

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews, the facility did not complete and/or update the level I pre-admission screening and resident reviews (PASSARs) for residents with qualifying medical diagnoses for six (#4, #5, #9, #13, #18 and #36) out of 18 residents reviewed for PASSARs Findings Included: 1. A review of Resident #9's admission record revealed an original admission date of 11/4/24, and a re-admission date of 11/2/25, with diagnoses to include but not limited to; other recurrent depressive disorders, post-traumatic stress disorder, chronic, anxiety disorder unspecified, and alcohol abuse with intoxication, unspecified. A review of Resident #9's annual minimum data set (MDS) for medications, dated 11/7/25, revealed the following under high-risk drug classes: antidepressant usage. A review of Resident #9's care plan revealed the following focus areas to include: - Trauma Informed Care-PTSD [post-traumatic stress disorder] and major depression. - PSYCHOTROPIC MED [medication]: The resident uses psychotropic medication r/t [related to] Antianxiety to manage: anxiety Antidepressant to manage: depression Hypnotic to manage: insomnia. - BEHAVIORAL: The resident has, a behavior problem r/t alleging not receiving medications, treatments from staff, confabulation, intermittent aggression with staff, alcohol use. A review of Resident #9's PASSAR, level I screen, dated 11/1/24, revealed no diagnoses were marked under section A &ndash; MI or suspected MI. 2. A review of Resident #4's admission record revealed an admission date of 4/4/2025, with diagnosis to include but not limited to; of major depressive disorder, recurrent, unspecified. A review of Resident #4's annual minimum data set (MDS) for medication, dated 12/22/2025, revealed the following under high- risk drug classes: Antidepressants usage. A review of Resident #4's physician orders dated January 2026 revealed the following: -Sertraline Hydrochloride (HCS) Oral Tablet 50 milligrams (mg), give 50 mg by mouth in the afternoon (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for depression. A review of Resident #4's Preadmission Screening and Resident Review (PASSAR), level 1 screen, dated 3/17/25, revealed no diagnoses were marked under Section A-MI or suspected MI. 3. A review of Resident #13 admission record revealed an original admit date of 5/7/2024 with diagnoses to include but not limited to major depressive disorder, and generalized anxiety disorder. A review of Resident #13's quarterly MDS, for medication, dated 12/17/2025, revealed the following high-risk drug classes: antidepressant usage. A review of Resident #13's care plan focus areas revealed the following to include: Mood and Behavioral. A review of Resident 13's physician orders dated January 2026 revealed: an order for Wellbutrin XL oral tablet (extended release 24-hour 150 milligrams (mg) to give one tablet by mouth one time a day for depression, ordered 2/6/2025. A review of Resident #13's PASSAR, level I screen, dated 5/1/2024, revealed no diagnoses were marked under section A- MI of suspected MI. A review of Resident #18's admission record revealed an admit date of 12/13/2024 with diagnoses to include but not limited to: major depression disorder recurrent moderate and anxiety disorder. A review of Resident #18's annual MDS, for medication, dated 11/12/2025, revealed the following high-risk drug classes: Antidepressant usage. Active Diagnoses revealed a new diagnosis of Post-Traumatic Stress Disorder (PTSD). A review of Resident #18's care plan focus areas revealed the following to include: Trauma Informed Care -PTSD (12/11/2025) and depression, Psychotropic medications, and Behavior. A review of Resident #18's PASSAR, level I screen, dated 12/09/2024, revealed no diagnoses were marked under section A- MI of suspected MI nor an updated PASSAR once PTSD was identified as a newly added diagnosis. A review of Resident #36's admission record showed an admit date of 8/29/2025 with diagnoses to include but not limited to, anxiety disorder unspecified and major depressive disorder recurrent unspecified. A review of Resident #36's MDS, Active Diagnoses, dated 12/03/2025, revealed a diagnosis of depression and anxiety. A review of Resident #36's physician orders dated January 2026 revealed an order for Alprazolam oral tablet 0.5 mg to give one tablet by mouth every eight hours for anxiety, ordered 8/30/2025. A review of Resident #36's PASSAR, level I screen, dated 8/15/2025, revealed anxiety disorder diagnosis was marked under section A- MI of suspected MI but missing depression. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/8/2026 at 1:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the facility currently does not have a designated individual to screen, determine accuracy, update and/or refer PASSRs for Level I or Level II completion. A review of the facility's policy titled, PASSR-Requirements for Completion Pre-admission Screening & Resident Review (PASSR), effective August 2025, showed the following policy statement: Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a nursing home. The screening is revised by admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain an effective infection prevention and control program by failing to 1.) ensure hand hygiene was offered for eight (20A, 21B ,22B, 23A,24A 24B, 25A, 26A, 26B, 28B) of the eight rooms observed prior to meals. (2) The facility failed to ensure staff wore appropriate personal protective equipment (PPE) while handling laundry for the facility in one of one laundry rooms. 3.) The facility failed to follow infection control practices related to respiratory equipment for one (#2) of two residents samples with oxygen. Findings Included: On 01/05/2026 at 10:40 a.m., observed Resident #2 sitting up in bed with the tray table in front of them. The resident was fully dressed and observed using oxygen with a nasal cannula in place. The resident stated they used oxygen during the day. Resident #2 said the staff have not changed the nasal cannula. Observed the nasal cannula tubing was labeled 11/10. Review of Resident #2's Treatment Administration Record (TAR) showed an order with a starting date of 10/6/025: Change nebulizer set up and tubing every week. Label tubing with date when changed. The resident's TAR listed the orders on following dates as having been completed: 11/9/2025, 11/16/2025, 11/23/2025, 11/30/2025, 12/7/2025, 12/14/2025, 12/21/2025, 12/28/2025, and 1/4/2026. An interview was conducted with the Unit Manager (UM) on 1/6/2026 at 10:57 a.m. The UM stated the respiratory therapist doesn't come every week. The UM stated the respiratory therapist follows respiratory residents and residents with tracheostomies. When asked if the tubing is changed weekly, she stated she would have to check the policy. The UM said it is common practice to change respiratory tubing weekly. The UM stated Resident #2's order in the MAR/TAR had to do with the nebulizer tubing. On 1/6/2026 at 11:20 am, Resident #2 gave surveyor permission to look at his nebulizer. Observed the nebulizer tubing was lying next to the resident's urinals on his nightstand with no date on the tubing. The only date found on the nebulizer was a bag hanging from the handle of the nightstand with a date of 10/20/2025. An interview was conducted with the Director of Nursing (DON) on 1/8/2026 at 3:00 pm. The DON stated the expectations for respiratory therapy to treat tracheostomy residents, residents who use oxygen and nebulizers. She stated the expectation for oxygen tubing is the nurses should change out tubing