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	05/11/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure accurate skin evaluations were completed in a timely manner for one resident (#1) out of three residents reviewed. Resident #1 was diagnosed with a Stage IV pressure ulcer to the sacrum and osteomyelitis and sent to a higher level of care for treatment. Findings included: A record review of Resident #1's SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 3/11/2026 at 7:29 a.m., showed a new pressure ulcer with the primary physician and family notified. A record review of Resident #1's admission Record showed an original admit date of 6/06/2013 with the following diagnoses: Traumatic subarachnoid hemorrhage without loss of consciousness, Type 2 Diabetes Mellitus without complications (DMII), Hemiplegia and Hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side, and other comorbidities. Resident #1 was discharged on 4/20/2026 to the hospital due to the pressure ulcer and re-admitted on [DATE]. A record review of physician orders showed the following orders:Cleanse wound bed with normal saline. Pat dry. Apply Medihoney dressing and secure with foam dressing. Change daily and prn every night shift for pressure injury treatment, ordered 3/11/2026 and a discontinuation date of 3/27/2026.Cleanse wound bed with normal saline. Pat dry. Apply Medihoney dressing and secure with foam dressing. Change daily and prn every night shift for wound care, ordered 3/17/2026 and discontinuation date of 4/16/2026. A review of Resident #1's Treatment Administration Record (TAR) for the month of March 2026 showed five missed wound dressing changes on 3/12, 3/15, 3/20, 3/28, and 3/29. A record review of physician orders showed the following orders:Cleanse wound bed with normal saline. Pat dry. Apply Medihoney dressing and secure with foam dressing. Change daily and prn every night shift for pressure injury treatment, ordered 3/17/2026 and a discontinuation date of 4/16/2026. A review of Resident #1's Treatment Administration Record (TAR) for the month of April 2026 showed Resident #1 had vascular wounds to his lower extremities and was receiving wound treatment, however, Resident #1 did not have documented wound care from 4/15/2026 to 4/19/2026. A record review of Resident #1's SW-Skin Issues revealed: 3/11/2026 - a new skin issue identified as a pressure ulcer/injury on the medial, sacrum. Stage 4 Pressure Ulcer/Injury (meaning the wound is full thickness skin and tissue loss).Acquired in-houseWound measured: Length in centimeters (cm) by Width (cm): by Depth (cm): by Area (cm2):. 4.84 x 3.59 x 0 x 12.76 50 % granulation, 50% slough, and light slough Serous and sanguineous fluid. A faint odor after cleaning. Surrounding tissue has erythema (redness of the skin-may be intense red to dark red or purple; with excoriation and skin that is at risk for breakdown with pitting edema extends<4 cm around wound). 3/17/2026 - evaluation of the medial sacrum Moderate seropurulent exudate Moderate odor after cleaning and the dressing is saturated 26-75%. No measurements noted. 3/24/2026 - evaluation of the medial sacrumMeasurement: 5 x 3.47 x 0 x 13.58. 100% escharModerate seropurulent exudate Moderate odor after cleaning and dressing with moderate saturation. 4/09/2026 - evaluation of the medial sacrum Measuring: 2.5 x 1.75 x 0.3 x 3.04Moderate odor after cleaning and dressing has moderate saturation4/15/2026 - evaluation of the medial sacrum Measuring: 1.98 x 4.45 x 0.2 x 6.2. A record review of Resident #1's SBAR form, dated 4/20/2026 at 12:00 a.m., showed: resident has wounds on buttocks and both ankle, I was told to send him out to (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	hospital for eval due to history of dvt [deep vein thrombosis]. A record review of Resident #1's care plan showed: A focus area of: The resident is at risk of developing a wound increased moisture at times. Has a diagnosis of DMII. Initiated 12/19/16. Goal: minimize wounds from developing. Interventions include: Observe for any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care, report to nurse if noted. Nurse will report to the physician if noted. Initiated 9/13/18. A focus area of: Incontinence: Resident #1 is incontinent of bladder and bowel at this time; may fluctuate in continence r/t (related to) brain injury, requires some assistance with toileting needs. dated initiated 12/19/16. Goal: Will minimize the risk of skin breakdown. Initiated: 12/19/16. Interventions included: Offer/assist with hydration - date initiated 12/19/16Check for incontinence with routine care, upon arising, before & mealtime, at bedtime and as needed. Provide incontinence as indicated. Date initiated: 12/19/16. A focus area of: Actual Wound: The resident has an actual wound, Location: sacrum, Location: Left ankle, Impaired Mobility, Pressure, diabetes initiated on 3/30/2026 and a revision on: 4/14/2026. Interventions to include but not limited to: Air mattress initiated 3/30/26. RD consult PRN initiated 3/30/26. Monitor wound weekly of location, highest stage and/ or visual stage, measure length, width, and depth, color of drainage, color of wound bed, presence of odor, tunneling or undermining, review for improvements, report declines to the MD (physician), date initiated 3/30/2026Observe for Pain, administer medication as ordered (refer to MD orders for current order), observe for effectiveness, date initiated 3/30/2026 No care plan for prevention of skin breakdown was found prior to 3/30/26. A focus area of Anticoagulation: The resident is on anticoagulant therapy medication r/t (related to) history of DVT, History of Stroke, date initiated 4/01/2026. Interventions to include but not limited to:Daily skin inspection. Report abnormalities to the nurse, date initiated 4/01/2026 A record review of Resident #1's hospital medical records showed an admission date of 4/20/2026 with a discharge date of 4/24/2026 to include the following discharge diagnoses:Acute ulceration of the lateral malleolus with underlying osteomyelitis, rightAcute ulceration of the lateral malleolus, leftAcute coccygeal abscess with underlying osteomyelitisSacral decubitus ulcer, Stage IVAnd the following medications:Ceftriaxone 