STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025035	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Utuqqanaat Inaat	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, interview, and observation, the facility failed to ensure that 3 Residents (#'s 2, 4, and 15), of 8 sampled residents, received adequate supervision to prevent falls. This failed practice placed these residents at risk for injury, impaired mobility, pain, and reduced well-being. Findings: Resident #2 Record review on 9/22-26/25 revealed Resident #2 was admitted with diagnoses that included cerebrovascular accident (CVA - also known as stroke, when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel). Further review revealed that Resident #2 had multiple falls: 6/25/25, 7/29/25, and 9/20/25. The fall that occurred on 9/20/25 resulted in a major injury. Review of Resident #2's care plans, dated 6/24/25 and 9/23/25, revealed: . [Resident #2] has limited physical mobility. AMBULATION: The resident uses rolling walker for walking . LOCOMOTION: [Resident] uses rollator for locomotion . Review of Resident #2's care plan, last review completed on 6/24/25, revealed: . Focus: [Resident #2] is High risk for falls. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance . [Resident #2] needs a safe environment with: even floors free from spills and/or clutter. a working and reachable call light. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure that [Resident #2] is wearing appropriate footwear (correct client footwear or nonskid socks when ambulating or mobilizing in w/c [wheelchair]. Follow facility fall protocol. Fall #1 Review of the facility's investigation #684 Un-witnessed fall, dated 6/25/25 at 5:27 AM, revealed Resident was ambulating to the bathroom when he/she suddenly felt dizzy which led to an unwitnessed fall. He/she was found to be lying on his/her back on the floor by staff. He/she denied losing consciousness and had no signs or symptoms of injury. During an interview on 9/24/25 at 11:57 AM, the Director of Nursing (DON) and the Administrator (ADM) stated that following Resident #2's fall on 6/25/25, the resident's in-room care plan was revised to require the assistance of one staff member and the use of a walker whenever the resident was out of bed. Fall #2 Review of the facility's investigation #694 Un-witnessed fall, dated 7/29/25 at 8:30 AM, revealed Resident #2 was found on the floor by staff after they had heard him/her calling out. He/she was lying on the floor on his/her right side beside his/her closet. Resident #2 stated he/she was looking for something in his/her closet and lost his/her balance. It was also noted that he/she did not call for assistance before getting up. The resident was assessed, and no injury was found. Review of Resident #2's in-room care plan, dated 8/17/25, revealed: Walk in room: limited Assist/ walker. Walk in unit: limited assist 1 person/ walker. Left sided weakness encourage use. Locomotion on unit: Limited 1 assist /walker. Locomotion off unit: Limited 1 assist /walker. Left sided weakness encourage use. Safety/fall precautions: Fall risk Q [every] 15 minute checks at night . During an interview on 9/24/25 at 11:57 AM, the DON and the ADM stated that after Resident #2's second fall on 7/29/25, the care plan was updated to include 15-minute checks during the day. Review of the electronic health record (EHR) revealed no physician orders for Q15 minute checks and no documentation of the every15 minute checks being completed. Fall #3 Review of the facility's investigation #698 Un-witnessed fall, dated 9/20/25 at 2:00 PM, revealed the staff responded to Resident #2 shouting for help. Resident #2 was found laying on the floor next to his/her refrigerator. The Resident told staff that he/she was walking to his/her window to get something and his/her shoe dragged and kicked off. This caused him/her to slip and land on his/her hip and hit his/her head. The incident was unwitnessed. Resident #2 was assessed; no injury was found at the time, and he/she was administered as needed pain medication. Resident was later evaluated at the Maniilaq Emergency Department where imaging was done to the head, pelvis, spine, chest, left femur, left hip, and left tibia-fibula. Review of the Maniilaq Emergency Department notes, dated 9/20/25 at 7:32 PM, revealed: Ct scan shows cortical fracture of the left femoral greater tuberosity. During an interview on 9/24/25 at 11:57 AM, the DON and the ADM stated following Resident #2's third fall on 9/20/25, the resident was placed on 15-minute checks around the clock. The DON and ADM stated that the fall on 9/20/25 occurred between the scheduled daily every 15-minute checks. Further review of Resident # 2 care plan, review completed on 9/23/25, revealed the addition of Q-15 minute checks while in bed for safety. Record review of Resident #2's in-room care plan dated 8/17/25, revealed an update, dated 9/20/25, Q-15 minute checks at all times. Record review of Resident #2's Morse Fall Scale (a standardized tool to assess a resident's risk of falling), dated 9/9/25, revealed a score of 65, scores of 45 and higher being considered high risk for falls. During an interview on 9/24/25 at 11:57 AM, the ADM stated that Resident #2 was currently being evaluated for a change of status