and bags. The nurse should make sure things are properly dated. The oxygen and nebulizer tubing should be changed weekly. Review of admission Records showed Resident #2 was admitted to the facility on [DATE] with diagnoses including but are not limited to Chronic obstructive pulmonary disease with acute exacerbation, Respiratory disorders in diseases classified elsewhere classified, Emphysema, and Pleural effusion. Review of Resident #2's Minimum Data Set (MDS), dated [DATE], Brief Interview for Mental Status (BIMS) score of 14. This BIMS score indicated they were cognitively intact. Review of Resident #2's Care Plan revealed a focus of Emphysema/COPD that requires oxygen use, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no interventions or tasks were found involving cleaning of the equipment. On 01/05/2026 at 12:40 p.m., observation of the lunch tray delivery for rooms 20A, 21B ,22B, 23A,24A 24B, 25A, 26A, 26B, and 28B. No hand hygiene was offered to the residents, and did not observe hand wipes provided on the lunch trays. An interview was conducted with the DON on 1/7/2026 at 9:59 a.m. The DON stated the administration monitors staff's infection control processes. The DON said the facility completes unannounced spot checks for compliance. The DON said this includes looking at laundry and housekeeping in the facility halls and perform audits of all employees. On 1/7/2026 at 10:30 a.m., an interview was conducted with Staff H, Laundry Aide (LA). Staff H, LA stated the facility has gloves, then he held up outdoor work gloves. Staff H, LA stated just throw the gloves in the washing machine to clean them. When asked about how he protects his clothing, he said he holds the soiled laundry away from his clothes. If the laundry is too soiled, then they dispose of it. Staff H, LA confirmed not throwing away residents' clothes that are soiled. Staff H, LA stated not usually wear a gowns. Staff H, LA stated having work clothes and street clothes so he can protect himself. Staff H, LA said the laundry arrives in red bags are washed separate from the other laundry. If there is a report of Clostridioides difficile (C-Diff) or bed bugs, then the staff separate them from the rest of the laundry. They sanitize them with heavy bleach. Staff H, LA said not seen any bed bugs or been told about bed bugs. Review of the facility policy titled Oxygen Therapy, with an effective date of August 2025, revealed the facility staff are to change out the nasal cannula weekly and as needed. No policy was provided regarding Laundry Process prior to survey exit.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure resident council meetings were documented as required for six of six months of resident council minutes requested. The facility could not demonstrate that they acted upon grievances voiced during resident council meetings. Findings Included: A review of the grievance log from June 2025 to December 2025 did not reveal any entries from Resident Council. During the Resident Council (RC) meeting on 1/7/2026 at 1:26 p.m. The RC members said they are not sure who the Grievance Official. The Grievance Official changes frequently, and they are not informed when the changes occur. The RC members said the staff never discuss the rationale behind unresolved issues, but We [the facility] will look into it is the answer received without resolution. On 1/7/26 at 5:12 p.m., an interview with the Nursing Home Administrator (NHA) was conducted. The NHA said the activities director had no documentation of the resident council minutes. The NHA said the expectation is the activities director should document what occurred in the resident council meetings on the minutes form. On 1/08/26 at 10:15 a.m., an interview with the Activities Director (AD) was conducted. The AD stated not having a resident come up to her to file a grievance outside of resident council. The AD stated there was one instance when a resident was missing money and investigated the issue herself. The AD stated not filing a grievance. The AD said she knows now a grievance should have been filed and grievances should be documented on the grievance form. On 1/08/26 at 12:15 p.m., an interview with Social Services Director (SSD) was conducted. The SSD stated when a grievance is received, it is logged, then given to the specific department to take care of it. The SSD said the grievance should have resolution within 72 hours, if possible. The SSD said she does not participate in resident council meetings and concerns from resident council have not been communicated to her. The SSD stated if a grievance is brought to the attention of any staff or the Activities Director during resident council, her expectation is those concerns would be brought to her attention and/or a grievance written. The SSD stated the NHA has not told her about any grievances discussed during resident council. On 01/08/26 at 3:15 p.m., an interview was conducted with the NHA. The NHA stated the grievance process, if initiated during the resident council meetings, would be initiated by a staff member if they are present during the meeting. If a staff member is not present, then the resident would initiate the grievance themselves or with any employee. The NHA stated the grievance form is then turned over to the SSD or NHA, for logging and completion. The department responsible for the area of concern handles the grievance, and writes on the grievance form the resolution. The NHA stated once the grievance is resolved, the form goes back to the SSD to be addressed with the person filing the concern. The NHA stated during Interdisciplinary Team (IDT) meetings, the team discuss all grievances and if they rise to a level of concern, they are pushed to the Quality Assurance and Performance Improvement (QAPI) committee. Review of the facilities policy titled Grievance/ Concern Management, effective date May 2025, revealed: 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, (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or to any other person. The concern may be filed verbally or in writing, and the reported may request to be anonyms. Procedure: 1. At, during, or after admission, the staff will provide a. an explanation of the facility concern process, . e. the names, job titles, and telephone numbers of the employees responsible for implementing the facility's concern procedure. 2. The facility will promptly 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, . 4. The NHA is responsible for oversight of the concern process . 6. Social Service Director in collaboration with the NHA will be the Grievance official at the facility . 9. The Resident Council will be reminded of the name and location of the Grievance Officer, how to file a concern; . The concern process will be reviewed at minimum annually with the Resident Council . 13. Complete a concern report investigation with summary and conclusion . 14. Social Services staff will provide information regarding compliance line information for unresolved concerns.