STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195538	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Skilled Nursing and Rehabilitation	2401 North Service Road Ruston, LA 71270

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record reviews and interview, the facility failed to ensure there was a sufficient number of skilled licensed nurses, nurses aides, and other nursing personnel to provide care and respond to each resident's basic needs. The facility failed to provide the minimum required staffing hours for 2 of 13 weekends during Fiscal Year Quarter 4 2025. Findings:Review of the facility's PBJ Staffing Date Report for Fiscal Year Quarter 4 2025 (July 1 to September 30) revealed excessively low weekend staffing was triggered. Review of the Staffing Pattern Forms for weekends from Fiscal Year Quarter 4 2025 revealed on 07/06/2025 the facility provided 255.70 hours and were required to provide 260.85. Further review revealed on 08/24/2025 the facility provided 271.20 hours and were required to provide 282 hours. On 01/12/2026 at 3:45 p.m. interview with S1Administrator confirmed the facility did not provide the minimum required staffing hours on 07/06/2025 and 08/24/2025.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to care for resident needs by: 1.) S9LPN leaving prescription medications at Resident #80's bedside unattended and failing to remain with the resident until the medications had been taken and 2.) failing to have documentation of Resident #55's Lasix medication being administered as ordered for 2 (#80 and #55) of 3 residents reviewed for competent nursing staff.Findings: Review of the facility's Administering Oral Medications Policy (Revised April 2019) revealed in part: Steps in the Procedure 21. Remain with the resident until all medications have been taken. Resident #80 Review of the medical record revealed Resident #80 had an initial admission date of 06/03/2022. Resident #80 had diagnoses that included hemiplegia, muscle wasting, obesity, muscle weakness, pain, debility and hypokalemia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #80 had intact cognition for daily decision making. On 01/11/2026 at 10:25 a.m. observation of Resident #80 revealed he was lying in the bed, a medication cup that contained 4 pills was located on his over bed table unattended. At this time, an interview with Resident #80 revealed the cup contained his morning medications that he did not take. On 01/11/2026 at 10:30 a.m. observation of Resident #80 with S9LPN revealed the medications were still at the bedside. At this time, interview with S9LPN confirmed the medications should not have been left at the bedside. S9LPN further confirmed she should have stayed with Resident #80 until he swallowed the medications. On 01/12/2026 at 3:30 p.m. S2DON confirmed the nurse should not have left the medications at the bedside unattended and the nurse should have stayed with the resident until the medications had been taken. Resident #55 Review of the record for Resident #55 revealed an admit date of 12/19/2025 with diagnoses of rhabdomyolysis, acute pulmonary edema, chronic kidney disease, heart failure, and atrial flutter. Review of the physician orders dated 12/31/2025 revealed: Lasix 10 mg/ml use 4 ml intravenous twice a day for edema for 3 days. Administer 1 dose today and then twice a day for 3 days. Review of the January 2026 Medication Administration Record revealed there was no documented evidence of Lasix administered as ordered on 01/01/2026 at 8:00 p.m., 01/02/2026 at 8:00 a.m. and 01/03/2026 at 8:00 p.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/2026 at 4:45 p.m., S2DON and S3Corporate Nurse confirmed there was no documented evidence of Lasix administered as ordered on 01/01/2026 at 8:00 p.m., 01/02/2026 at 8:00 a.m. and 01/03/2026 at 8:00 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews the facility failed to store, prepare and distribute food in accordance with professional standards for food safety. This had the potential to affect the 117 residents served meals from the kitchen.Findings:Findings:On 01/11/2026 at 8:00 a.m. during the initial observation and tour of the kitchen, staff were currently serving breakfast. Observation of the staff serving breakfast revealed:S8Dietary was using his gloved hand to serve bacon, then touched fried eggs, then touched toast, biscuits and pancakes and the scoop handle for the scrambled eggs with the same gloved hand. At 8:09 a.m., an interview with S8Dietary confirmed he used the same gloved hand to touch the fried eggs, bacon, biscuits, toast and pancakes and scoop handle for the scramble eggs. At 8:10 a.m., observation of the refrigerator revealed the following items were undated: three salads, 22 sandwiches and two bowls of soup. At 8:15a.m., an interview with S7Cook confirmed the salads, sandwiches and bowls of soup were not dated. Further observation of the kitchen environment revealed there was a bag of pink lemonade for the drink dispenser that was sitting directly on the floor. At 8:20 a.m., an interview with S8Dietary confirmed the pink lemonade bag was lying directly on the floor. Further observation of the kitchen area revealed there was an open package of cleaner on the upper shelf above the food preparation table. S7Cook confirmed the package of cleaner was on the shelf above the food preparation table. Observation of the walk-in freezer revealed there was an undated bag of fish and two undated bags of chicken. Observation of the walk-in refrigerator revealed the following undated items: one pan of diced tomatoes, one pan of diced tomatoes with the lid open, one pan of diced green pepper and one bag of salad fixings. On 01/11/2026 at 8:40 a.m., an interview with S7Cook confirmed the above issues in the kitchen area. On 01/11/2026 at 11:21 a.m. observation of the steam table food