STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025037	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yukon Kuskokwim Elder's Home	1100 Chief Eddie Hoffman Hwy Bethel, AK 99559

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to honor the rights of 17 residents (#s 1-17) out of 18 residents (total census) to be informed of, to participate in, or refuse the facility's decolonization program (a medical intervention aimed at eliminating antimicrobial-resistant microorganisms). Specifically, the facility did not notify the residents and/or their representatives of the decolonization program, the rationale and risks and benefits of the use of the following interventions: Chlorhexidine as a soap substitute used during showers, andMupirocin 2% topical ointment (used to treat bacterial skin infections) nasal swab for five days every other week. These failed practices denied all residents and their representatives, the opportunity to be informed of treatments applied to them and placed them at potential risk for adverse effects Findings:Record review on 3/2-6/26 of the quarterly Minimum Data Set (MDS - a federally required nursing assessment), revealed 15 residents had antibiotic checked as is taking and indication noted in the following MDS:Resident #1's MDS dated [DATE];Resident #2's MDS dated [DATE], 1/15/26;Resident #3's MDS dated [DATE], 2/9/26;Resident #4's MDS dated [DATE], 10/26/25, 12/18/25;Resident #5's MDS dated [DATE] and 3/2/26;Resident #6's MDS dated [DATE], 2/11/26;Resident #7's MDS dated [DATE], 1/26/26;Resident #9's MDS dated [DATE], 1/12/26;Resident #10's MDS dated [DATE];Resident #11's MDS dated [DATE], 12/22/25;Resident #14's MDS dated [DATE];Resident #15's MDS dated [DATE], 2/9/26;Resident #16's MDS dated [DATE];Resident #17's MDS dated [DATE]; andResident #21's MDS dated [DATE]. Record review from 3/2-6/26 of Residents #1, #2, #3, #4, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #21 medical diagnosis list included preventive measure clinical diagnosis Encounter for Prophylaxis.Record review 3/2-6/26 of the residents' medication orders, revealed 17 residents had an order of: Order name: Mupirocin topical, Status: completed, Details: 1 app [application], nasal, both nares [nostrils], form Ointment, BID [twice a day], M-F [Monday to Friday].Further review of the medical record revealed the following:Resident #1 had 10 weeks of completed ointment application from 11/16/25 to 2/26/26;Resident #2 had 12 weeks of completed ointment application from 9/27/25 to 2/26/26;Resident #3 had 17 weeks of completed ointment application from 7/13/25 to 2/26/26;Resident #4 had 5 weeks of completed ointment application from 12/14/25 to 2/26/26;Resident #5 had 7 weeks of completed ointment application from 12/15/25 to 2/26/26;Resident #6 had 17 weeks of completed ointment application from 7/1/25 to 2/26/26;Resident #7 had 8 weeks of completed ointment application from 11/16/25 to 2/22/26;Resident #8 had 4 weeks of completed ointment application from 1/11/26 to 2/26/26;Resident #9 had 15 weeks of completed ointment application from 8/11/25 to 2/26/26;Resident #10 had 13 weeks of completed ointment application from 9/8/25 to 2/26/26;Resident #11 had 8 weeks of completed ointment application from 11/24/25 to 2/26/26;Resident #12 had 10 weeks of completed ointment application from 10/19/25 to 2/26/26;Resident #13 had 18 weeks of completed ointment application from 6/29/25 to 2/26/26;Resident #14 had 9 weeks of completed ointment application from 11/10/25 to 2/26/26;Resident #15 had 13 weeks of completed ointment application from 9/8/25 to 2/26/26;Resident #16 had 2 weeks of completed ointment application from 2/8/26 to 2/26/26; (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	andResident #17 had 10 weeks of completed ointment application from 10/27/25 to 2/26/26.During an interview on 3/4/26 at 5:38 PM, when asked why those residents mentioned above were on Mupirocin 2% topical ointment antibiotic, the Medical Director (MD) stated the Mupirocin was used for the facility's decolonization protocol. He explained the facility had been using Chlorhexidine gluconate as soap substitute during residents' shower days and every other week the residents were given Mupirocin 2% topical ointment nasal swab. When asked the rationale of the decolonization protocol, the MD stated to remove bacteria in the nose and the skin. When asked if the decolonization protocol was experimental research, the MD stated it was not, but it was considered facility's performance improvement. When asked what diagnosis supported the use of Mupirocin 2% topical ointment, the MD stated, Preventive measure Z29.9 [medical diagnosis code].During the same interview, when asked if the residents