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain a safe, clean, comfortable homelike environment related to rusted equipment, unpainted, damaged and uncleanable surfaces in the laundry room and 13 (2,6,10,11,14,16,19,20,21,23,26,28 and 29) of 28 resident rooms toured and one of one laundry room toured Findings included: 1. On 1/5/26 at 10:30 a.m., an observation of room [ROOM NUMBER] revealed the dresser drawers, to the left of the bed closest to the window, were coming off the tracks and slanted. The wall closest to the door had a linear groove, the length of the resident's bed, where paint was peeling and scraped off. Observations of the bathroom shared by room [ROOM NUMBER] and 17 had towels wrapped around the toilet which were brown-stained. The plunger on the floor next to the toilet had no bag over it. On 1/5/26 at 11:13 a.m., an observation of room [ROOM NUMBER] revealed the top drawer of the dresser was missing. Observations of the bathroom shared by room [ROOM NUMBER] and 19 revealed the toilet had a wad of toilet paper and feces in it, a plunger next to the toilet with no bag over it, and an area of the ceiling closest to the toilet had multiple spots dark in color. On 1/5/26 at 3:38 p.m., an observation of room [ROOM NUMBER], behind and under the A-bed, revealed multiple missing and cracked floor tiles, the cove base was separated from the wall exposing the dry wall which had brown and black bio growth material. A thin metal wire about 4 feet wide was on the floor. Area by the A-bed revealed a tube feeding pump that had multiple light brown colored stains along the pole. On 1/7/26 at 9:44 a.m., an interview was conducted with the Director of Nursing (DON). She said she did not know who cleaned the intravenous (IV) and tube feeding pumps. 2. On 01/05/2026 at 9:15 a.m., an observation of room [ROOM NUMBER] bathroom had water leaking out of the bathroom into room [ROOM NUMBER]. Half an inch of standing water was observed in the bathroom. The baseboard surrounding the bathroom door in room [ROOM NUMBER] had discolored line around the drywall. The wall felt wet. On 01/05/2026 at 9:40 a.m., an observation of the bathroom door in room [ROOM NUMBER], was hard to open. The baseboards surrounding the door were in disrepair. The front of nightstand drawer on side 23B was broken. On 01/05/2026 at 10:23 a.m., an observation of a puddle of water and stained flooring at the base of the toilet for room [ROOM NUMBER]. The floor under the enteral feeding pump next to bed 28A, was soiled with a sticky brown substance. The wall behind the bed had holes. On 1/05/2026 at 10:40 a.m., an observation of water on the floor in front of the toilet for room [ROOM NUMBER]. The door had a hole, and a ball of tissue was placed in the hole for privacy. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/05/2026 at 10:47 a.m., an observation of room [ROOM NUMBER]'s bathroom toilet had a yellow puddle at the base with a urine odor and the bathtub full of brown colored water. An interview was conducted with Resident #2 on 01/05/2026 at 10:40 a.m. Resident #2 stated the bathroom backs up occasionally. An interview was conducted with the Housekeeping Director on 01/05/2026 at 10:49 a.m. The HD stated the water build up in the room [ROOM NUMBER]'s bathtub could have been from the drainage line back up. The HD said this is the first time the lines have backed up this severely. The HD said the toilets back up occasionally. On 01/05/2026 at 11:09 a.m. a follow up interview was conducted with the HD. The HD stated the backup was only affecting one hall. The HD stated the plumber said it's the main pipe backing up, of the sewer line. On 1/7/2026 at 10:30 a.m., an observation was made of the laundry facility with the Director of Nursing (DON). Observed standing water with considerable debris in the drainage channel behind the washing machines. The debris was blocking the drainage from the right side of the channel. Staff H, Laundry Assistant (LA) stated the water will drain if it fills up enough to get to the other side. Staff I, LA, stated the drainage channel behind the washing machines will overflow occasionally. On 1/8/2026 at 10:27 a.m., a follow up observation of the laundry facility, the drainage canal behind the washing machines remained blocked and full of dirty water. An interview was conducted with a Staff H, LA on 1/7/2026 at 10:30 a.m. Staff H, LA stated they clean the lint trap daily, but no records are kept of when the lint trap is emptied. Staff H said they clean the washing machine filters every Friday but also do not keep logs of when this maintenance is completed. An interview was conducted with the Maintenance Manager (MM) on 1/8/2026 at 1:55 p.m. The MM stated the laundry facility will call him for an emergency. The MM stated the staff are supposed to report all issues in electronic maintenance system to report any issues in need of repair or of concern. The MM stated not knowing the process for the drains to the washing machines but would expect it to be monthly. The MM stated he will locate the policy for laundry and provide. 3. During an interview on 1/7/2026 at 10:02 a.m. the Housekeeping Director (HD) stated, Housekeeping is responsible for the entire building, if we have issues we find in the rooms we report it verbally to maintenance. An observation was made with the HD of room [ROOM NUMBER]. The HD stated room [ROOM NUMBER] had recently been deep cleaned, the room was well lit, the floors were clean. The furniture was in disrepair with the dresser finish was peeling and the drawers were broken. The HD stated, I report this information to the Maintenance Director verbally and nothing seems to get done. I realize that I can't clean the areas that are uncleanable, but we try and report that to maintenance. As far as equipment that is in disrepair, I'm contracted, so that falls on the staff and the facility to purchase equipment, we only purchase equipment that we use for housekeeping. The cleaning of the IV polls is the responsibility of nursing and housekeeping. During an interview with Staff A, Housekeeping Aide (HA) on 1/7/2026 at 12:30 p.m. Staff A, HA (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, It is not my responsibility to clean the feeding pumps and pump polls. During an interview with the Regional Maintenance Director (RMD) on 1/7/2026 at 1:24 p.m. The RMD stated, the staff are supposed to be submitting work orders in the electronic reporting system, however the staff are not reporting all issues in the reporting system. The expectation is to have the employees input or report the concern directly into electronic maintenance system. The employees have the training on the program. The RMD stated the staff are in serviced that resident or life safety is fixed first, wheelchairs or resident equipment comes next, we then prioritize the remainder of the issues. The RMD stated that they are not completing any type of room audits, but room audits are supposed to be completed. The RMD would expect to see better documentation. During an interview and observation with the RMD on 1/7/2026 at 2:20 p.m. the following rooms: -room [ROOM NUMBER] toilet broken and overflowing with pests flying, -the east storage room had rusty IV polls that the RMD identified as having non-cleanable surface, -room [ROOM NUMBER] shower tiles were missing, -room [ROOM NUMBER] wall is not cleanable with holes. -room [ROOM NUMBER] water on floor with baseboards dislodged, -room [ROOM NUMBER], baseboards missing, exposing drywall and cement, -room [ROOM NUMBER], toilet is clogged, floor tile is damaged, -room [ROOM NUMBER] hole in door and toilet clogged, -room [ROOM NUMBER] bathtub is not cleanable due to brown oxidation, -room [ROOM NUMBER] dresser broken and wall is damaged, -room [ROOM NUMBER] bathroom ceiling is stained with a bio growth and a broken dresser, -room [ROOM NUMBER] tube feeding pump entire pole had numerous areas of oxidation, tiles in the bathroom are damaged, -room [ROOM NUMBER] blinds are broken, and faucet is not cleanable, -room [ROOM NUMBER] bathroom wall is damaged and not cleanable. The RMD stated all above areas would need to be fixed. Review of a document titled Job Description, undated, revealed: Position, Maintenance Director, reports to Administrator. 1. Summary of position: The Maintenance Director is responsible for the overall maintenance of the (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility and provides direction for all activities related to plant operations. The Maintenance Director ensure the facility, equipment and utilities are maintained in good working order and facility grounds are properly maintained in accordance with facility policies and State and Federal regulations. 2. Essential duties and responsibilities: Perform minor repairs and supervises the day-to-day repair, improvement and preventative maintenance of the facility to ensure that machines continue to run smoothly, building systems operate efficiently, or the physical condition of facility does not deteriorate. Requested the Cleaning and Maintenance Repair policy and procedure. The RMD stated not having the policies although the Maintenance Director Job Description, covers the responsibilities. Photographic evidence obtained.		

