing a verbal authorized controlled substance prescription.The following procedure statement stated: Written valid prescriptions for a controlled substance medication may be faxed to the pharmacy from the facility for dispensing and the original hard copy is then sent to the pharmacy following state and federal regulations.ELEMENTS OF A VALID CONTROLLED SUBSTANCE PRESCRIPTION include the following but are not limited to: .The prescriber can fax the valid signed controlled substance prescription or order from the chart if all valid elements are noted to the pharmacy for dispensing.The pharmacist can receive a phone order for schedule III through V controlled substance from the prescriber (or his agent) commit the information to writing and create the valid controlled substance prescriptionThe pharmacist can receive a verbal emergency authorization for Schedule II controlled medications if communicated directly to the pharmacist by the prescriber. If a verbal authorization is received by the pharmacist, the pharmacist will contact the facility nurse. If the controlled substance is needed as an emergency, the pharmacist may provide authorization to the nurse to access the controlled substance from the emergency supply located in the facility.Incomplete prescriptions and verbal orders for controlled substances may not be edited or changed by facility nursing staff. Controlled substance medications prescriptions from physician assistants and nurse practitioners, who are authorized to prescribe controlled drugs, are valid if they comply with the requirements listed above, or in accordance with state law, and comply with applicable formularies or prescribing protocols that have been provided to the facility by the responsible physician.2. The prescriber may need to be contacted to verify or clarify a prescription when needed (for example when the resident has allergies to the medication, contraindications to the medication, administration directions are not clear, the prescription does not contain all valid elements).DOCUMENTATION OF THE CONTROLLED SUBSTANCE ORDERS Each controlled substance medication order is documented in the residence (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record with the date, time, and signature of the person receiving the prescription. The medication order is recorded on the physician order sheet or the telephone order sheet and recorded on the medication administration record(MAR). For written valid controlled substance prescriptions received by the facility:The prescription is faxed to the pharmacy by the prescriber or prescriber's agentIf this is not possible the facility nurse on duty faxes the prescription to the pharmacy with a notation of his/her name and the facility name on the cover sheet or order as the sender. After faxing to the pharmacy, the nurse on duty to deface the written prescription to prevent diversion by writing faxed to pharmacy with the date, time and his/ her initials. A copy of the defaced prescription should also be placed in the resident's medical record for future referenceThe pharmacy prepares the medication based on the faxed copy of the prescription and the pharmacy representative may request a pick up the original written prescription(with the nurse's notation above) prior to handing off the dispense controlled substance.New orders for controlled substance medications originating in the facility should be handled as followers: If the prescriber is present in the facility, all new orders for controlled substance medications must be written, contain all required elements and be signed by the prescriber before leaving the facility.If unable to provide their written prescription in an emergency situation, the prescriber verbally communicates the order directly to the pharmacist for a limited quantity.When assessing controlled substance medications from the facilities emergency kit, refer to section 3.4 emergency pharmacy service and emergency kits.