temperatures taken by S7Cook revealed the pureed au gratin potatoes were 116 degrees Fahrenheit and the chopped pork loin was 127 degrees Fahrenheit. Further observation revealed S7Cook did not reheat the pureed au gratin potatoes or the chopped pork loin prior to serving. Observations revealed the pureed au gratin potatoes were served to residents #4, #9, #25, #47, #54, #87, #88, #99, #108 and #118 and the chopped pork loin was served to residents #2, #22, #30, #31, #38, #49, #53, #62, #68, #91, #100, #104, and #117. Further observation of the lunch meal revealed S8Dietary continued to use his gloved hand to touch the serving scoop handles and then pick up the rolls and place them on the resident's tray. During an interview on 01/12/2026 at 9:30 a.m. with S10Dietary Manager, S10Dietary Manager agreed with the above issues and reported they would be fixed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment by 1) failing to follow EBP and infection control practices during urinary catheter care and bathing and 2) failing to store unused respiratory equipment in a sanitary manner when not in use for 3 (#10, #61, #91) of 4 residents reviewed for infection control. Findings: 1.Review of the Enhanced Barrier Precautions Cheat Sheet dated 03/2024 revealed in part: Enhanced Barrier Precautions (EBP)- Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDRO's may be indirectly transferred from resident-to resident during these high-contact care activities. Examples of EBP residents: Wounds- includes chronic wounds, but are not limited to pressure ulcers, diabetic ulcers, unhealed surgical wounds and venous stasis ulcers. Indwelling medical devices- include central lines, urinary catheters, feeding tubes, and tracheostomies/vents. EBP are indicated during: Dressing Bathing/showering in a shared/common shower room Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care; any skin opening requiring dressing. Implementation: Gowns and gloves are used during high-contact sessions. Before entering the resident's room: Gather all needed supplies and materials; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clean Hands; Correctly put on a gown and gloves; After care, throw away gown and gloves; clean hands again. Resident #10 On 01/12/2026 at 1:45 p.m. review of the record for Resident #10 revealed an admit date of 11/05/2025 with diagnoses in part of metabolic encephalopathy, mild protein calorie malnutrition, stage 3 pressure ulcer to the sacral region, hypertension, Dementia, chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and personal history of venous thrombosis and embolism. Further review of the record revealed Resident #10 had a PEG tube placed with an order for Isosource 1.5 at 70 ml/hour continuous and had a indwelling urinary catheter. Review of the quarterly MDS assessment dated [DATE] revealed Resident #10 had a BIMS of 8 indicating moderate cognitive impairment. Review of the functional abilities revealed Resident #10 was dependent on staff for all ADLs, dependent on staff to roll in bed, and was incontinent of bowel and bladder. On 01/13/2026 at 10:35 a.m. observation of the door to Resident #10's room revealed there was an Enhanced Barrier sign posted. On 01/13/2025 at 10:35 a.m. observation of a bed bath and catheter care performed by S5CNA and S6CNA revealed upon entering Resident #10's room, S5CNA and S6CNA did not put on a gown. Further observation revealed S5CNA performed catheter care without a gown on. Observation revealed S6CNA washed Resident #10's face without a gown on. S5CNA placed soap into the washbasin and cleaned the resident's penis with soap and water and then placed the washcloth back into the soapy water. S5CNA then retrieved the same washcloth that was just used to clean Resident #10's penis and wiped the resident's buttocks, then his legs and over an open blister on the resident's leg and then placed the same washcloth back into the soapy water. S5CNA then washed Resident #10's lower legs with the same washcloth that was used on the resident's penis, buttocks and legs. On 01/13/2025 at 11:09 a.m., an interview with S5CNA regarding the catheter care and bath revealed she agreed that she and S6CNA did not use a gown while performing the care and should have and that she did use the same washcloth to bathe the resident after she had cleaned the resident's penis. 2. Facility's Oxygen Administration policy revised February 2025 revealed in part: Steps in the Procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Oxygen cannula and tubing will be changed within 7-10 days or if visibly soiled. Store in a covered device (i.e. plastic bag, kangaroo pouch) between uses. Resident #61 Review of the record for Resident #61 revealed an admit date of 11/06/2025 with diagnoses in part of cerebral vascular accident, dysphasia, acute respiratory failure, protein calorie malnutrition, hypertension and muscle wasting and atrophy. On 01/11/2026 at 3:30 p.m., observation of Resident #61's room revealed a nebulizer mask was lying directly on the table next to the resident's bed and was not covered. Further observation revealed the Yankauer oral suction instrument was sitting directly on the suction machine and was not covered. On 01/11/2026 at 4:04 p.m., an interview with S4LPN confirmed the nebulizer mask was supposed to be placed in a black bag and the Yankauer oral suction instrument was supposed to be stored in a clear plastic bag. S4LPN confirmed the nebulizer mask and the Yankauer oral suction instrument were not stored correctly. Resident #91 Record review revealed Resident #91 was admitted to the facility on [DATE] with diagnoses including: interstitial pulmonary disease, unspecified; pulmonary fibrosis, unspecified; chronic pulmonary edema; and mild intermittent asthma, uncomplicated Review of Resident #91's annual Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 