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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. Based on record review and interview, the facility failed to implement its grievance process. The facility did not ensure resident's grievances from Resident Council were received, investigated, and a resolution provided or discussed for six of six months of resident council meeting minutes reviewed. Findings Included: Resident #9 said the residents are not sure who the Grievance Official is currently. The Grievance Official changes, and they must look at the paper on one of the office doors to find out the current person. The staff never discuss the rationale behind unresolved issues. We will look into it is the answer the residents receive all the time without any resolution. On 1/7/26 at 5:12 p.m., an interview with the NHA was conducted. She said the activities director had no documentation of the resident council minutes. She said the expectation is the activities director should document what occurred in the resident council meetings on the minutes. She then said the activities director has some notes and would provide copies of what documentation was completed. On 1/08/26 at 10:15am., an interview with the Activities Director was conducted. She stated she has not had a resident come up to her to file a grievance outside of resident council. She stated there was one instance when a resident was missing money and she investigated the issue herself. She stated she did not file a grievance. She said she knows now she should have filed a grievance and grievances should be documented on the grievance form. On 1/08/26 at 12:15pm, an interview with Social Services was conducted. She stated when she receives a grievance, she logs it, then gives it to the specific department to take care of it. She stated she has 72 hours to resolve the grievance. She said she does not participate in resident council meetings and concerns from resident council have not been communicated to her yet. She stated if a grievance is brought to the attention to staff or the Activities Director during resident council, her expectation is those concerns would be brought to her attention. She stated the NHA has not told her about any grievances discussed during resident council. On 01/08/26 at 3:15 pm, an interview was conducted with the NHA. He stated the grievance process, if initiated during the resident council meetings, would be initiated by a staff member if they are present during the meeting. If a staff member is not present, then the resident would initiate the grievance with any employee. He stated the grievance form is then turned over to the Social Services Director or NHA and then is handled by the Social Services Director. The form is then signed, received, and transferred to the appropriate area of concern. The area of concern handles the problem, and writes on the grievance form the resolution. He stated once the grievance is resolved, it goes back to the Social Services Director to be addressed with the Resident. He stated during Interdisciplinary Team (IDT) meetings, the team discuss all grievances and if they rise to a level of concern, they are pushed to the Quality Assurance and Performance Improvement (QAPI) committee. Review of the facilities policy titled Grievance/ Concern Management, effective date May 2025, revealed 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 reported may request to be anonyms. (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The procedure revealed 1. At, during, or after admission, the staff will provide a. an explanation of the facility concern process, e. the names, job titles, and telephone numbers of the employees responsible for implementing the facility's concern procedure. 2. The facility will promptly 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, 4. The NHA is responsible for oversight of the concern process, 6. Social Service Director in collaboration with the NHA will be the Grievance official at the facility , 9. The Resident Council will be reminded of the name and location of the Grievance Officer, how to file a concern .The concern process will be reviewed at minimum annually with the Resident Council, 13. Complete a concern report investigation with summary and conclusion, 14. Social Services staff will provide information regarding compliance line information for unresolved concerns.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on observations, interviews and record review, the facility did not ensure the appropriate staff member referred one (#7) with serious mental disorder(s)/diagnoses to the State's Mental Health authority for Level II Preadmission Screening and Resident Review (PASRR) out of 18 residents sampled. A record review of Resident #7's admission Record showed an original admit date of 11/27/2025 with diagnoses to include but not limited to: Epilepsy, unspecified, not intractable , without status epilepticus Anxiety disorder, unspecified Latent syphilis, unspecified as early or late Bipolar disorder, current episode mixed, severe, with psychotic features Major depressive disorder, recurrent, unspecified Alcohol abuse with intoxication, unspecified A record review of Resident #7's PASSR dated 01/27/2025 showed in Section A. MI or suspected MI (mental illness) (check all that apply) showed Substance Abuse as the only MI. On 01/08/2026 at 1:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the facility currently does not have a designated individual to screen, determine accuracy, update and/or refer PASSRs for Level I or Level II. The DON stated Resident #7 does not have behavior issues. A review of the facility's policy titled, PASSR-Requirements for Completion Pre-admission Screening & Resident Review (PASSR), effective August 2025, showed the following policy statement: Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre admission screening program (see 42 CFR 483.100) required to be performed on all individuals prior to admission to a nursing home. The screening is revised by admissions for suspicion of serious mental illness and intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility and includes private pay, Medicare, and Medicaid admissions regardless of payer source.