

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Utugqanaat Inaat		STREET ADDRESS, CITY, STATE, ZIP CODE 436 Mission Street Kotzebue, AK 99752	
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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to: 1) Develop written policies and procedures regarding the visitation rights for residents to include procedures for safety restrictions or limitations; and 2) Implement reasonable safety restrictions or limitations against a visitor for 1 Resident (#4), out of 1 resident reviewed, when abuse by way of misappropriation of resident property was suspected. The facility's failure to establish procedures for implementing reasonable safety restrictions placed all 18 residents at risk for continued unrestricted access by visitors when concerns involving abuse, exploitation, coercion, criminal activity, disruptive behavior, or illegal substances were identified. The facility failed to implement measures to protect Resident #4 when abuse was suspected. Resident #4 was subjected to potential misappropriation of resident property causing the resident to not have money when needed, a bank overdraft, and seizure of a social security check by the bank causing the resident to be without money in May 2026 and June 2026. Findings:1) Visitation Policy Review of State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 229; Issued 4/25/25, revealed the Code of Federal Regulations (CFR) 483.10(f)(4)(iii) and (v) addressed the resident rights to receive visitors of his or her choosing at the time of his or her choosing, as well as, the facility's obligation to initiate safety restrictions or limitations when needed: - 483.10(f)(4)(iii) - The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; - 483.10(f)(4)(v) - The facility must have written policies and procedures regarding the visitation rights, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. Further review of the regulation guidance revealed: . ?Reasonable clinical and safety restrictions' include a facility's policies, procedures, or practices that protect the health and security of all residents and staff. These may include, but are not limited to. Denying access or providing limited and supervised access to an individual if that individual is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation had been completed or has been found to be abusing, exploiting, or coercing a resident. Denying access to individuals who have been found to have been committing criminal acts such as theft; Denying access to individuals who are inebriated or disruptive; or Denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility which places residents' health and safety at risk. Review of the facility-provided policy LTC - Visitation Rights of Residents, last reviewed 3/11/26, revealed: The resident has the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable.With respect to any restrictions on (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in May 2026. When asked what she did about this concern, the DON stated they talked to Resident #4 about not giving Friend #18 his/her money. When asked what she had done to protect the resident, the DON stated they were going to try and get Resident #4 a conservator and that the Social Worker was working on it. The DON stated they did not stop the resident from going out with Friend #18 because it was his/her right to do so. During an interview on 7/28/26 at 3:19 PM, when asked if the facility protected the resident by restricting Friend #18's contact with Resident #4, the Administrator stated they had not done this because it was a resident right to allow Resident #4 to visit with whom he/she wanted. When asked if the Administrator was aware of the regulatory obligation to have written policies and procedures regarding reasonable restrictions or limitations for safety restrictions, particularly with suspected abuse like misappropriation of resident property, the Administrator stated she was not aware of this. Review of Resident #4's leave-of-absence log, dated 12/29/25 through 7/20/26, showed that Friend #18 took Resident #4 from the facility 25 times, with 11 of those absences taking place from May on after leadership identified a potential abuse concern. At the time of survey, there were no restrictions from Friend #18 taking Resident #4 from the facility. A review of Resident #4's progress notes, dated 1/29/26 to 7/24/26, revealed multiple documented events where Friend #18 had unrestricted access to Resident #4's bank account that was not addressed by the facility: - 1/29/26 at 6:02PM (Late Entry) - Elder made a phone call to [his/her] friend [#18] and told [him/her] over the telephone 'Hey, I have \$51.00 dollars in my bank account, come up and get my bank card and go to AC and get the money.' - 1/29/26 at 7:39 PM - Elder contacted friend [#18] to retrieve their bank card for the purpose of withdrawing funds. Elder stated friend needed money and it was [his/her] choice. Supervisor made aware due to potential concerns for financial vulnerability. - 1/29/26 at 7:42 PM (Late Entry) - Elder friend [#18] came to facility at this time and retrieved elders bank card and pack of cigarettes then left facility with those items. Supervisor made aware. - 1/30/26 at 5:38 PM - Elders friend [#18] returned to facility to supposedly return bank card. When nurse asked elder for [his/her] bank card to lock up safely [he/she] said 'I don't have it. [He/she] did not give it back to me.' This nurse checked [his/her] room for the bank card and did not find it. Elder stated [he/she] said [he/she] would be back.' - 1/31/26 at 8:39 PM - Elder called friend [#18] to return bank card. [Friend #18] arrived with a friend. Returned bank card at this time also gave elder \$100 in cash. Elder then mentioned [he/she] wanted to give [Friend #18] \$20.00 [Friend #18] refused and left the facility. This writer and two staff CNA [Certified Nursing Assistant] present. Bankcard and money placed in elder purse in facility safety area. - 2/8/26 at 5:34 AM - Elder used phone to call friend [#18] Elder stated 'come here, go to the bank and get my money then go buy yourself cigarettes.' Elder hung up the phone walked over to the dining area for breakfast. - 3/9/26 at 8:07 PM - Elder received a visit from a friend identified as [Friend #18]. Elder voluntarily provided [Friend #18] with a shopping list, debit card, and associated PIN to facilitate a purchase. Per Elder, [Friend #18] is expected to return the purchased items and the bank card this evening. - 3/9/26 at 8:41 PM - [Friend #18] returned with purchased items and elder's debit card. Debit card and \$26 in cash locked away in elder's wallet per protocol. - 4/8/26 at 6:41 PM - Elder left facility with friend [#18] due to return later this evening. Educated friend [#18] on being responsible of elder safety. Elder in stable condition. Elder and staff counted elders remaining balance in purse \$18 elder signed paper confirming. Supervisor aware. - 4/8/26 at 8:20 PM - Elder returned from outing escorted by friend [#18]. Elder now has a balance of \$0 in cash. Elder returned in stable condition. - 5/3/26 at 9:03 PM - Elder returned from outing with friend [#18]. Elder left with \$120 returned with \$30.30 and a receipt from bank of a withdrawal \$70.00. Remaining balance in bank \$4. Elder signed paper understanding. - 5/12/26 at 9:06 PM - Elder returned back from outing with [Friend #18]. Elder seems (continued on next page)		

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	under the influence. Barely able to stand up periodically. Elder stated that [he/she] was high and that [he/she] smoked while out. Stumbling. Elder unable to walk to room/Elder had to be assisted to room with rolling chair by cna. Elder came back with \$0.00 cash. Elder stated [he/she] spent all of [his/her] money while out. Will continue to monitor and provide support as needed. - 6/3/26 at 5:28 PM - Elder left out of the facility with friend [#18]. Elder left with purse containing ID, bank card, keys and \$10.82 in cash. - 6/28/26 at 5:30 PM - Elder went out with [Friend #18], [he/she] wanted to get out and get some fresh air and a pizza. - 6/29/26 at 8:13 PM - Elder return from outing with friend [#18]. Elder has \$10.89c [cash] 2 bank cards and ID. Elder in stable condition. - 6/30/26 at 8:46 PM - Elder returned from outing w/ [with] friend [#18]. Elder returned with \$26.00 two bank cards and ID. Elder in stable condition.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**.Based on record review and interview, the facility failed to: 1) Report an allegation of abuse to the State Agency as required under CFR 483.12(c)(1). Specifically, the facility did not report suspected misappropriation of resident property for 1 Resident (#4), out of 1 resident reviewed, when first identified in January 2026; and 2) Develop and implement an accurate reporting policy for allegations of abuse that aligned with regulatory requirements. Not reporting a concern for abuse in an appropriate and timely manner subjected Resident #4 to continued misappropriation of resident property and financial insecurity causing the resident to not have money when needed, a bank overdraft, and seizure of a social security check by the bank causing the resident to be without money in May 2026 and June 2026. Not having accurate reporting requirements within their policy placed all residents (based on a census of 18) at risk for exposure to abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. Findings:1) Resident #4 Record review on 7/23-29/26 revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia, such as hallucinations and delusions, and mood disorder symptoms, such as depression) and the diagnosis other symptoms and signs involving cognitive functions and awareness (a billable code used to document cognitive symptoms that do not fit into a more specific neurological or psychiatric diagnosis). Review of Resident #4's Pre-admission Screening and Resident Review (PASRR - A federally required assessment to ensure individuals with serious mental illness or intellectual disabilities meet requirements to be admitted to a nursing home and have appropriate mental health services if needed) level II assessment, dated 6/10/26, revealed: .the individual carries a documented history of schizoaffective disorder, grave disability, moderate cognitive impairment, unspecified depression, dementia, and cerebral ischemia [insufficient blood flow to the brain]. [He/she] has been identified as being at risk for acute safety concerns. The individual acknowledged some degree of memory difficulty and recognized that [he/she] would be unable to care for [himself/herself] outside the facility. During an interview on 7/23/26 at 3:01 PM, the Administrator stated Resident #4 had a friend (#18) who checked him/her out of the facility routinely. Friend #18 would take Resident #4 straight to the bank after leaving the facility and obtain money from Resident #4. The Administrator stated in May 2026, facility leadership identified a greater concern about this situation involving Resident #4 and Friend #18 after the resident's bank account became overdrawn and the resident had no money available for personal use. Then in June 2026, the resident's social security check was seized by the bank to cover these delinquent funds. When asked if the leadership would classify this concern as misappropriation of resident property, the Administrator described the concern as financial abuse. When asked what the facility did once this concern escalated to potential abuse, the Administrator stated they talked to Friend #18 several times to stop taking Resident #4's money, but he/she would counter, saying the resident gave it to him/her. The leadership also talked to Resident #4 about not giving Friend #18 money, however he/she would say Friend #18 asked for it and he/she has helped me out in the past. They have also encouraged Resident #4 to keep his/her bank card in the facility when he/she left with Friend #18, but the resident sometimes didn't. The leadership would like to get Resident #4 a conservator because they felt Resident #4 needed assistance with finances. When asked if this had been initiated, the Administrator stated it had not happened at this time. The Administrator stated Friend #18 was (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	told he/she needed to stop taking Resident #4's money in June 2026 and warned the friend they would report it if it didn't stop, but thus far the facility had not reported the concern. When asked if the Administrator was a mandated reporter, the Administrator stated she was. When asked why she did not report this concern, the Administrator stated she did not report because Resident #4 stated he/she felt Friend #18 wasn't taking advantage of him/her. During an interview on 7/28/26 at 11:41 AM, the Social Worker stated that she believed Friend #18 was manipulating Resident #4 to take his/her money. When asked how long she has had this