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Based on record review, observation, and interview, the facility failed to ensure staff followed accepted standards of practice for hand hygiene for 5 residents (#'s 5, 8, 11, 14, and 15), out of 5 residents observed. Specifically, staff failed to perform hand hygiene during personal cares and medication administration. This failed practice had the potential to place all residents at risk of contamination and transmission of infections. Findings: Resident #5 Record review on 9/22-26/25 revealed Resident #5 was admitted to the facility with diagnoses that included Type 2 Diabetes Mellitus (non-insulin-dependent diabetes). An observation on 9/23/25 at 12:55 PM, revealed Licensed Nurse (LN) #2 prepared Resident #5's insulin injection at the medication cart wearing gloves. LN #2 walked over to Resident #5 and offered him/her the medication. Resident #5 agreed and LN #2 pushed him/her in his/her wheelchair to his/her room wearing the same gloves. Without changing gloves or performing hand hygiene, LN #2 cleansed an area on Resident #5's abdomen with an alcohol wipe and administered the insulin injection. Resident #8 Record review on 9/22-26/25 revealed Resident #8 was admitted to the facility with diagnoses that included Type 2 Diabetes Mellitus. An observation on 9/23/25 at 12:46 PM, revealed LN #2 prepared Resident #8's insulin injection at the medication cart wearing gloves. LN #2 walked over to Resident #8 and offered him/her the medication. Resident #8 agreed and LN #2 pushed him/her in his/her wheelchair to his/her room wearing the same gloves. Without changing gloves or performing hand hygiene, LN #2 cleansed an area on Resident #8's abdomen with an alcohol wipe and administered the insulin injection. Resident # 11 Record review on 9/22-26/25 revealed Resident #11 was admitted to the facility with diagnoses that included dementia (decline in intellectual functioning, including problems with memory, reasoning and thinking), chronic kidney disease stage 2 (a mild loss of kidney function often with early signs of kidney damage), and systolic heart failure (a condition where the left ventricle cannot contract effectively, leading to impaired blood pumping out of the heart). An observation on 9/24/25 at 10:00 AM, revealed Certified Nursing Assistant (CNA) #2 and CNA #5 entered Resident #11's room without performing hand hygiene. After speaking with the resident, the CNA's exited the room, and were observed looking around for the location of the alcohol-based hand rub dispenser outside of the room. Once found, both staff performed hand hygiene, put on gloves, and assisted the resident into the bathroom. With their gloved hands, the CNAs helped the resident lower his/her pants and brief, after which the resident sat on the toilet while both CNAs waited outside of the bathroom doorway. When Resident #11 was finished, CNA #5 re-entered the bathroom and wiped the resident wearing the same gloves. Next, while still wearing the dirty gloves, CNA #5, along with CNA #2 pulled up the resident's brief and pants then removed their gloves. Next, without performing hand hygiene, CNA #2 pushed the resident into the common area without offering hand hygiene to the resident prior to leaving the bathroom. Resident #14 Record review on 9/22-26/25 revealed Resident #14 was admitted to the facility with diagnoses that included diastolic congestive heart failure (heart failure caused by the hearts inability to relax and fill properly), localized edema (fluid accumulation in the tissues limited to a specific area), and chronic obstructive pulmonary disease (a progressive lung condition that causes airflow limitation and breathing difficulty due to airway and air sac damage). An observation on 9/24/25 at 9:34 AM, revealed CNA #1 and LN #2 entered Resident #14's room to assist him/her to the bathroom. Both staff performed hand hygiene and put on gloves. CNA #1 pushed the resident in his/her wheelchair to the commode and the resident self-transferred with assistance to stand in front of the commode. Using gloved hands, CNA #1 assisted the resident by pulling down the resident's pants and brief. While on the commode, LN #2 removed the resident's dirty brief from around the resident's ankles. CNA #1 handed LN #2 a new brief. Without changing gloves or performing hand hygiene, LN #2 placed the new brief above the resident's pants, which were still around the resident's ankles while the resident was still urinating. At the same time, CNA #1 prepared a damp wipe using toilet paper and a spray. When Resident #14 finished urinating, he/she stood up and turned around to be wiped. CNA #1 wiped the resident. Without changing gloves or performing hand hygiene, CNA #1 pulled up the resident's pants with LN #2's assistance, who was still wearing the dirty gloves from the brief change. The resident then turned around and sat back down in the wheelchair. Without performing hand hygiene and wearing the same gloves used to wipe the resident, CNA #1 pushed the resident up to the sink so the resident could wash his/her hands. Resident #15 Record review on 9/22-26/25 revealed Resident #15 was admitted to the facility with diagnoses that included dementia and a closed fracture of the right femur in an unspecified part of the femoral neck (break in the upper part of the thigh bone just below the ball of the hip