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility did not 1. Ensure a care plan was initiated for one (#4) of two residents reviewed for mental health diagnoses; and 2. did not ensure care plans were initiated and/or implemented for two (#34 and #23) of three residents reviewed for smoking. Findings include: 1. A review of Resident #4's admission record revealed an admission date of 04/04/2025, with diagnosis to include but not limited to, major depressive disorder, recurrent, unspecified. A review of Resident #4's annual minimum data set (MDS), for medications, dated 12/22/2025, revealed the following under high- risk drug classes: antidepressants usage. A review of Resident #4's physician's orders dated January 2026 revealed the following to include: -Setraline Hydrochloride (HCS) Oral Tablet 50 milligrams (mg), give 50 mg by mouth in the afternoon for depression. A review of Resident #4's care plan revealed no documentation of interventions or focus area related to major depression diagnosis. On 1/8/26 at 11:24 a.m., an interview was conducted with the Clinical Reimbursement Director (CRD). The CRD reviewed Resident # 4's orders and confirmed the Resident #4 did not have a care plan for depression. The CRD stated Resident #4 recently discussed depression and recent loss of a family member during the recent care plan meeting. The CRD said the depression diagnosis was not triggered on the MDS. The CRD stated if a resident is receiving medication for depression, it should be put in their care plan. 2. On 1/7/26 at 11:27 a.m., an observation of Resident #34 revealed he was self-propelling in the wheelchair from the hall to the smoking area for the resident's designated smoking time. Further observations of the designated smoke time revealed Resident #34 took a cigarette that was on his lap and Staff E, Certified Nursing Assistant (CNA) proceeded to light the cigarette. Staff E, CNA was not observed providing him a cigarette from the facility's designated box where residents smoking materials are kept. An observation of Resident #34 revealed the bottom of a white and green cigarette box was seen coming out underneath his shirt. A review of Resident #34's admission record revealed an initial admission date of 8/26/24 and re-admission on [DATE] with diagnoses to include but not limited to; metabolic encephalopathy, malignant neoplasm of prostate, secondary malignant neoplasm of bone, muscle wasting and atrophy, not elsewhere classified, unspecified site, unsteadiness on feet, and alcohol abuse, uncomplicated. A review of Resident #34's care plan revealed the following: (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- SMOKING: Resident is a current smoker Date Initiated: 06/19/2025., with interventions to include, Inform of Facility Smoking Policy Date Initiated: 06/19/2025 . Smoking Materials Kept by Facility Staff Date Initiated: 06/19/2025. On 1/7/26 at 2:47 p.m., an interview with Staff E, CNA was conducted. Staff E, CNA said residents are not supposed to have their cigarettes on them. Staff E, CNA said when supervised smoking, the staff provides the residents' their cigarettes and lights them. Staff E, CNA said I know of three residents, to include Resident #34, who have their cigarettes with them. Staff E, CNA confirmed being aware Resident #34 had cigarettes because during the designated smoke time he took one out and had her light the cigarette. Staff E, CNA said she did not inform the Director of Nursing (DON) or a supervisor/manager about the residents having the cigarettes or lights. Staff E, CNA said the residents know they are not supposed to have them and are aware of the policy, they just don't pay attention. On 1/7/26 at 11:32 a.m., Resident #23 was observed in the patio during the designated smoking time smoking a cigarette independently. A review of Resident #23's admission record revealed an admission date of 12/19/25. Further review of the admission record revealed diagnoses to include endocarditis, valve unspecified, other lack of coordination, muscle wasting and atrophy, not elsewhere classified, multiple sites, pyogenic arthritis, unspecified, and discitis, unspecified, cervical region. An initial review of Resident #23's care plan revealed no documentation related to smoking. A follow-up review of Resident #23's care plan revealed a smoking specific care plan was created on 1/8/26. A review of Resident #23's admission nursing note, dated 12/20/25, revealed no documentation related to the resident being a smoker. A review of Resident #23's progress notes revealed the following to include: - 12/24/25, .[Resident #23] is a smoker. Smoking cessation provided and declined. - 12/30/25 psychiatry admission note, .Substance: smoker. - 1/3/26, . Resident is a smoker with no desire to quit. Smoking cessation education provided. - 1/8/26 psychiatry note, .Substance: smoker. A review of Resident #23's smoking safety education and acknowledgement, dated 12/20/25, revealed smokes is marked. On 1/8/26 at 11:45 a.m., an interview was conducted with the CRD. The CRD said being responsible for completion of the MDS and care plans. The CRD stated on admission the nurse completes the admission assessment and the data automatically triggered certain care plan subjects. The CRD said after the admission assessment is completed MDS clarifies to make sure the care plan is individualized, as initially it is a general care plan. The CRD said in the first ten days of the residents' admission a meeting is scheduled where the Interdisciplinary Team (IDT) would discuss the care plan. The CRD said information about the resident is also populated on a 24-hour report, which included a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary of what occurred the night before. She said if anything happened and/or nurses document a change then it is discussed in the IDT meeting. The CRD said taking notes during those meetings and updates the resident's care plan if needed. The CRD said Resident #23 had a care plan meeting yesterday where the resident told her she smoked. The CRD confirmed prior to 1/7/26, she did not know Resident #23 smoked. She confirmed the admission evaluation did not identify Resident #23 as a smoker. The CRD said the smoking consent and evaluation/assessment does not drive the care plan, but if it was discussed in the IDT meeting she would have acquired the information that way. She stated, It's probably something we need to look into, regarding adding information to the care plan that she is not aware of. She said whoever had the information about Resident #23 being a smoker could have added that to the care plan. On 1/8/26 at 12:41 p.m., an interview with the Director of Nursing (DON) was conducted. The DON said the staff member who is assigned to supervise the designated smoke time takes hydration and the smoke cart/box, which contains the resident's items, out to the patio. The DON said the staff member is supposed to provide an apron and/or assistive device to the residents that need those items. She said the staff member also passed cigarettes from the residents' cartons with their names on them. The DON said residents cannot have their lighters and should not have their cigarettes on them. She stated, They should go into the smoke box. She said staff should be confiscating their smoking materials if they are aware the resident had them. The DON said if the resident does not want to comply, then staff should make someone aware on the administrative team. She confirmed all residents are asked upon admission if they smoke. The DON said Resident #23 initially said she did not smoke and was using a nicotine patch. She confirmed Resident #23 signed a smoking consent on 12/20/25 that showed she smokes. The DON said she did not have an answer as to why a smoking care plan was not completed. A review of the facility's policy titled Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, dated February 2024, revealed the following: POLICY . The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives and time frames and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan is reviewed and revised periodically, and the services provided or arranged are consistent with each resident's written plan of care. PROCEDURE . 