concern, the Social Worker stated shortly after the Resident's December 2025 admission, sometime in January or February 2026. When asked what she did about this concern to protect the resident, the Social Worker stated she talked to the Administrator about it and also talked to Resident #4. Also, the Social Worker wanted to petition to get a conservator for Resident #4 but had not done this yet. When asked if she was a mandated reporter, the Social Worker stated she was. When asked if she reported this concern, the Social Worker stated she did not because she didn't feel there was anything to report. During an interview on 7/28/26 at 1:22 PM, the Director of Nursing (DON) stated staff suspected Friend #18 was taking resident #4's money in May 2026. When asked what she did about this concern, the DON stated they talked to Resident #4 about not giving Friend #18 his/her money. When asked what she had done to protect the resident, the DON stated they were going to try and get Resident #4 a conservator and that the Social Worker was working on it. When asked if she was a mandated reporter, the DON stated she was. When asked why she did not report this concern, the DON stated because Resident #4 was giving Friend #18 the money. Review of Resident #4's leave-of-absence log, dated 12/29/25 through 7/20/26, showed that Friend #18 took Resident #4 from the facility 25 times, with 11 of those absences taking place from May through July, after leadership identified a potential abuse concern. At the time of survey, there were no restrictions from Friend #18 taking Resident #4 from the facility. A review of Resident #4's progress notes, dated 1/29/26 to 7/24/26, revealed multiple documented events where Friend #18 had unrestricted access to Resident #4's bank account that was not addressed by the facility: - 1/29/26 at 6:02PM (Late Entry) - Elder made a phone call to [his/her] friend [#18] and told [him/her] over the telephone 'Hey, I have \$51.00 dollars in my bank account, come up and get my bank card and go to AC and get the money.' - 1/29/26 at 7:39 PM - Elder contacted friend [#18] to retrieve their bank card for the purpose of withdrawing funds. Elder stated friend needed money and it was [his/her] choice. Supervisor made aware due to potential concerns for financial vulnerability. - 1/29/26 at 7:42 PM (Late Entry) - Elder friend [#18] came to facility at this time and retrieved elders bank card and pack of cigarettes then left facility with those items. Supervisor made aware. - 1/30/26 at 5:38 PM - Elders friend [#18] returned to facility to supposedly return bank card. When nurse asked elder for [his/her] bank card to lock up safely [he/she] said 'I don't have it. [He/she] did not give it back to me.' This nurse checked [his/her] room for the bank card and did not find it. Elder stated [he/she] said [he/she] would be back.' - 1/31/26 at 8:39 PM - Elder called friend [#18] to return bank card. [Friend #18] arrived with a friend. Returned bank card at this time also gave elder \$100 in cash. Elder then mentioned [he/she] wanted to give [Friend #18] \$20.00 [Friend #18] refused and left the facility. This writer and two staff CNA [Certified Nursing Assistant] present. Bankcard and money placed in elder purse in facility safety area. - 2/8/26 at 5:34 AM - Elder used phone to call friend [#18] Elder stated 'come here, go to the bank and get my money then go buy yourself cigarettes.' Elder hung up the phone walked over to the dining area for breakfast. - 3/9/26 at 8:07 PM - Elder received a visit from a friend identified as [Friend #18]. Elder voluntarily provided [Friend #18] with a shopping list, debit card, and associated PIN to facilitate a purchase. Per Elder, [Friend #18] is expected to return the purchased items and the bank card this evening. - (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/9/26 at 8:41 PM - [Friend #18] returned with purchased items and elder's debit card. Debit card and \$26 in cash locked away in elder's wallet per protocol. - 4/8/26 at 6:41 PM - Elder left facility with friend [#18] due to return later this evening. Educated friend [#18] on being responsible of elder safety. Elder in stable condition. Elder and staff counted elders remaining balance in purse \$18 elder signed paper confirming. Supervisor aware. - 4/8/26 at 8:20 PM - Elder returned from outing escorted by friend [#18]. Elder now has a balance of \$0 in cash. Elder returned in stable condition. - 5/3/26 at 9:03 PM - Elder returned from outing with friend [#18]. Elder left with \$120 returned with \$30.30 and a receipt from bank of a withdrawal \$70.00. Remaining balance in bank \$4. Elder signed paper understanding. - 5/12/26 at 9:06 PM - Elder returned back from outing with [Friend #18]. Elder seems under the influence. Barely able to stand up periodically. Elder stated that [he/she] was high and that [he/she] smoked while out. Stumbling. Elder unable to walk to room/Elder had to be assisted to room with rolling chair by cna. Elder came back with \$0.00 cash. Elder stated [he/she] spent all of [his/her] money while out. Will continue to monitor and provide support as needed. - 6/3/26 at 5:28 PM - Elder left out of the facility with friend [#18]. Elder left with purse containing ID, bank card, keys and \$10.82 in cash. - 6/28/26 at 5:30 PM - Elder went out with [Friend #18], [he/she] wanted to get out and get some fresh air and a pizza. - 6/29/26 at 8:13 PM - Elder return from outing with friend [#18]. Elder has \$10.89c [cents] 2 bank cards and ID. Elder in stable condition. - 6/30/26 at 8:46 PM - Elder returned from outing w/ [with] friend [#18]. Elder returned with \$26.00 two bank cards and ID. Elder in stable condition. 2) Facility's Reporting Abuse Policy Procedures Review of State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 232; Issued 7/23/25, revealed the Code of Federal Regulations (CFR) 483.12(b) and (c) addressed the reporting requirements for LTC facilities when allegations of abuse are reported: - CFR 483.12(b): The facility must develop and implement written policies and procedures that: - CFR 483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: - 483.12(c)(1): Ensure that all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, - or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the facility-provided policy LTC - Abuse Prevention, Identification, Investigation, Reporting and Protection, last reviewed 3/11/26, revealed: . Types of Abuse. Abuse is defined as. Misappropriation of residents property is defined as the illegal or improper use of a resident's resources for the personal profit or gain of another person; or borrowing resident funds; or spending resident funds without the resident's consent; or if the resident is not capable of consenting; or spending resident funds to acquire items for use in common areas when such purchase is not initiated by the resident. Further review of the policy revealed: .Investigation. Any staff member observing or receiving a report of misappropriation will immediately notify their supervisor and the administrator. Confirmation of misappropriation of resident property and physician or sexual abuse will be reported to law enforcement by Administrative personnel. Allegations of abuse or neglect will be reported within 24 hours to appropriate state survey agency by the administrator and/or his designee. Results of the investigation will be reported to the state survey agency within 5 days after initial reporting. Reporting. The following are required by law to report abuse or suspected abuse. Licensed practical nurse or registered nurse. Caregiver of a (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	vulnerable adult. Social Worker. Administrator of a nursing home, residential care, or health care facility. If, in the performance of their duties, any of the above have cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect a report shall be made no later than 24 hours after first having cause for the belief to the departments central information and referral services for vulnerable adults. The policy's verbiage did not align with CFR 483.12(c) and 483.12(c)(1) regulatory requirements to report allegations of abuse, neglect, exploitation or mistreatment immediately, but no later than two hours after the allegation was made. The Reporting section of the facility's policy directed staff to report concerns to the department's central information and referral services for vulnerable adults; however, the policy did not clearly identify the State Survey Agency or Adult Protective Services to which allegations of abuse were to be reported, resulting in an incomplete reporting protocol		

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NAME OF PROVIDER OR SUPPLIER Utuqqanaat Inaat		STREET ADDRESS, CITY, STATE, ZIP CODE 436 Mission Street Kotzebue, AK 99752	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**.Based on record review and interview, the facility failed to: 1) provide 1 resident (#12), out of 1 resident reviewed, with a written notice of transfer/discharge at least 30 days prior to the transfer or discharge in a language and manner they understand to include the reason for the transfer or discharge and the resident's appeal rights, including information on how to obtain an appeal form and assistance with completing and submitting an appeal hearing request; 2) provide the resident's written notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman (OLTCO) and to accurately report to the OLTCO where the resident discharged to; and 3) Develop and implement an accurate transfer/discharge policy regarding notification of transfer/discharge that aligned with regulatory requirements. This failed practice denied the resident his/her right to receive the notice and know of his/her right to understand and exercise the right to appeal the transfer or discharge decision. Findings:1) Resident #12 Record review on 7/23-29/26 revealed resident #12 was admitted on [DATE] with diagnoses that include; major depressive disorder, history of falling, hypertension (high blood pressure), hyperlipidemia (high cholesterol), urinary incontinence, anemia, benign prostatic hyperplasia (enlarged prostate). Further review revealed Resident #12 discharged from the facility on 2/27/26. Review of Resident #12's Care Conference Summary, dated 2/16/26, which was the resident's discharge conference, revealed: . Resident Goals of Care: safe discharge planning . Risks/Needs/Preferences/Strengths: Doesn't want to leave . Discharge Plan/Return to Community Referral: Safe discharge to the community . Special Requests/Choices/Conditions: wants to stay longer, however doesn't meet criteria . Elder refused to have assistance [with] filling out applications for housing. Staff will continue to offer assistance [with] safe discharge planning . Elder asked staff to [lie] on authorization so [he/she] can stay longer . Further review of Resident #12's medical record revealed: 1) no discharge planning progress notes; and 2) one hand-written discharge summary prepared by the DON and signed by Provider #7. There was no discharge order. Review of Resident #12's medical record revealed no notification of discharge paperwork. Review of Resident #12's Discharge Summary, handwritten note, dated 2/27/26, revealed: . Brief History: [AGE] year old [male/female] admitted for endurance and strength training. [which was not an accurate representation for why he/she was admitted] Pertinent Physical and Laboratory Findings: Improvement in ADL status. Improvement in labs. Does not meet requirements for long term care . Further review revealed no documentation as to why the resident was being discharged or where Resident #12 discharged to. During an interview on 7/29/26 at 8:21 AM, the Administrator stated Resident #12's admission intent was to stay long-term, he/she wasn't admitted strictly for rehab services, and there was no documentation to support why this resident was discharged from the facility. The medical record revealed no other provider notes documenting the reason for the resident's discharge, where he was discharging to, or disposition at discharge. During an interview on 7/23/26 at 3:01 PM, the Administrator stated resident came to the facility very weak but barely met admission standards. The resident was only approved for 85 days of stay. When asked about Resident's discharge, the Administrator stated the Resident was very evasive with any kind of discharge planning. Attempts to work with the resident on senior housing applications were attempted but the resident refused. When asked if there was documentation for these attempts and the resident's refusals, the Administrator stated there was none. When asked about the resident's original housing situation, the Administrator stated he/she couch surfed from house to house. When asked (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	why Resident #12 was discharged , the Administrator stated he/she met PT (Physical Therapy) goals, didn't participate in the program, and