9 indicating that Resident #91 had moderate cognitive impairment. Review of Resident #91's active physician's orders revealed an order for the facility to administer oxygen at 2 liters per minute as needed for shortness of breath. On 01/11/2026 at 9:30 a.m., Resident #91 observed to have an oxygen concentrator in her room. Oxygen humidifying water bottle on concentrator was dated 12/16/2025. Oxygen tubing connected to the concentrator was not stored in a bag and was observed touching the floor. Resident #91 was not wearing the oxygen and concentrator was off. On 01/12/2026 at 8:42 a.m., Resident #91 observed lying in bed eating breakfast. Oxygen concentrator observed in room with oxygen tubing attached. Concentrator was turned off and the oxygen tubing observed laying on the floor. On 01/12/2026 at 2:38 p.m., an observation made with S2DON confirmed that Resident #91's oxygen tubing was not stored in a bag and agreed that staff should have stored the oxygen tubing in a bag.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assess residents for self-administration of medications for 1 (#1) of 1 sampled residents observed for medications available at the bedside. Findings:Facility's Self-Administration of Medications policy revised December 2016 revealed, in part: Policy StatementResidents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation1. As part of their overall evaluation, the staff with the assistance from the practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.2. In addition to general evaluation of decision-making capacity, the interdisciplinary team will perform an assessment of Self Administration of Medications Form, or equivalent including (but not limited to) the resident's:a. Ability to read and understand medication labels;b. Comprehension of the purpose and proper dosage and administration time for his or her medications;c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medications; andd. Ability to recognize risks and major adverse consequences of his or her medications.4. If the resident is determined to self-administer, then he/she will be capable and willing to assume control and responsibility for his/her medication. The resident must sign the Consent for Administration of Medication Form regarding and agree to abide by the restrictions for handling and storage of medication according to one of the following plans. 6. All medication is kept in a locked cabinet (night stand) in the resident's room where it is not accessible by other residents. The resident is responsible for remembering to go to the cabinet at each time the medication is due, take the appropriate amount of medication, return the containers to the locked cabinet and keep the cabinet secure always. Resident must be instructed on the necessity of reporting each dose used to the nursing staff. Resident #1 Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including encephalopathy, unspecified; Parkinsonism, unspecified; essential tremor; chronic obstructive pulmonary disease, unspecified; and shortness of breath. Review of Resident #1's current Minimal Data Set (MDS) Assessment revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 indicating that Resident #1 was cognitively intact. Review of Resident #1's active physician's orders revealed an order dated 09/18/2025 for Flonase Allergy Relief Suspension 50 micrograms/actuation (Fluticasone Propionate (Nasal)) 1 inhalation in both nostrils two times a day. On 01/11/2026 at 10:48 a.m., 01/12/2026 at 8:47 a.m., and 01/12/2026 at 2:25 p.m., observations revealed a bottle of fluticasone was in Resident #1's room on top of a dresser at the foot of the bed. On 01/11/2026 at 10:48 a.m., an interview with Resident #1 revealed that she self-administers the fluticasone and facility staff bring her a new bottle when she needs one. On 01/12/2026 at 3:10 p.m., an observation made with S2DON confirmed that Resident #1 had a bottle of Fluticasone in the room. On 01/12/2026 at 3:40 p.m., an interview with S3Corporate RN confirmed that Resident #1 did not have an order to self-administer medications or medication self-administration assessment completed by the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview the facility failed to ensure a resident's tube feeding bag had documentation including the resident's identifying information, type of formula, and date and time it was started for 1 (#61) of 1 resident reviewed for tube feeding. Findings:Review of the facility's Enteral Tube Feeding via Continuous Pump policy and procedure with a revised date of 08/04/2019 revealed in part:Purpose:The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings.General Guidelines:Check the enteral nutrition label against the order before administration. Check the following information:Resident name, ID and room number;Type of formula;Date and time formula was prepared;Route of delivery;Method (pump, gravity, syringe); andRate of administration (ml/hour)Review of the record for Resident #61 revealed an admit date of 10/31/2025 with diagnoses in part of cerebral vascular accident, dysphasia, malnutrition, and PEG tube placement.Review of the current physician's orders revealed an order for nothing by mouth and a tube feeding order of Isosource 1.5 at 55 ml/hour.On 01/11/2026 at 3:30 p.m., observation of the tube feeding bag that was currently infusing at 55 cc/hr with 150cc water bolus every 4 hours revealed the bag of tube feeding was not labeled with the resident's identifying information, type of formula that was infusing, or the date and time it was started.On 01/11/2026 at 4:00 p.m., an interview with S4LPN confirmed the tube feeding bag that was currently infusing for Resident #61 was not labeled with resident's identifying information, type of formula that was infusing, or the date and time it was started and should have been.