2. Update to Care Plans a. Ongoing updates to care plans are added by a member of the IDT, as needed . 3. Dates and documentation on the care plan a. New, revised, or discontinued Problems, Goals, or Interventions are dated for the date the documentation was made.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure activities of daily living, specifically nail care was provided for three (#5, 21, and 43) of six residents reviewed who required assistance with personal hygiene. Findings included: On 01/05/2026 at 9:30 a.m., observed Resident #21 sitting up in bed. Observed the resident had soiled, long fingernails. Observed scratches on their right upper arm. Resident #21 stated the wounds on their legs are due to lymphedema. The bandage on the right leg had a date of 01/02. On 1/7/2026 at 11:40 a.m., observed Resident #21 sitting in his bed. Resident #21 stated the facility does not cut his nails but wished the facility would. Observed several of the long nails had broken and were hanging on the nail bed. Review of admission Records showed Resident #21 was admitted to the facility on [DATE] with diagnoses including but are not limited to chronic obstructive pulmonary disease, muscle wasting and atrophy, and type 2 diabetes mellitus without complications. Review of Resident #21's Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 11. This BIMS score indicated they have mildly impaired cognition. Review of the Functional Abilities revealed a level two for personal hygiene, which is substantial or maximal assistance. The helpers would have to complete more than half the effort during personal hygiene. Review of Resident #21's Care Plan revealed a focus area for (Activity of Daily Living) ADL performance deficit. The intervention listed personal hygiene set up. Review of Resident #21's tasks for Certified Nursing Assistant (CNA) revealed the No Nail Care was marked for the following dates: 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/17/2025, 12/18/2025, 12/19/2025, 1/1/2026, 1/2/2026, 1/5/2026, 1/6/2026 and 1/7/2026. There were no other dates marked for nail care from 12/10/2025 through 1/7/2026. On 01/05/2026 at 3:29 p.m., observed Resident #43 sitting on the side of their bed. Observed the resident had long, soiled toenails and wounds on toes 2 and 3 of the right foot. Resident #43 reported podiatry would come every month. The resident stated podiatry has not seen him in a while. On 1/6/2026 at 9:40 a.m., Resident #43 was receiving wound care. Staff D, Register Nurse, Unit Manager (RN/UM) stated podiatry comes in once or twice a month and has seen the resident in the past. Observed Staff D, RN/UM applying betadine to the resident's toes on his right foot. Review of Resident #43's Care Plan revealed a focus of Skin Integrity Risk. The resident has potential/actual impairment to skin integrity related to edema- water blisters which cause open areas on bilateral lower legs. Intervention listed to Monitor/document location, size and treatment of skin. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to medical doctor. Review of admission Records showed Resident #43 was admitted to the facility on [DATE] with diagnoses including but are not limited to: other specified mononeuropathies of bilateral lower limbs, cellulitis, unspecified, muscle wasting and atrophy, not elsewhere classified, type 2 diabetes mellitus without complications. Review of Resident #43's MDS, dated [DATE], showed a BIMS score of 15. This BIMS score indicated resident cognitively intact. Review of Functional Abilities revealed the personal hygiene section was not completed. Review of Resident #43's Progress Notes revealed the following:-On 11/13/2025 at 12:21 p.m., the resident hit his right foot on the table in the dining room causing his fifth toe to bleed and bruise, on the toes of the right foot. Upon assessment, the right toenail was noted to be bleeding underneath. The resident's toenail was long and loose. The area was cleaned and covered with band aid. Social services was notified to place the resident on the podiatry list.-On 11/14/2025 at 2:19 p.m., podiatry saw Resident #43 for the toenail on the right fifth digit. New orders were received from podiatry for betadine treatment for the toes. Review of Resident #43's podiatry notes, dated 11/14/2025, revealed the resident's nails were long and thickened. Manual nippers and an electric grinder were used to perform toenail debridement to patients' tolerance. The podiatrist recommended ongoing preventative routine debridement of devitalized or contaminated tissue. They recommended debridement to relieve the pressure from the necrotic presence on the nail and provide a better cosmetic appearance. Debulking (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nail will help decrease the fungal load. If there are further problems, then surgical removal of the nail will be considered. No other podiatry notes were found in the record after the November 2025 visit. An interview with the Social Services Director (SSD) was conducted on 1/6/2025 at 9:13 a.m. The SSD stated the facility provides podiatry, hearing, dental, and psych services, but no beauty salon. She noted that the Activities Department may have days where they get the residents nails done. The SSD stated podiatry comes to the facility. The SSD said the nursing staff should be handling cutting the residents' fingernails. If the nails are soiled, the nurses should handle taking care of cleaning. The SSD stated she was not sure who cuts the residents' toenails if there is not a podiatry service, but nursing should know. On 01/08/2026 at 9:33 a.m., an observation was made of Resident #5 during a skin sweep assessment with Staff D, RN/UM. Resident #5 was observed with long fingernails on her left contracted hand. The middle finger was observed touching her left hand but no breakdown to hand. Staff D stated the Activities Director, or the CNAs can clip residents' nails. Staff J, CNA, who was assisting Staff D, stated nail care was a task for the CNAs under the nail care tab. On 1/8/2026 at 12:18 p.m., an interview with SSD was conducted. The SSD stated she found out yesterday there is a binder at the nursing station with all the ancillary services. The SSD upon checking the binder yesterday, there was nothing in the binder. If the patient has a concern, then the staff puts it in the binder. The CNAs should inform the nurse. CNA's do the care, and they should let the nurses know and the nurse should put it in the book. The SSD stated the need for nail care does not have to be care planned if it is not an ongoing issue. The SSD said there is a form residents' sign at admission to receive ancillary services. An interview was conducted with the DON on 1/8/2026 at 3:00 p.m. The DON stated the expectations for podiatry care is that if there is an issue, then staff need to notify SSD. The resident would need to be added to the podiatry list. The DON stated issues can be diabetes, or poor wound healing, and anything like that. She noted they don't even require one of those issues, if they need their nails cut, then they can be added to the list. The CNAs do not cut toenails but can cut fingernails. No policy and procedure was received by end of survey related to nail care.