the resident left daily to go out into the community. The Administrator stated he/she was only approved for 85 days, and it was very hard to get those days approved. When asked if an attempt was made to get more days authorized for the resident, the Administrator stated she was told by the past Administrator, who completed the LTC authorizations, the resident would not qualify, so no. When asked if the resident was admitted for rehab, the Administrator stated, No. When asked if it was the resident's right to not participate in the program and go out into the community, the Administrator stated it was the resident's right to do so. The Administrator could not state why the resident was discharged from the facility other than the resident was only approved for 85 days. The Administrator agreed that every resident was only authorized for a limited number of days and re-authorizations were completed on every resident routinely. The Administrator could not state why Resident #12 was not offered the same opportunity. During the survey, leadership confirmed there was no discharge planning documentation, no notification of discharge given, and no way of knowing where Resident #12 was going when he/she left the facility. Review of the facility's discharge notification faxed to the LTC Ombudsman's Office, dated 3/5/26, revealed Resident #12 D/C [discharged] to home on 2/27/26. When leadership was asked about this, they acknowledged the resident didn't discharge to his/her home and that they couldn't identify where he/she went after leaving the facility. During an interview on 7/28/26 at 11:41 AM, the Social Worker stated she was an LPN and had no degree or license as a Social Worker. She stated she completed a 10-hour online course and started working with no training. The Social Worker stated she was still learning the role. When asked about Resident #12's discharge, and if a notification of discharge was provided to the Resident, the Social Worker stated she didn't know what that was. When asked about discharge planning, the Social Worker stated about two or three weeks prior to discharge she approached the resident to discuss where he/she was going, what the resident was going to do, and what his/her discharge would look like. She attempted to review housing applications with the resident, but he/she refused. He/she was also banned from one of them for past behavior. When asked if there was any documentation on any of these discussions or attempts to complete housing applications, the Social Worker stated there was not. When asked if Resident #12's authorization for admission was attempted to be extended, the Social Worker stated she was told by the past Administrator Resident #12 would not re-qualify, so there was no re-authorization attempted. When asked how she ensured Resident #12 was safely discharged , the Social Worker stated they completed a discharge care conference, but the resident would not give any information. When asked if she implemented the facility's Transfer and Discharge policy (of documenting discharge planning and notification), the Social Worker stated she thinks she read the policy but didn't know the content and stated there was little to no training for the Social Worker role. During an interview on 7/28/26 at 1:22 PM, when asked if she could assure staff accurately completed the discharge process for Resident #12, the DON stated, No. The DON stated the Resident's discharge should have been an AMA (against medical advice) but was not. The DON stated she did not see any documentation to show the resident was notified of discharge and was not aware of the regulatory requirement to notify the resident in writing or give residents appeal rights. During an interview on 7/28/26 at 2:30 PM, Provider #7 stated he was the Medical Director for the long-term care and oversaw the medical care for the residents. When asked about Resident #12's admission and care, Provider #7 stated he had rounded on Resident #12's care a couple of times and remembered him/her to be overall stable. Resident #12 was his/her own decision maker, and he/she required one-person assist with bathing, toileting, and dressing. Resident #12 was also incontinent. When asked how he determined what level (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of assistance a resident would need with ADLs, Provider #7 stated he would ask the nurses while rounding. When asked about Resident #12's discharge on [DATE], Provider #7 stated he was informed that it was a planned discharge and did talk with Resident #12 prior to him/her leaving. Provider #7 stated he didn't have a concern with Resident #12's home environment. When asked if Resident #12 had a home, Provider #7 stated he could not elaborate on that. Provider #7 stated he didn't get an understanding of where Resident #12 was going and did not ask where he was being discharged to. When asked Provider #7 documented a provider discharge summary note for Resident #12, Provider #7 stated he usually completed a discharge summary note for residents discharging but did not do one for Resident #12. Review of Resident #12's progress note, dated 2/25/26, revealed: Elder stated, 'I only have two days left here maybe I will fall down and break my hip so I can stay longer' Resident redirected and educated on importance of safety and preventing injury. Staff alerted to provide frequent checks on elder . During an interview on 7/28/26 at 3:19 PM, when asked if there was adequate documentation within the medical record to show the resident's discharge was properly handled, the Administrator stated, No. When asked if the resident was given a notification of discharge, the Administrator stated the facility did not have a notification of discharge form, and it was normally completed verbally. When asked if the resident was given rights to appeal information, the Administrator stated, No. During an interview on 7/29/26 at 11:44 AM, when asked how his/her discharge occurred, Resident #12 stated he was told on Friday, 2/27/26, you are leaving this weekend, pack all your stuff. Resident #12 stated he/she asked for more days to prepare where he/she would go, because he/she had no plan, but staff were adamant I had to leave. Resident #12 stated he/she told them he/she would have liked to have stayed at the facility but they made up their mind [that he/she had to leave]. When asked how it felt knowing he/she had to discharge, Resident #12 got emotional, his/her voice cracked and said, not wanted. When asked how leaving without a plan affected him/her, Resident #12 stated, there I was outside, I didn't have enough money, and it was wintertime. Resident #12 stated he/she had no idea where he/she was going to go. He/she started staying with friends, but it wasn't a place to stay long because they were drinking and he/she didn't feel safe in those situations. When asked if staff helped to try and find Resident #12 a place to go once discharged , Resident #12 stated the discussion about housing never happened. The staff just told him/her to gather his/her stuff, place it at the door, and leave. Staff told Resident #12 he/she could come back to get his/her belongings when he/she found a place to stay. During the course of the survey, leadership was not able to adequately show proof of an appropriate discharge or prove they provided a safe discharge. They did not notify the resident of discharge or his/her rights to appeal. 2) Facility's Transfer/Discharge Policy Notification Procedures Review of the facility-provided policy Transfer or Discharge, last reviewed 1/23/26, revealed: - . ADDITIONAL CONSIDERATION(S): A. Notice to Patient of Intent to Transfer or discharge: 1. The transfer notice is to include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State Long Term Care Ombudsman: To be completed by Social Service Director in Long Term Care. Office of Long Term Care Ombudsman 3745 Community Park Loop, Suite 200 Anchorage, Alaska 99508 Local - (907) [PHONE NUMBER] Fax - (907) [PHONE NUMBER] Toll Free - (800) [PHONE NUMBER] 2. Prior to transferring or discharging a patient, Utuqqanaat Inaat will notify the patient and/or their representative of the intent to transfer or discharge, and the reason for such action. 3. Discharge planning will ensure that the patient has sufficient preparation and education to enable them to safely leave the facility . Further review of the policy revealed it did not include the regulatory requirement to: 1) Provide the notice of transfer/discharge at least 30 days prior to the transfer or discharge; or the notice must be made as soon as practicable before transfer or discharge (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when: (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or(E) A resident has not resided in the facility for 30 days. 2) Include a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request per CFR 483.15(c)(5)(iv); and 3) For nursing facility residents with intellectual or developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.) per CFR 483.15(c)(5)(vi); and 4) For nursing facility residents with a mental disorder or related disabilities, the mailing address and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act per CFR 483.15(c)(5)(vii)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure 1 resident (#12), out of 1 resident reviewed for care planning, was afforded the opportunity to participate in the development and implementation of his/her person-centered plan of care. This failed practice deprived the resident of the opportunity to participate in care planning and provide input regarding his/her needs, goals, choices, and preferences. Findings:Record review on 7/23 - 29/26 revealed Resident #12 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, history of falling, primary hypertension (high blood pressure), hyperlipidemia (high cholesterol), urinary incontinence, anemia, benign prostatic hyperplasia (enlarged prostate), and lower back pain. Further review revealed Resident #12 was discharged from the facility on 2/27/26. Review of Resident #12's medical record revealed no admission paperwork to include: 1) consent for treatment; 2) admission Agreement; 3) Explanation of Charges; 4) Acknowledgement of receiving the Resident Rights; and 5) Acknowledgement of receiving the Resident Handbook. Review of Resident #12's most recent admission MDS (Minimum Data Set - a federally required nursing assessment), dated 12/22/25, revealed the Resident was coded as having clear speech, was able to make self-understood, understood others, and had a brief interview for mental status (BIMS - a cognitive screening tool used to assess memory and thinking) of 14 (on a scale of 00 to 15, which indicated a normal cognitive level with no impairments). Review of Resident #12's medical record revealed only one care conference meeting note, dated 2/16/26, which was the resident's discharge care conference. Further review revealed no initial care conference meeting was documented, nor any other progress notes or interdisciplinary notes to indicate Resident #12 was involved in his/her planning of care while at the facility. During an interview on 7/28/26 at 3:19 PM, the Administrator stated that leadership was unable to provide Resident #12's admission paperwork that included: 1) consent for treatment; 2) admission Agreement; 3) Explanation of Charges; 4) Acknowledgement of receiving the Resident Rights; and 5) Acknowledgement of receiving the Resident Handbook. The Administrator further stated there were no other care conferences held for Resident #12 during his/her admission. The Administrator stated there was usually an initial admission care conference held around the time of a resident's admission, but Resident #12 did not have one completed. During an interview on 7/29/26 at 11:44 AM, Resident #12 stated he/she didn't recall attending or being invited to attend care conference meetings. Review of the facility-provided Residents Rights and Facility Responsibilities, undated and which was supposed to be offered upon admission, revealed: . Each resident has the right to be informed of, and participate in his or her treatment including: to be fully informed in advance about changes to the plan of care; the right to be informed in advance of the care to be furnished and the type of care giver or professional that will furnish [care]. Review of the facility-provided policy LTC -Quarterly MDS/Care Plan Review, last reviewed 4/7/26, revealed: Residents will have a CMS standardized clinical assessment no less frequently than quarterly. This will be done through the RAI process. This quarterly review is to ensure the care plan is reflective of the resident's current needs and also identify if there have been significant changes in the resident's condition which may warrant a more comprehensive assessment. The care plan will be reviewed at least every 92 days with revisions made as needed. The resident/responsible party will be invited to participate in the scheduled care conference.		