and/or their representatives were notified of the protocol, he stated No. He explained that just like any medication prescription, he would not notify the representative in every dosage changes. When asked if the protocol was discussed during the resident's care conference, the MD stated it was not, if the topic comes up just like in other medications, then he would.During an interview on 3/5/26 at 8:25 AM, Licensed Nurse (LN) #1, stated all residents were receiving Mupirocin 2% topical ointment nasal swab to bring down infection, but was not sure what infection was being prevented.During an interview on 3/5/26 at 3:15 PM, the Director of Nursing (DON) stated he did not find any documentation regarding residents and/or their representatives notification of the facility's decolonization program. The DON also stated there should have been a notification.During an interview on 3/5/26 at 6:15 PM, the Administrator stated there should be a notification based on the decolonization program.Document review on 3/6/26 at 7:30 AM of the facility's Decolonization QAPI [Quality Assurance and Performance Improvement] Program (SHIELD: Shared Healthcare Intervention to Eliminate Life-threatening Dissemination of Multidrug-Resistant Organisms (MDROs), undated, revealed in the program approach section, Resident Communications outlined the following activities: Discussion at Resident's Council meeting, Ombudsman notification, and Resident admission Packet letter.The facility was asked to provide documentation of the above approaches; however, none was submitted. Instead, the Administrator provided the MD's text messages.Review of the email from the Administrator, dated 3/6/26 at 7:34 AM, revealed a response from the Medical Director .[name of the Administrator]: With regard to the decolonization program, the plan to (1) inform residents at a resident council, (2) notify the ombudsman, and (3) add a letter to all admits in the admission packet, this was all from a plan template from another organization. We neither adopted nor implemented that plan. Substituting chlorhexidine gluconate for the previous bath soap and administering nasal mupirocin were viewed as essentially risk-free interventions, and I did not obtain special consent before these management changes.Review of the email response from the resident representative of Residents #2, #13, #17, dated 3/6/26 at 9:44 AM, when asked regarding facility's notification of the decolonization program, revealed: I have no idea what that is, so probably not.Review of the facility's posted YOUR RIGHTS AND RESPONSIBILITIES, undated, revealed: As patient you have the right to.receive the information about .the procedure and treatments, and any known risks and side effects which may result.make informed decisions and have reasonable participation by you and your family in the decision involving your health care including .procedures, or involvement in research.Review of the facility's admission Packet, revised on 1/2/20, revealed it contained a document titled Consent for Medical Treatment & Billing, this document revealed: .each resident has the right to refuse any proposed procedures(s) and treatment(s); no resident will be involved in any research or experimental procedures without his/her knowledge and consent.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1) accurate grievance officer contact information was available to residents and representatives through required postings or individual notice, and2) clear instructions were provided on how to file and submit grievances, as grievance forms and admission information did not include submission instructions.These failed practices resulted in all residents (based on a census of 18) and resident representatives not having reliable access to the grievance process due to inaccurate grievance officer identification and unclear submission instructions. This placed residents at risk for delayed reporting and resolution of concerns and created a facility-wide system failure that limited residents' ability to access and utilize the grievance process Findings:During random observations from 3/2-6/26, the grievance notice was observed posted throughout the facility in residents' rooms. The notice revealed that residents and others could submit complaints anonymously, concerning resident abuse, neglect, and/or misappropriation of resident property in the facility with Health Facilities Licensing & Certification, Medicaid Fraud Unit, Disability Law Center of Alaska, Office of Long Term Care Ombudsman, Kepro BFCC-10 Program (Beneficiary and Family Centered Care Quality Improvement Organization serving Region 10), and Adult Protective Services.The notice identified the designated Grievance Official as