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not ensure weekly skin sweep evaluation were done for three (13, 36, and 5) out of three residents. Findings included: A record review of weekly skin sweeps for Residents #5, 13 & 36 showed the following: Resident #5 had weekly skin sweeps on 12/06/2025, 12/18/2025 and 01/07/2026 with 12/18/2025 showed a skin impairment under right eye for discoloration. Resident #13 had weekly skin sweeps on 12/06/2025 and no further skin sweeps documented. Resident #36 had weekly skin sweeps on 12/06/2025 and no further skin sweeps documented. During an interview on 01/05/2026 at 9:20 a.m., Resident #13 stated her bottom is sore. Resident #13 said sitting in her wheelchair for an extended time as well feels her bottom hits the springs of the bed under the mattress. On 01/08/2026 at 9:33 a.m., an observation occurred with Staff D, Registered Nurse/Unit Manager (RN/UM) and Staff M, Certified Nursing Assistant (CNA) for skin sweep assessments for Residents #5, 13 and 36. Resident 36 was found with skin integrity concern. Resident #36's breast folds and abdominal folds had glistening red discoloration left and right, with white-yellow cottage cheese -like substance present. Staff D, RN/UM had a lengthy conversation with Resident #36 and concluded the plan is to be contacting the physician for orders and would let the nurse know. Resident #36 stated this is an ongoing issue. Staff D, RN/UM stated this was a positive (meaning abnormal skin integrity) find and the findings will be documented. On 01/08/2026 at 1:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations are for the nurses to perform daily skin sweep evaluations on their residents and to document and report any finding(s) to the provider and if appropriate the resident representative. The DON stated skin sweep evaluations notifications are on the dash board of the resident's electronic chart. The DON stated these notifications on the dashboard are for reminders to the nurse. The DON stated during clinical meetings in the morning, she and the team review only positive findings and follow up with orders. A review of the facility's policy titled, Weekly and prn Skin Check , effective [DATE] showed a policy statement: The weekly and PRN skin check is used to document skin condition throughout the resident/patient's 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 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 for readmission to the facility and for extended leave of absence LOA. Findings should be documented on the weekly and PRN skin check documentation tool. The policy's procedure include but is not limited to: Once a week and when an area of skin impairment is reported the skin checks 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. 5. Identify new impairments on the figures with an X. 6. Document actions taken based on the skin check. a. No new areas of skin impairment b. See skin grid for both previously identified and newly identified areas. c. See Nursing Progress Note Document skin impairment of minor appearance not requiring treatment, in the nurses note. To include but not limited to small superficial abrasions, small bruises on hands, arms, or shins, small, reddened areas such as mosquito bites. 7. If there are Changes checked: a. Update the Plan of Care as appropriate and indicate the plan was reviewed. b. Make a notation on the 24- hour report so that the Interdisciplinary Team IDT will be notified.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Alpine Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3456 21st Ave S Saint Petersburg, FL 33711	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure residents were free from accident hazards for two (#34 and #23) of three residents reviewed for smoking as evidenced by residents not being evaluated, care plan interventions were not developed and implemented, and the smoking procedure/policy was not followed. Findings included: 1. On 1/7/26 at 11:27 a.m., an observation of Resident #34 revealed he was self-propelling in the wheelchair from the hall to the smoking area for the resident's designated smoking time. Further observations of the designated smoke time revealed Resident #34 took a cigarette that was on his lap and Staff E, Certified Nursing Assistant (CNA) proceeded to light his cigarette. Staff E, CNA was not observed providing him a cigarette from the facility's designated box where residents smoking materials are kept. An observation of Resident #34 revealed the bottom of a white and green cigarette box was seen coming out underneath his shirt. A review of Resident #34's admission record revealed an initial admission date of 8/26/24 and re-admission on [DATE] with diagnoses to include metabolic encephalopathy, malignant neoplasm of prostate, secondary malignant neoplasm of bone, muscle wasting and atrophy, not elsewhere classified, unspecified site, unsteadiness on feet, and alcohol abuse, uncomplicated. A review of Resident #34's care plan revealed the following:- SMOKING: Resident is a current smoker Date Initiated: 06/19/2025., with interventions to include, Inform of Facility Smoking Policy Date Initiated: 06/19/2025 . Smoking Materials Kept by Facility Staff Date Initiated: 06/19/2025. A review of Resident #34's evaluations revealed no smoking evaluation or assessment was completed. On 1/7/26 at 2:47 p.m., an interview with Staff E, CNA was conducted. Staff E, CNA said residents are not supposed to have their cigarettes on them. Staff E, CNA said when she supervised smoking, she provides the residents with their cigarettes and lights them. She said she knows of three residents, to include Resident #34, who have their cigarettes with them. She confirmed she was aware Resident #34 had his cigarettes on him because during the designated smoke time he took one out and she lit it. Staff E, CNA said she did not inform the Director of Nursing (DON) or a supervisor/manager about the residents she was aware of that had cigarettes with them. She said the residents know they are not supposed to have them and are aware of the policy. A review of Resident #34's smoking safety education and acknowledgement, dated 8/26/24, revealed the following under guidelines, 1. Smoking or tobacco materials should be labeled with the resident's name and will be maintained in a secure location. Residents may not keep any smoking or tobacco materials in their room, or on their person, to include but may not be limited to: lighters, matches, cigarettes, pipes, cigars, e-cigarettes or any other smoking materials. Facility staff will provide materials and assist each resident as needed during the posted smoking times, in the designated area. 2. On 1/7/26 at 11:32 a.m., Resident #23 was observed in the patio during the designated smoking time smoking a cigarette independently. A review of Resident #23's admission record revealed an admission date of 12/19/25 with diagnoses to include endocarditis, valve unspecified, other lack of coordination, muscle wasting and atrophy, not elsewhere classified, multiple sites, pyogenic arthritis, unspecified, and discitis, unspecified, cervical region. An initial review of Resident #23's care plan revealed no documentation related to smoking. A follow-up review of Resident #23's care plan revealed a smoking specific care plan was created on 1/8/26. A review of Resident #23's admission nursing note, dated 12/20/25, revealed no documentation related to the resident being a smoker. A review of Resident #23's progress notes revealed the following to include:- 12/24/25, .