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. .Based on record review and interview, the facility failed to ensure 1 resident (#12), out of 1 resident reviewed, was informed, orally and in writing, of the resident's rights upon admission. The facility was unable to demonstrate that the resident received the required notice of resident rights and services or that receipt of the information was acknowledged in writing. This failed practice had the potential to affect Resident #12's awareness of the resident's rights and responsibilities during the stay in the facility. Findings:A review of the facility's admission packet (a packet of documents to review and/or sign upon admission) revealed the document Resident Rights and Facility Responsibilities, undated, which revealed: . Each resident has the right to be informed, both orally and in writing (including Braille) in a language that the resident understands of his/her rights and all the rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. Further review revealed the facility's admission packet contained a Resident Rights acknowledgment form requiring the resident's signature to document that the rights were read or explained to the resident: I have read the Resident's Rights and Facility Responsibilities or had them read to me. I fully understand them and have no questions at this time. I understand that I can ask questions later as well. Resident #12's medical record revealed no completed acknowledgement of resident rights. There was no documentation that Resident #12 acknowledged receipt of these resident rights by signature, no acknowledgement the resident rights were provided orally to him/her, or a note stating resident understood/acknowledged these rights. During an interview on 7/28/26 at 3:19 PM, the Administrator stated that leadership was unable to locate Resident #12's admission paperwork that included: 1) Acknowledgement of receiving the Resident Rights; and 2) Acknowledgement of receiving the Resident Handbook		

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. .Based on record review and interview, the facility failed to ensure 1 resident (#12), out of 1 Medicaid eligible resident reviewed, was informed in writing, at the time of admission or when the resident became eligible for Medicaid, of the items and services included under the State Medicaid plan for which the resident could not be charged and those items and services offered by the facility for which the resident could be charged, including the amount of those charges. This failed practice had the potential for Resident #12 to incur charges without being informed which items and services were covered under Medicaid and which items and services could result in out of pocket costs. Findings:A review of the facility's admission packet (a packet of documents to review and/or sign upon admission) revealed: 1) A Consent to Treat signature page which documented: This Consent to Treat is made between the following parties: Utuqqanaat Inaat and. Resident. The Facility shall admit and provide the services specified herein to the Resident until the date of the Resident's discharge. Additional Terms and Conditions are included in the admission Packet to follow. 2) An admission Agreement which documented: . Acknowledgements. Before signing, the undersigned acknowledge they have received and read this Agreement in its entirety, and have received the following information. Explanation of charges, providing a list of what items and services are not included in the private Daily room charge, Medicare benefits or any other applicable programs; and 3) An Explanation of Charges document which indicated items and services covered in the daily room rate, as well as other items and services offered by the facility which the resident may be charged out of pocket for. Review of Resident #12's medical record revealed there was no signed or dated consent for treatment; admission agreement; or explanation of charges in his/her record. During an interview on 7/28/26 at 3:19 PM, the Administrator stated that leadership was unable to locate Resident #12's admission paperwork that included: 1) Consent for Treatment; 2) admission Agreement; and 3) Explanation of Charges. During an interview on 7/28/26 at 1:22 PM, the Director of Nursing (DON), stated that he/she was responsible for ensuring all paperwork related to admissions were completed and acknowledged that adequate documentation was missing from Resident #12's chart. During an interview on 7/29/26 at 9:25 AM, the past Administrator stated he/she could not answer why resident #12 did not have any admission notices in his/her medical record chart		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to investigate an allegation of suspected financial abuse/exploitation involving 1 resident (#4), out of 1 resident reviewed, and failed to implement effective protective measures since January 2026 when concerns were first identified, and when allegations continued to occur unresolved. These failures allowed the suspected perpetrator continued access to Resident #4 and the resident's financial resources after facility leadership identified the concern. The facility's failure to investigate the allegation and implement effective protective measures allowed Friend #18 continued access to Resident #4 and his/her financial resources. Resident #4 subsequently experienced continued depletion of his/her personal funds, an overdrawn bank account, and loss of access to his/her Social Security payment when the bank applied the payment toward the delinquent balance. The financial losses interfered with Resident #4's ability to use his/her funds according to her expressed preferences, including his/her stated desire to save money for his/her grandchildren, and resulted in the resident borrowing money from a family member for his/her own personal needs. Findings:Record review on 7/23-29/26 revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia, such as hallucinations and delusions, and mood disorder symptoms, such as depression) and the diagnosis other symptoms and signs involving cognitive functions and awareness (a billable code used to document cognitive symptoms that do not fit into a more specific neurological or psychiatric diagnosis). Review of Resident #4's Pre-admission Screening and Resident Review (PASRR - A federally required assessment to ensure individuals with serious mental illness or intellectual disabilities meet requirements to be admitted to a nursing home and have appropriate mental health services if needed) level II assessment, dated 6/10/26, revealed: .the individual carries a documented history of schizoaffective disorder, grave disability, moderate cognitive impairment, unspecified depression, dementia, and cerebral ischemia [insufficient blood flow to the brain]. [He/she] has been identified as being at risk for acute safety concerns. The individual acknowledged some degree of memory difficulty and recognized that [he/she] would be unable to care for [himself/herself] outside the facility. During an interview on 7/23/26 at 3:01 PM, the Administrator stated Resident #4 had a friend (#18) who checked him/her out of the facility routinely. Friend #18 would take Resident #4 straight to the bank after leaving the facility and obtain money from Resident #4. The Administrator stated in May 2026, facility leadership identified a greater concern about this situation involving Resident #4 and Friend #18 after the resident's bank account became overdrawn. The Administrator further stated that Resident #4 .had no money to do what she wanted to do, which resulted in the Resident's inability to use personal funds according to his/her preferences. Then, in June 2026, the resident's Social Security check was seized by the bank to cover these delinquent funds. When asked if the leadership would classify this concern as misappropriation of resident property, the Administrator described the concern as financial abuse. When asked what the facility did once this concern escalated to potential abuse, the Administrator stated they talked to Friend #18 several times to stop taking Resident #4's money, but he/she would counter, saying the resident gave it to him/her. The leadership also talked to Resident #4 about not giving Friend #18 money, however he/she would say Friend #18 asked for it and he/she has helped me out in the past. They have also encouraged Resident #4 to keep his/her bank card in the facility when he/she left with Friend #18, but the resident sometimes didn't. The Administrator stated Resident #4 came out of his/her room at night (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	once reporting that Friend #18 had his/her bank card and hadn't returned it. When asked if anything else had been done, the Administrator stated nothing else had been done. The leadership would like to get Resident #4 a conservator because they felt Resident #4 needed assistance with finances. When asked if this had been initiated, the Administrator stated it had not happened at this time. When asked if an investigation was initiated to determine if this concern was ruled out or confirmed, the Administrator stated no investigation had occurred. During an interview on 7/23/26 at 4:18 PM, Resident #4 further stated he/she wasn't giving Friend #18 any more money because he/she wanted to save money to send to his/her grandchildren. Resident #4 stated he/she stopped giving money to Friend #18 a month ago, however this was not an accurate interpretation per staff interviews and ongoing concerns from leadership. During an interview on 7/28/26 at 11:41 AM, the Social Worker stated that she believed Friend #18 was manipulating Resident #4 to take his/her money. When asked how long she has had this concern, the Social Worker stated shortly after the Resident's December 2025 admission, sometime in January or February 2026. The Social Worker stated Resident #4 would leave with Friend #18 and return to the facility with small amounts of money remaining. In addition, purchased items and cash would be left a Friend #18's residents. Furthermore, the Social worker stated that the resident had to borrow money from a family member due to insufficient personal funds. During the same interview, when asked what she did about this concern to protect the resident, the Social Worker stated Resident #4 thought Social Security was taking her money when in fact her account was overdrawn. The Social Worker provided her awareness of the concern approximately in January or February 2026 with the Administrator, as well as spoke to Resident #4 about the concern. Also, the Social Worker wanted to petition to get a conservator for Resident #4 but had not done this yet. When asked if an investigation was initiated to determine if this concern was ruled out or confirmed, the Social Worker stated no investigation had occurred. During an interview on 7/28/26 at 1:22 PM, the Director of Nursing (DON) stated staff suspected Friend #18 was taking the resident's money in May 2026. When asked what she did about this concern, the DON stated they talked to Resident #4 about not giving Friend #18 his/her money. When asked what she had done to protect the resident, the DON stated they were going to try and get Resident #4 a conservator and that the Social Worker was working on it. When asked if an investigation was initiated to determine if this concern was ruled out or confirmed, the DON stated no investigation had occurred. During an interview on 7/28/26 at 4:35 PM, Certified Nursing Assistant (CNA) #12 stated the resident would continue to leave with Friend #18 and come back with no money. CNA #12 further stated he/she raised the concern of financial misappropriation with the Social Worker and considered the situation a form of abuse. During an interview on 7/28/26 at 4:51 pm, License Nurse (LN) #27 stated due to Resident #4's cognitive deficits, he/she was concerned about the resident's finances. He/she stated he/she would help count the Resident's money after being out with Friend #18 and always came back with significantly less personal funds due to concerns that Friend #18 was manipulating his/her for money. During an interview on 7/28/26 at 4:59 pm, CNA #10 stated he/she had concerns about Resident #4 leaving