2 grams IV (intravenous) q (every) 24 hours for 36 days, IV Rocephin 2 grams daily until 5/30/2026Metronidazole 500 mg (milligram) oral tablet, 2x daily for 36 days, PO (oral) Flagyl 500 mg every 12 hours until 5/30/2026Oxycodone 5 mg oral tablet, one tablet q 8 hours for 3 days, PRN (as needed) painVancomycin 1.25 grams IV, 2x daily for 34 days, IV Vancomycin 1 gram every 12 hours and pharmacy to dose until 5/30/2026, maintain vancomycin trough level 15-20 On 5/11/2026 at 11:15 a.m., an interview was conducted with Staff A, Registered Nurse (RN). Staff A, RN stated she would review all her assigned residents' evaluations daily to see if she has a skin check evaluation to do. Staff A, RN stated it can be difficult to navigate through the electronic medical records (EMR), but she will review all her residents to see who is due a weekly skin evaluation. Staff A, RN stated she would also review all her assigned residents for any skin/wound treatments in the Treatment Administration Record (TAR). Staff A, RN stated if she discovers a new skin condition during her evaluation, she would immediately notify the Director of Nursing (DON), the resident's primary physician and family. Staff A, RN stated she would complete a Change of Condition (COC), as well as a risk management incident report. Staff A, RN stated a skin check weekly evaluation is created with the date the note was started and locked on the same day. Staff A, RN stated she has been instructed to complete her skin assessment and lock her note on the same day. Staff A, RN stated she could only speak on her behalf of how she conducts skin weekly evaluations. On 5/11/2026 at 12:05 p.m., an interview was conducted with Staff B, Licensed Practical Nurse (LPN). Staff B, LPN stated she would normally do her skin sweep evaluations on the resident's shower day. Staff B, LPN stated she has been in the facility for so long she just knows when there is a skin sweep evaluation due. Staff B, LPN stated she would interview her interviewable residents if they had any skin concerns such as a rash. Staff B, LPN stated for her assigned residents who cannot communicate or have limited communication skills, she would perform a skin weekly evaluation. Staff (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	B, LPN stated in the electronic chart, her daily dashboard would indicate under evaluations when a skin weekly evaluation is due. Staff B, LPN stated if the skin weekly evaluation is overdue the evaluation would turn red, indicating the skin sweep evaluation was overdue. Staff B, LPN stated it will remain red until the skin sweep evaluation is done. Staff B, LPN stated created date is when the skin sweep evaluation was done and she will lock her note. On 5/11/2026 at 10:45 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the nurse will put in the skin sweep evaluation on the date it is due per the EMR. The DON stated the created date is when the nurse inputs the skin sweeps and the locked date is when the nurse signs off on the documentation. The DON stated skin sweeps should be done within 24 hours of when they are due. A review of Resident #1's skin check weekly was discussed with the DON. The DON acknowledged Resident #1's skin sweeps from 02/28, 3/07, 3/14 and 3/21/2026 created and locked on 3/23/2026 was an issue. On 5/11/2026 at 1:34 p.m., an interview was conducted with the Nursing Home Administrator and the DON. The DON stated he does official wound rounds every Tuesday. The DON stated his first encounter with Resident #1's wound was during his first day in his current role. The DON stated the wound was a Stage 4 with areas of slough but stated the wound appeared to be healing over the next few weeks. The DON acknowledged new areas of concern to Resident #1's right foot had developed with the appropriate notification to the primary physician and resident representative. The DON stated on 4/17/2026 (Friday) he notified the primary physician for potential worsening of his wounds especially the right foot. The DON stated the primary physician came in on this day and observed the wounds himself and stated to transfer the resident to the hospital on Monday the 20th for higher level of care for his wounds. The DON stated wound cultures were not ordered. On 5/11/2026 at 4:04 p.m., a telephone interview was conducted with Resident #1's primary physician. The primary physician stated the resident had peripheral vascular disease which contributed to his wounds especially to his feet. The primary physician stated overall vascular issues can contribute to skin breakdown such as his coccyx/sacrum area. The primary physician stated he did see the sacral wound and stated he saw tunneling and exposed bone. With this he made the decision to transfer to higher level of care. The primary physician stated it was unfortunate he developed osteomyelitis in these areas. The primary physician stated he was not aware of the facility's policy to perform weekly skin sweeps. A review of the facility's policy titled, Weekly and prn Skin Checks, effective date October 2021 showed the following: Policy statement: The Weekly and PRN skin check is used to document skin condition throughout the resident/patient stay in the facility. The nurse will conduct weekly skin check and or a PRN check when applicable as a proactive measure to identify impairment or suspected impairment timely to reduce the risk of further decline in skin integrity. It is suggested that a designated member of the nursing team complete the weekly skin checks for group of residents/patients in order to ensure continuity. If a new area of impairment is identified during or between scheduled checks, it should be documented on the weekly and PRN skin check and the appropriate skin grid initiated depending on the cause. A skin check should be completed on admission or readmission to the facility and for extended leave of absence, L. O. A. Findings should be documented on the weekly and PRN skin check documentation tool. Procedure: . 1. Once a week and when an area of skin impairment is reported the skin check should be documented on the Weekly and PRN Skin Check Documentation tool. If a new area is identified the appropriate skin grid should be initiated within 8 hours.