[Resident #23] is a smoker. Smoking cessation provided and declined.- 12/30/25 psychiatry admission note, .Substance: smoker.- 1/3/26, . Resident is a smoker with no desire to quit. Smoking cessation education provided.- 1/8/26 psychiatry note, .Substance: smoker. A review of Resident #23's smoking safety education and acknowledgement, dated 12/20/25, revealed smokes is marked. On 1/7/26 at 4:25 p.m., an interview with the Director of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) revealed Resident #34 and #23 do not have a smoking evaluation and assessment. On 1/8/26 at 11:45 a.m., an interview was conducted with the Clinical Reimbursement Director (CRD). The CRD said on admission the nurse completed the admission assessment and the data automatically triggers certain care plan subjects. The CRD said after the admission assessment is completed, she clarified to make sure the care plan is individualized, as initially it is a general care plan. The CRD said in the first ten days of the residents' admission a meeting is scheduled where the Interdisciplinary Team (IDT) would discuss the care plan. The CRD said information about the resident is also populated on a 24-hour report, which included a summary of what occurred the night before. She said if anything happened and/or nurses document a change then it is discussed in the IDT meeting. The CRD said she takes notes during these meetings and updates the resident's care plan if needed. The CRD said Resident #23 had a care plan meeting yesterday where the resident told her she smoked. The CRD confirmed prior to 1/7/26, she did not know Resident #23 smoked. She confirmed the admission evaluation did not identify Resident #23 as a smoker. The CRD said the smoking consent and evaluation/assessment does not drive the care plan, but if it was discussed in the IDT meeting she would have acquired the information that way. She stated, It's probably something we need to look into, regarding adding information to the care plan that she is not aware of. She said whoever had the information about Resident #23 being a smoker could have added that to her care plan. On 1/8/26 at 12:41 p.m., a follow-up interview with the DON was conducted. The DON said the staff member who is assigned to supervise the designated smoke time takes hydration and the smoke cart/box, which contains the resident's items, out to the patio. The DON said the staff member is supposed to provide an apron and/or assistive device to the residents that need those items. She said the staff member also passed cigarettes from the residents' cartons with their names on them. The DON said residents cannot have their lighters and should not have their cigarettes on them. She stated, They should go into the smoke box. She said staff should be confiscating their smoking materials if they are aware the resident had them. The DON said if the resident does not want to comply, then staff should make someone aware on the administrative team. She confirmed all residents are asked upon admission if they smoke. The DON confirmed Resident #23 signed a smoking consent on 12/20/25 that showed she smokes. The DON said she did not have an answer as to why a smoking care plan was not completed. A review of the facility's policy titled Smoking/Tobacco Use, dated August 2024, revealed the following: POLICY . Suspicion of Non-compliance necessary, and with resident consent or physician order in case of safety concerns, physical inspection of resident/storage areas will be performed by staff, including following contact with visitors who may be suspected of providing the resident with smoking materials and or associated articles. Smoking restrictions will not be assessed against residents for the convenience of the staff, but for the safety and well-being of the residents, staff, and visitors. The smoking agreement will be provided to the resident/resident representative to review and re-sign. PROCEDURE . 4. Smoking/tobacco materials should be labeled with the resident's name and maintained in a secure location. Residents may not keep combustible smoking materials in their room. Residents are not to retain lighters, matches, cigarettes, e-cigarettes, ignitable tobacco products, or other smoking materials in their personal possession. Care Plan 1. Initiate upon admission. 2. Review quarterly at minimum, with change in condition and as indicated.		

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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 (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 9 On 01/04/2026 at 18:00 (6:00 p.m.) medication was not administered with the chart code 9 On 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 9 The 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 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 - (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waiting on pharmacy to deliver On 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 pharmacy On 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 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 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prescription. The 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 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 agent. If 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 reference. The 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 follows: 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.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, and record reviews, the facility failed to maintain an effective pest control management system in one (East Wing) of two Wings and in one (room [ROOM NUMBER]) of twenty-eight rooms. Findings Included: During an interview on 01/07/2026 at 11:14 AM, Resident #8 stated, The rooms have pests and we need someone to help us keep the bathrooms and rooms clean. During an interview on 01/08/2026 at 1:52 PM with Staff J, Certified Nursing Assistant (CNA) stated, If I see bugs, I will tell the Nursing Home Administrator (NHA) or the Director of Nursing (DON), however I don't use the bug book to report pest sightings. During an interview on 01/07/2026 at 1:24 PM the Regional Maintenance Director (RMD) stated, The gap in the pest control plan is that our pest log is not being utilized as it should be, and the company I believe is performing their tasks, but I still find live bugs throughout the building. We do not do any type of room round audit but were supposed to do them and it's not getting input in the electronic reporting system. We would like to see better documentation. During observation and interview on 01/07/2026 at 2:20 PM with the RMD the following rooms, he noted that all rooms identified were correct as represented in the notes as follows:-room [ROOM NUMBER] toilet broken and overflowing with pests flying,-East Wing exit, live spiders, on the exit ceiling and the hallway leading to the exit, Review of a facility document titled Service Inspection Report from the contracted pest control company, dated from 5/2025 to 1/2026, signed by the pest control technician, showed multiple sightings and treatments for rodents and pests. Review of a facility policy and procedure titled Pest Control dated 8/2024, revealed: The facility will strive to protect the residents, staff and visitors from insects and other pests by controlling infestation through contracts with outside pest control agencies. Evaluate effectiveness of services and contact pest control agency if additional services are needed.		