with Friend #18 who would keep his/her bank card and staff having to contact Friend #18 to return it. During an interview on 7/28/26 at 5:22 PM, LN #14 stated Friend #18 came to the facility approximately once or twice each week and that concerns regarding Friend #18 and Resident #4's money were frequently discussed among staff. The LN stated he/she heard Friend #18 asking for money from Resident #4 to pay utility bills. Resident #4 responded to Friend #18, I get paid tomorrow, come get me and we'll pay your electricity bill. Review of Resident #4's leave-of-absence log, dated 12/29/25 through 7/20/26, showed that Friend #18 took Resident #4 from the facility 25 times, with 11 of those absences taking place from May through July after leadership identified a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Utuqqanaat Inaat		STREET ADDRESS, CITY, STATE, ZIP CODE 436 Mission Street Kotzebue, AK 99752	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential abuse concern. At the time of survey, there were no restrictions from Friend #18 taking Resident #4 from the facility. A review of Resident #4's progress notes, dated 1/29/26 to 7/24/26, revealed multiple documented events where Friend #18 had unrestricted access to Resident #4's bank account that was not addressed by the facility: - 1/29/26 at 6:02 PM (Late Entry) - Elder made a phone call to [his/her] friend [#18] and told [him/her] over the telephone 'Hey, I have \$51.00 dollars in my bank account, come up and get my bank card and go to AC and get the money.' - 1/29/26 at 7:39 PM - Elder contacted friend [#18] to retrieve their bank card for the purpose of withdrawing funds. Elder stated friend needed money and it was [his/her] choice. Supervisor made aware due to potential concerns for financial vulnerability. - 1/29/26 at 7:42 PM (Late Entry) - Elder friend [#18] came to facility at this time and retrieved elders bank card and pack of cigarettes then left facility with those items. Supervisor made aware. - 1/30/26 at 5:38 PM - Elders friend [#18] returned to facility to supposedly return bank card. When nurse asked elder for [his/her] bank card to lock up safely [he/she] said 'I don't have it. [He/she] did not give it back to me.' This nurse checked [his/her] room for the bank card and did not find it. Elder stated [he/she] said [he/she] would be back.' - 1/31/26 at 8:39 PM - Elder called friend [#18] to return bank card. [Friend #18] arrived with a friend. Returned bank card at this time also gave elder \$100 in cash. Elder then mentioned [he/she] wanted to give [Friend #18] \$20.00 [Friend #18] refused and left the facility. This writer and two staff CNA [Certified Nursing Assistant] present. Bank card and money placed in elder purse in facility safety area. - 2/8/26 at 5:34 AM - Elder used phone to call friend [#18] Elder stated 'come here, go to the bank and get my money then go buy yourself cigarettes.' Elder hung up the phone walked over to the dining area for breakfast. - 3/9/26 at 8:07 PM - Elder received a visit from a friend identified as [Friend #18]. Elder voluntarily provided [Friend #18] with a shopping list, debit card, and associated PIN to facilitate a purchase. Per Elder, [Friend #18] is expected to return the purchased items and the bank card this evening. - 3/9/26 at 8:41 PM - [Friend #18] returned with purchased items and elder's debit card. Debit card and \$26 in cash locked away in elder's wallet per protocol. - 4/8/26 at 6:41 PM - Elder left facility with friend [#18] due to return later this evening. Educated friend [#18] on being responsible of elder safety. Elder in stable condition. Elder and staff counted elders remaining balance in purse \$18 elder signed paper confirming. Supervisor aware. - 4/8/26 at 8:20 PM - Elder returned from outing escorted by friend [#18]. Elder now has a balance of \$0 in cash. Elder returned in stable condition. - 5/3/26 at 9:03 PM - Elder returned from outing with friend [#18]. Elder left with \$120 returned with \$30.30 and a receipt from bank of a withdrawal \$70.00. Remaining balance in bank \$4. Elder signed paper understanding. - 5/12/26 at 9:06 PM - Elder returned back from outing with [Friend #18]. Elder seems under the influence. Barely able to stand up periodically. Elder stated that [he/she] was high and that [he/she] smoked while out. Stumbling. Elder unable to walk to room/Elder had to be assisted to room with rolling chair by cna. Elder came back with \$0.00 cash. Elder stated [he/she] spent all of [his/her] money while out. Will continue to monitor and provide support as needed. - 6/3/26 at 5:28 PM - Elder left out of the facility with friend [#18]. Elder left with purse containing ID, bank card, keys and \$10.82 in cash. - 6/28/26 at 5:30 PM - Elder went out with [Friend #18], [he/she] wanted to get out and get some fresh air and a pizza. - 6/29/26 at 8:13 PM - Elder return from outing with friend [#18]. Elder has \$10.89c [cash] 2 bank cards and ID. Elder in stable condition. - 6/30/26 at 8:46 PM - Elder returned from outing w/ [with] friend [#18]. Elder returned with \$26.00 two bank cards and ID. Elder in stable condition. Review of the facility-provided policy LTC - Abuse Prevention, Identification, Investigation, Reporting and Protection, last reviewed 3/11/26, revealed: . Types of Abuse. Abuse is defined as. Misappropriation of residents property is defined as the illegal or improper use of a resident's resources for the personal profit or gain of (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another person; or borrowing resident funds; or spending resident funds without the resident's consent; or if the resident is not capable of consenting; or spending resident funds to acquire items for use in common areas when such purchase is not initiated by the resident. Further review of the policy revealed: .Investigation. Any staff member observing or receiving a report of misappropriation will immediately notify their supervisor and the administrator. Confirmation of misappropriation of resident property and physician or sexual abuse will be reported to law enforcement by Administrative personnel. Allegations of abuse or neglect will be reported within 24 hours to appropriate state survey agency by the administrator and/or his designee. Results of the investigation will be reported to the state survey agency within 5 days after initial reporting.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**.Based on record review, interview, and observation, the facility failed to implement an effective discharge planning process for 1 Resident (#12), out of 1 resident discharge reviewed, to include documentation of: 1) ongoing discharge planning goals throughout the resident's admission to include: a) identification of discharge needs and the development of a discharge plan; b) regular re-evaluation for need of possible modifications of the discharge plan; c) involvement of the interdisciplinary team in the ongoing process of developing the discharge plan; d) involvement of the resident in the development plan; and e) addressing the resident's goals of care and treatment preferences at discharge; 2) the basis and reason for discharge; and 3) sufficient preparation and orientation to ensure safe and orderly discharge. These failed practices resulted in Resident #12 leaving the facility without an established safe destination or adequate preparation to meet his/her ongoing care needs. Following discharge, Resident #12 experienced unstable and unsafe living conditions, inadequate access to food, two falls, including one that required ambulance assistance after the resident was unable to get up from the street, increased fear and depression, and worsening pain after losing assistance with medications and topical pain treatment. Resident #12 also reported that his/her weight decreased from approximately 165 pounds while residing at the facility to approximately 130 pounds following discharge, which the resident attributed to not having enough food. Findings:Resident #12 Record review on 7/23-29/26 revealed Resident #12 was admitted to the facility on [DATE] with diagnoses that included low back pain, major depressive disorder, history of falling, and unspecified urinary incontinence. Review of Resident #12's provider health and physical note, dated 11/18/25, revealed: . Physical for LTC [long term care] placement . [He/she] is seeking admission to long-term care due to [his/her] declining functional status and unsafe living conditions. The patient reports progressive difficulty with mobility over the past several years, now unable to walk and experiencing frequent falls. [He/she] describes [his/her] feet as being similar to [his/her] hands, with toes that cannot move or turn up, causing significant pain and contributing to instability . [His/her] fingers and toes are becoming claw-like and [he/she] stated it is hard to open medication bottles [on] [his/her] own and [to] self hygiene . [He/she] has fallen multiple times . The patient reports ongoing urinary incontinence . Function: Bathing, Dressing, Toileting, Transferring: 1 person assist -- high risk for falls .Review of systems. musculoskeletal: Positive for pain in feet and hands. Positive for inability to move toes. Positive for joint deformity in toes and fingers. Positive for muscle weakness. Positive for back pain. Positive for joint stiffness. Appearance. Patient is ambulating with a very wide based gait. [He/she] uses cane at all the time to prevent falls. Chronic pain behavior as usual. Oriented in time, place, person. Able to have a conversation with me and seem to understand my questions and answered them pretty well. Arthritis pain. Arthritis with hand and foot deformities, pain, and functional impairment; worsening toes contractures/hammer toes; contributing to falls and difficulty ambulating. Review of Resident #12's medical record revealed a Facility Verification Form, for admission, undated, revealed: We have information indicating that the person listed above is a patient in your facility. Before we can determine this person's eligibility for Medicaid or calculate their cost-of-care obligation, we need the following information: Date of admission: [DATE]. Expected length of stay . More than six months . Name of Facility: Utuqqanaat Inaat . Review of Resident #12's Long Term Care Facility Authorization Request, dated 11/20/25, revealed the request was completed for a new admission with an intended length of stay identified as Long Term Placement (more than 90 (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days). The authorization documented that Resident #12 required 24-hour supervision, one-person extensive assistance with activities of daily living (ADLs), meal preparation, chore services, medication administration, provisions for safety, and transportation. The authorization further documented that alternative community placement was not feasible or appropriate due to the lack of available community support services, the resident's skilled needs exceeding available community resources, and the absence of family to provide care. The documented discharge plan stated Resident #12 could only be transferred to a facility that provided 24-hour supervision and assistance due to the resident's complex medical and physical needs. Review of Resident #12's admission minimum data set assessment (MDS - a federally required nursing assessment), dated 12/22/25, revealed Resident #12 had a brief interview for mental status (BIMS - a cognitive screening tool used to assess memory and thinking) score of 14 (on a scale of 00 to 15, which indicated a normal cognitive level with no impairments). Further review revealed Resident #12 needed supervision/touch support (which indicated a helper was needed to provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activities and that assistance may have been needed throughout the activity or intermittently) for oral hygiene; upper body dressing; lower body dressing; putting on/taking off footwear; personal hygiene; chair/bed to chair transfer; toilet transfer; care transfer; and walking certain distances. Further review revealed Resident #12 needed partial/moderate assistance (which indicated a helper did less than half the effort. The helper lifted, held, or supported the resident's trunk or limbs, but provided less than half the effort) for toileting hygiene; shower/bathe self; and tub/shower transfer. The admission MDS assessment documented that Resident #12's weight upon admission was 147 lbs. During an interview on 7/23/26 at 3:01 PM, the Administrator stated resident came to the facility very weak but barely met admission standards. The resident was only approved for 85 days of stay. When asked about the Resident's discharge, the Administrator stated the Resident was very evasive with any kind of discharge planning. Attempts to work with the resident on senior housing applications were attempted but the resident refused. When asked if there was documentation for these attempts and the residents' refusals, the Administrator stated there was none. When asked about the resident's original housing situation, the Administrator stated he/she couch-surfed from house to house. When asked why Resident #12 was discharged, the Administrator stated he/she met PT (Physical Therapy) goals, didn't participate in the program, and the resident left daily to go out into the community. The Administrator stated he/she was only approved for 85 days, and it was very hard to get those days approved. When asked if an attempt was made to get more days authorized for the resident, the Administrator stated she was told by the past Administrator, who completed the LTC authorizations, the resident would not qualify, so no. When asked if the resident was admitted for rehab, the Administrator stated, No. When asked if it was the resident's right to not participate in the program and go out into the community, the Administrator stated it was the resident's right to do so. The Administrator could not state why the resident was discharged from the facility other than the resident was only approved for 85 days. The Administrator agreed that every resident was only authorized for a limited number of days and re-authorizations were completed on every resident routinely. The Administrator could not state why Resident #12 was not offered the same opportunity. Review of Resident #12's Primary Care Provider note, dated 2/12/26 and completed by Provider #7, revealed Resident #12 had diagnoses that included cerebellar ataxia, traumatic brain injury related to a fall in 2017, chronic pain, mild cognitive impairment, hypertension, recurrent falls, and progressive functional decline affecting multiple activities of daily living. The provider documented that Resident #12 continued to require one-person assistance with bathing, dressing, toileting, and transfers. Resident #12 was independent with feeding and remained (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent of urine, requiring the use of briefs. The provider note also documented ongoing evaluation and treatment for joint pain, rheumatoid arthritis, and significant right foot deformity and degenerative joint disease. Conservative treatment was recommended for the resident's foot condition. Review of Resident #12's medical record revealed no initial care conference meeting was documented, nor any other progress notes or interdisciplinary notes to indicate Resident #12 was involved his/her planning of care while at the facility. Review of Resident #12's one and only Care Conference Summary, dated 2/16/26, which was the resident's discharge conference, revealed: . Resident Goals of Care: safe discharge planning . Risks/Needs/Preferences/Strengths: Doesn't want to leave . Discharge Plan/Return to Community Referral: Safe discharge to the community . Special Requests/Choices/Conditions: wants to stay longer, however doesn't meet criteria . Elder refused to have assistance [with] filling out applications for housing. Staff will continue to offer assistance [with] safe discharge planning . Elder asked staff to [lie] on authorization so [he/she] can stay longer . Further review of Resident #12's medical record revealed: 1) no discharge planning progress notes; and 2) one hand-written discharge summary prepared by the DON and signed by Provider #7. There was no discharge order. Review of Resident #12's medical record revealed no notification of discharge paperwork. Review of Resident #12's Discharge Summary, handwritten note, dated 2/27/26, revealed: . Brief History: [AGE] year old [male/female] admitted for endurance and strength training. [which was not an accurate representation for why he/she was admitted] Pertinent Physical and Laboratory Findings: Improvement in ADL status. Improvement in labs. Does not meet requirements for long term care . Further review revealed no documentation as to why the resident was being discharged or where Resident #12 discharged to. Review of the facility's discharge notification faxed to the LTC Ombudsman's Office, dated 3/5/26, revealed Resident #12 D/C [discharged] to home on 2/27/26. When leadership was asked about this, they acknowledged the resident didn't discharge to his/her home and that they couldn't identify where he/she went after leaving the facility. During an interview on 7/28/26 at 11:41 AM, the Social Worker stated she was an LPN and had no degree or license as a Social Worker. She stated she completed a 10-hour online course and started working with no training. The Social Worker stated she was still learning the role. When asked about Resident #12's discharge, and if a notification of discharge was provided to the Resident, the Social Worker stated she didn't know what that was. When asked about discharge planning, the Social Worker stated about two or three weeks prior to discharge she approached the resident to discuss where he/she was going, what the resident was going to do, and what his/her discharge would look like. She attempted to review housing applications with the resident, but he/she refused. He/she was also banned from one of them for past behavior. When asked if there was any documentation on any of these discussions or attempts to complete housing applications, the Social Worker stated there was none. When asked if Resident #12's authorization for admission was attempted to be extended, the Social Worker stated she was told by the past Administrator that Resident #12 would not re-qualify, so there was no re-authorization that was attempted. When asked how she ensured Resident #12 was safely discharged , the Social Worker stated they completed a discharge care conference, but the resident would not give any information. When asked if she implemented the facility's Transfer and Discharge policy (of documenting discharge planning and notification), the Social Worker stated she thinks she read the policy but didn't know the content and stated there was little to no training for the Social Worker role. During an interview on 7/28/26 at 1:22 PM, when asked if she could assure staff accurately completed the discharge process for Resident #12, the DON stated, No. The DON stated the Resident's discharge should have been an AMA (against medical advice) but was not. The DON stated she did not see any documentation to show the resident (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified of discharge and was not aware of the regulatory requirement to notify the resident in writing or give residents appeal rights. During an interview on 7/28/26 at 2:30 PM, Provider #7 stated he was the Medical Director for the long-term care and oversaw the medical care for the residents. When asked about Resident #12's admission and care, Provider #7 stated he had rounded on Resident #12's care a couple of times and remembered him/her to be overall stable. Resident #12 was his/her own decision maker, and he/she required one-person assist with bathing, toileting, and dressing. Resident #12 was also incontinent. When asked how he determined what level of assistance a resident would need with ADLs, Provider #7 stated he would ask the nurses while rounding. When asked about Resident #12's discharge on [DATE], Provider #7 stated he was informed that it was a planned discharge and did talk with Resident #12 prior to him/her leaving. Provider #7 stated he didn't have a concern with Resident #12's home environment. When asked if Resident #12 had a home, Provider #7 stated he could not elaborate on that. Provider #7 stated he didn't get an understanding of where Resident #12 was going and did not ask where he was being discharged to. When asked whether Provider #7 documented a provider discharge summary note for Resident #12, Provider #7 stated he usually did complete a discharge summary note for the residents discharging but did not do one for Resident #12. During an interview on 7/28/26 at 3:19 PM, when asked if there was adequate documentation within the medical record to show the resident's discharge was properly handled, the Administrator stated, No. When asked if the resident was given a notification of discharge, the Administrator stated the facility did not have a notification of discharge form, and it was normally completed verbally. When asked if the resident was given rights to appeal information, the Administrator stated, No. During the survey, there was an identified inconsistency between care plan (which documented Resident #12 was fully independent in all ADLs), the MDS assessments (which documented Resident #12 needed supervision/touch assistance with some ADLs and partial/moderate assistance for some ADLs), and LTC provider notes (which documented one-person assist in all ADLs except feeding). During an interview on 7/28/26 at 3:19 PM, the Administrator acknowledged Resident #12 needed assistance in most ADLs and the care plan did not reflect that. The Administrator stated Provider #7 considered the need for ADLs assistance as a one-person assist. Review of Resident #12's progress note, dated 2/25/26, revealed: Elder stated, 'I only have two days left here maybe I will fall down and break my hip so I can stay longer' Resident redirected and educated on importance of safety and preventing injury. Staff alerted to provide frequent checks on elder . Review of Resident #12's discharge MDS, dated [DATE], revealed Resident #12 had a BIMS score decreased to 13 (which still indicated a normal cognitive level with no impairments). Further review revealed Resident #12 continued to need supervision/touch support for oral hygiene; upper body dressing; lower body dressing; putting on/taking off footwear; personal hygiene; chair/bed to chair transfer; toilet transfer; care transfer; and walking certain distances. Further review revealed Resident #12 needed for assistance with toileting hygiene; shower/bathe self; and tub/shower transfer was upgraded to supervision/touch support, however still needed that level of functional care. The discharge MDS assessment documented that Resident #12's weight upon discharge was 160 lbs. During an interview on 7/29/26 at 8:21 AM, the Administrator stated Resident #12's admission intent was to stay long-term, he/she wasn't admitted strictly for rehab services, and there was no documentation to support why this resident was discharged from the facility. The Administrator further stated there were no other care conferences held for Resident #12 during his/her admission. The Administrator stated there was usually an initial admission care conference held around the time of a resident's admission, but Resident #12 did not have one completed. The medical record revealed no other provider notes documenting the reason for the resident's discharge, (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	where he was discharging to, or disposition at discharge. During the course of the survey, the leadership confirmed there was no discharge planning documentation, no notification of discharge given, and no way of knowing where Resident #12 was going when he/she left the facility. During an interview on 7/29/26 at 9:25 AM, the past Administrator stated she was in charge of completing the initial authorizations and re-authorizations for the LTC residents. When asked about Resident #12's admission, the past Administrator stated she completed Resident #12's initial authorization for his/her admission. The past Administrator recalled Resident #12's cognitive status had only mild cognitive deficits. Resident #12's functional status needs were listed on the authorization. Resident #12 was approved for a 90-day stay, and he/she was admitted into the facility. At the time of admission, the past Administrator stated Resident #12 was more debilitated than he/she was in the past (as she knew him/her from the community). When asked about Resident #12's discharge, the past Administrator stated she recalled he/she went out into the community pretty much every day. So, because of this, she did voice her concerns to the nursing team that when it came to a reauthorization, the resident would not qualify for reauthorization due to his/her level of function. The past Administrator stated the facility would have resistance because his/her level of function was not as acute as when he/she was when admitted . When asked if a re-authorization was attempted for Resident #12, the past Administrator initially stated she submitted a re-authorization to extend the resident's stay, and they came back stating he/she didn't meet criteria. Because of this, the LTC staff informed him/her that he/she was denied a continued stay at the facility. The past Administrator stated the resident was not happy with that and Resident #12 relayed that he/she didn't want to leave the facility, but staff explained, he/she was denied to stay. When asked if going out into the community was a resident right, the past Administrator stated, she agreed with that. When asked, why then would that be a determining factor for him/her to have to leave the facility, the past Administrator stated because his/her level of functioning showed he/she didn't need the LTC level of care. When reminded he/she needed touch support, which was considered one-person assist by Provider #7, with most ADLs, the past Administrator stated that level of care was documented on the re-authorization and the state still denied more days. When surveyors asked to see the re-authorization paperwork and the state's denial, the past Administrator stated she would try and locate this information. The past Administrator then came back and stated that no re-authorization was completed and based on Resident #12's level of functioning, and his/her leaving the facility daily, she had determined he/she wouldn't meet criteria and didn't want to waste the State's time by submitting a re-authorization and just determined by herself that Resident #12 wouldn't meet criteria for more days. When asked what the past Administrator looked at to determine if a resident met criteria for a re-authorization, the past Administrator stated she would have looked at cognitive status, ADLs function level of need status for transfers, bathing, locomotion, and dressing. The past Administrator stated she found this information through a chart review, talked to staff, and used her own observations. When asked if she looked at the MDS assessments when making this determination, she said she did not because it was just a snapshot in time and didn't reflect the overall level of function. When shown Provider #7's progress note, dated 2/12/26, which determined that Resident #12 was a one-person assist with bathing, dressing, toileting, transferring and when shown that the 12/22/25 admission MDS assessment and 2/27/26 discharge MDS assessment which indicated he/she was supervision/touch support for oral hygiene; toileting hygiene; shower/bathe self; upper body dressing; lower body dressing; putting on/taking off footwear; personal hygiene; chair/bed to chair transfer; toilet transfer; tub/shower transfer; care transfer; and walking certain distances, the surveyor asked how she could determination that the resident's level of functioning (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Utuqqanaat Inaat		STREET ADDRESS, CITY, STATE, ZIP CODE 436 Mission Street Kotzebue, AK 99752	
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need didn't meet criteria for continued stay. The past Administrator stated, right or wrong, she made the determination that the resident wouldn't be approved for re-authorization because it was a nursing assessment and she was a nurse, and it was what she observed at the time. During an interview on 7/29/26 at 10:46 AM, LN #11 stated he/she assisted with the initial authorization forms, and he/she did assist with Resident #12's initial authorization. When asked to explain Resident #12's authorization, LN #11 stated because Resident #12 had issues with ambulation, was unstable on his/her feet, and was incontinent were the factors in needing the LTC level of care. Resident #12 didn't have any family at the time, and he/she was staying at a friend's house. He/she experienced chronic pain in his/her hands and feet. These factors were used to determine that he/she needed 24-hour supervision and care. LN #11 stated he/she only assisted with initial authorizations and did not help with re-authorizations. During an interview on 7/29/26 at 11:44 AM, Resident #12 stated he/she was admitted to the facility because he/she needed help because he/she had difficulty with his/her right leg and because his/her hands were clawed and he/she couldn't help himself/herself anymore. Resident #12 stated when he/she first got there, it was to be there for an extended period of time, but because he/she was able to move (as in walking) and staff didn't have to do a lot for him/her, he/she was told that he/she could only stay for three months. Resident #12 stated he/she wanted to stay there, but staff told him/her that he/she had to go. When asked about his/her experience with staff, Resident #12 stated his/her overall stay at the facility was good. However, the leadership was not open to residents who voiced their opinions or wanted to be part of their care. Resident #12 stated there was a nurse that teased the residents, and one time the resident called attention to this in a meeting when residents were invited to speak. Resident #12 stated he/she told the staff if they treat people like that, he/she would go to the board meeting and tell them. Resident #12 stated the staff asked him/her not to do that. He/she stated staff treated him/her differently after that and avoided talking to him/her. When asked how his/her discharge occurred, Resident #12 stated he/she was told on Friday, 2/27/26, you are leaving this weekend, pack all your stuff. Resident #12 stated he/she asked for more days to prepare where he/she would go, because he/she had no plan, but staff were adamant I had to leave. Resident #12 stated he/she told them he/she would have liked to have stayed at the facility but they made up their mind [that he/she had to leave]. When asked how it felt knowing he/she had to discharge, Resident #12 got emotional, his/her voiced cracked and said, not wanted. When asked how leaving without a plan affected him/her, Resident #12 stated, there I was outside, I didn't have enough money, and it was wintertime. Resident #12 stated he/she had no idea where he/she was going to go. He/she started staying with friends, but it wasn't a place to stay long because they were drinking and he/she didn't feel safe in those situations. When asked if staff helped to try and find Resident #12 a place to go once discharged, Resident #12 stated the discussion about housing never happened. The staff just told him/her to gather his/her stuff, place it at the door, and leave. Staff told Resident #12 he/she could come back to get his/her belongings when he/she found a place to stay. Resident #12 stated when he/she was at the facility, they helped him/her set-up for showers and clothes for dressing because his/her fingers were clawed. Having staff apply cream everyday helped with pain, but he/she doesn't have that support anymore. Resident #12 stated he/she was afraid all the time now and has safety concerns now that he/she is not at the facility. Resident #12 stated he/she had fallen twice since leaving the facility, once an ambulance was called because he/she was lying in the street and couldn't get up. Resident #12 further stated he/she was currently living in a cabin on the beach; however, it is about a three and a half mile walk on sand and because he/she used a cane to walk, it was a struggle and almost impossible to walk on when it rained. When asked if he/she had enough to (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eat, Resident #12 stated he/she was not able to get enough to eat and that he/she was 165 lbs. when he/she was at the facility and now weighed 130 lbs. Losing 35 lbs. has caused his/her health to decline. Resident #12 has been down and depressed since leaving the facility, and his/her pain has been bad because he/she had no support with his/her medications and cream. Resident #12 stated he/she doesn't have enough money and worries all the time. An observation on 7/29/26 at 11:44 AM, revealed that when compared to Resident #12's 12/15/25 admission picture, and then seeing the resident on 7/29/26, surveyors would not have been able to identify him/her as the same person. Resident #12's face was very gaunt, much skinnier than his/her admission picture, and had no semblance of the facial features he/she had in December 2025. During the course of the survey, the leadership was not able to adequately show proof of an appropriate discharge or prove they provided a safe discharge. They did not notify the resident of discharge or his/her rights to appeal. Review of the facility-provided policy Transfer or Discharge, last reviewed 1/23/26, revealed: - CMS [Centers of Medicaid and Medicare Services] requirements for the transfer or discharge of LTC residents. Policy. Patients and/or guardians shall be directly involved with all decisions related to transfer and discharges of Elders. Transfer or discharge of Elders will be done in accordance with the following criteria. The facility must permit each patient to remain in the facility, and not transfer or discharge unless: 1. The transfer or discharge is necessary for the welfare of the patient and the patient's needs cannot be met at the facility; 2. Transfer or discharge is appropriate because the health of the patient has improved sufficiently so the patient no longer needs the services provided by the facility; 3. The safety of individuals in the facility is endangered; 4. The health of the individuals in the facility would otherwise be endangered; 5. The patient has failed, after reasonable and appropriate notice, to pay for (or have paid for under Medicare or Medicaid) a stay at Utuqqanaat Inaat. 6. The facility ceases to operate. - 1. Prior to any transfer or discharge, the multidisciplinary team, including the provider, will conduct an appropriate assessment to determine if a new plan of care would allow Utuqqanaat Inaat to continue meeting the patient's needs. - 2. Detailed, multidisciplinary planning will begin upon admission, so should begin far enough in advance that the patient's needs when they leave the facility will be appropriately met. A care conference to discuss what will be required to meet the patient's needs, as well as the teaching needs of the patient and family, will be scheduled when necessary. This multidisciplinary conference is to include patient and/or guardian in the discussion to ensure patient's goals and preferences relative to transfer or discharge are heard. Written discharge instructions detailing the routine medications, diet, activity, care needs, and any follow-up appointments for the patient will be given at the time of discharge. - 3. The provider will write an order to transfer or discharge the patient. The provider will document in the chart the reason for the transfer or discharge. In the case of a transfer, the provider order should include the specific chart information that is to be sent with the patient (i.e., history & physical, lab results, x-ray reports, EKGs [electrocardiogram or EC is a non-invasive test that records the electrical activity of the heart to diagnose various heart conditions], consultations). - 4. Upon receiving the provider order to transfer or discharge the patient, the Charge Nurse will notify the patient, their family and/or representative, and Social Services. The patient should be notified as soon as possible of the date of the transfer or discharge. The reason for the transfer or discharge will be explained to the patient and their family or guardian. The patient will be given written notice of the reason for the discharge or transfer.		

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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 record review and interview, the facility failed to develop and/or implement a comprehensive person-centered care plan for 1 Resident (#12), out of 6 sampled residents, that included measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, the facility failed to develop a care plan that accurately reflected the resident's functional abilities and need for assistance with ADLs (Activities of Daily Living - basic self-care tasks essential for maintaining personal health and independence). This failed practice placed Resident #12 at risk for receiving insufficient assistance with ADLs, transfers, and mobility despite assessed functional limitations and a history of falls. Findings:Resident #12 Record review on 7/23-29/26 revealed Resident #12 was admitted to the facility on [DATE] with diagnoses that included low back pain, major depressive disorder, history of falling, and unspecified urinary incontinence. Review of Resident #12's provider health and physical note, dated 11/18/25, revealed: . Physical for LTC placement . [He/she] is seeking admission to long-term care due to [his/her] declining functional status and unsafe living conditions. The patient reports progressive difficulty with mobility over the past several years, now unable to walk and experiencing frequent falls. [He/she] describes [his/her] feet as being similar to [his/her] hands, with toes that cannot move or turn up, causing significant pain and contributing to instability . [His/her] fingers and toes are becoming claw-like and [he/she] stated it is hard to open medication bottles [on] [his/her] own and [to] self hygiene . [He/she] has fallen multiple times . The patient reports ongoing urinary incontinence . Function: Bathing, Dressing, Toileting, Transferring: 1 person assist -- high risk for falls .Review of systems. musculoskeletal: Positive for pain in feet and hands. Positive for inability to move toes. Positive for joint deformity in toes and fingers. Positive for muscle weakness. Positive for back pain. Positive for joint stiffness. Appearance. Patient is ambulating with a very wide based gait. [He/she] uses cane at all the time to prevent falls. Chronic pain behavior as usual. Oriented in time, place, person. Able to have a conversation with me and seem to understand my questions and answered them pretty well. Arthritis pain. Arthritis with hand and foot deformities, pain, and functional impairment; worsening toes contractures/hammer toes; contributing to falls and difficulty ambulating. Review of Resident #12's admission minimum data set assessment (MDS - a federally required nursing assessment), dated 12/22/25, revealed Resident #12 had a brief interview for mental status (BIMS - a cognitive screening tool used to assess memory and thinking) score of 14 (on a scale of 00 to 15, which indicated a normal cognitive level with no impairments). Further review revealed Resident #12 needed supervision/touch support (which indicated a helper was needed to provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activities and that assistance may have been needed throughout the activity or intermittently) for oral hygiene; upper body dressing; lower body dressing; putting on/taking off footwear; personal hygiene; chair/bed to chair transfer; toilet transfer; care transfer; and walking certain distances. Further review revealed Resident #12 needed partial/moderate assistance (which indicated a helper did less than half the effort. The helper lifted, held, or supported the resident's trunk or limbs, but provided less than half the effort) for toileting hygiene; shower/bathe self; and tub/shower transfer. Review of Resident #12's Primary Care Provider Note, dated 2/12/26 and written by Provider #7, revealed: . [AGE] year-old [male/female] past medical history cerebellar ataxia [dysfunction in the cerebellum resulting in coordination and balance issues], TBI [traumatic (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brain injury - a brain injury caused by external force, such as a blow, bump, jolt, or penetrating object that causes brain injury] secondary to a fall in 2017, chronic pain, mild cognitive impairment, hypertension and recurrent falls being seen today for 30-day visit. Patient admitted due to progressive functional decline with multiple ADLs. Since admission, patient has been doing well. 02/02/2026: ANMC [Alaska Native Medical Center] rheumatology follow-up. Patient evaluated for arthralgias [joint pain] and rheumatoid factor XV [refers to an autoantibody produced by the immune system that mistakenly targets healthy immunoglobulin molecules in the body, forming immune complexes that deposits in tissues, triggering chronic inflammation and contributes to damage in conditions such as rheumatoid arthritis]. Patient reported morning stiffness to [his/her] hands, right wrist ultrasound showing cellulitis and an elevated CRP [blood test that indicates inflammation in the body]. [He/she] was diagnosed with seronegative RA [a form of rheumatoid arthritis where patients exhibit typical RA symptoms such as joint pain, swelling, stiffness]. 01/22/2026: ANMC orthopedic consult. Evaluated for severe right foot hallux valgus [a bunion - a deformity where the big toe angles toward the second toe creating a bony bump at the base of the big toe] and first MTP DJD [metatarsophalangeal degenerative joint disease - a degenerative disease of the big toe joint]. Patient is not interested in surgical options. Conservative therapy recommended with supportive footwear, toe spacers, bunion orthosis [devices to relieve pain, improve foot function, and slow bunion progression]. Function: Bathing: 1 person assist; Dressing: 1 person assist; Toileting: 1 person assist; Transferring: 1 person assist; Feeding: Independent; Continence: Urine incontinent --- uses diapers. Review of Resident #12's care plan, last reviewed 12/29/25, revealed: - Focus: [Resident #12] has an ADL self-care performance deficit r/t [related to] low back pain which was initiated on 12/16/25 and cancelled on 3/30/26. Further review revealed inaccurate Interventions/Tasks associated with this Focus problem included: - BATHING/SHOWERING: [Resident #12] is able to shower independently with set up;- DRESSING: [Resident #12] is able to dress independently;- ORAL CARE: [Resident #12] has upper and lower dentures. [Resident #12] requires oral inspection weekly and Report changes to the Nurse;- PERSONAL HYGIENE/ORAL CARE: [Resident #12] is independent with oral care.- TOILET USE: [Resident #12] is able to toilet independently;- TRANSFER: [Resident #12] is able to transfer independently. During the survey, this inconsistency between the care plan (which documented Resident #12 was fully independent in all ADLs), the MDS assessments (which documented Resident #12 needed supervision/touch assistance with some ADLs and partial/moderate assistance for some ADLs), and Provider #7's notes (which documented one-person assist in all ADLs except feeding) was identified. During an interview on 7/28/26 at 3:19 PM, the Administrator acknowledged Resident #12 needed assistance in most ADLs and stated the care plan did not reflect what the MDS assessment captured and it should have. The Administrator stated Provider #7 considered the need for ADL assistance as a one-person assist. Review of the facility-provided policy LTC -Quarterly MDS/Care Plan Review, last reviewed 4/7/26, revealed: Residents will have a CMS standardized clinical assessment no less frequently than quarterly. This will be done through the RAI process. This quarterly review is to ensure the care plan is reflective of the resident's current needs and also identify if there have been significant changes in the resident's condition which may warrant a more comprehensive assessment. The care plan will be reviewed at least every 92 days with revisions made as needed. The resident/responsible party will be invited to participate in the scheduled care conference.		