Grievance Officer #1 and listed the following contact information: grievanceofficer#1@ykhc.org, 1100 Chief [NAME] Hwy, P.O. Box 2687 Bethel, AK 99559, Phone: [PHONE NUMBER]. However, Grievance Officer #1 was not the facility's current designated Grievance Official.During an interview on 3/5/26 at 11:10 AM, the Administrator stated residents were provided with information about external agencies and contacts through facility bulletin boards. The Administrator stated, For each site there's a bulletin board with all of the phone numbers. previous surveys are in a basket underneath. both units have the bulletin board. the residents can see them. The Administrator also stated the information may not always be easily accessible. When shown the picture of the grievance folder in the units, the Administrator stated: That was a folder, but it was covered with a box of gloves, a box of masks. instructions and the contact information were not easily visible.During the same interview, the Administrator stated she assumed responsibility for the facility's grievance process in October (2025) after identifying a need for more formal tracking, explaining: we used to have a social worker who used to normally deal with all grievance policies. The Administrator reported she implemented a grievance log to better document and track complaints. She stated that prior to October 2025 the Social Worker, identified as Grievance Officer #1, managed grievances.The administrator further stated that grievances may be submitted by residents, family members, or friends, and staff would assist individuals when needed, explaining, If a person has a complaint and they're not able to fill it out, then we assist or the family assists or however they want it done.During the same interview, the Administrator stated residents were generally informed about the grievance process through staff rather than formal postings and that residents may submit grievances anonymously and explained, You can fill out the form. if a person is unable to fill it out and not have their name, a family member usually puts their name. She added that complaints were commonly routed through nursing staff, . they go to the nurse or get put in the box. most of the time they're handed into [in to] the nurse and come straight to me.The Administrator also stated she provided residents with her direct contact information during resident council a while ago, explaining, I put my direct cell number on all my cards. so that they knew that they could reach out to me individually. However, minutes documenting this interaction could not be found in the Resident Council meeting records.During the same interview on 3/5/26 at 11:10 AM, the Administrator stated grievance information should be included in the admission packet but acknowledged that detailed instructions on the grievance form or process were not currently being included.Review of the document admission Agreement, undated, revealed: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Elder's Home Complaint or Grievance Procedure - From time to time, residents or their families may have a question or problem regarding their stay at Elder's Home. Elder's Home has a procedure to address these concerns. Residents and their families are encouraged to discuss any concerns with the Director of Nursing or Social Services. If one of these members of management is unable to resolve the concern, the resident or family member is encouraged to discuss the concern with the Administrator of the facility. The resident or family may also fill out a grievance form, which is located in the lobby. The admission agreement did not include instructions on how to submit the completed grievance form, where it should be submitted, or who the designated grievance officer was.Review of the Yukon-Kuskokwim Health Corporation - Grievance Report, undated, revealed a standardized form used to document and resolve resident or family concerns. The form included sections for receipt of grievance information, documentation of the concern, facility follow-up actions, resolution status, notification method, and completion signatures from responsible staff, including the Administrator, Director of Nursing, and Social Worker. The form did not include instructions for residents or representatives regarding how or where the form should be submitted.During an interview on 3/4/26 at 2:10 PM, with the Resident Council, Residents (#1, #2, #4, #8, #10, #14) stated they did not know who the Grievance Officer (GO) was or how to formally submit a grievance. When asked who they would go to if they had a complaint or concern, residents were uncertain. Resident #14 identified a staff member and stated they would go to CNA #9, referring to him/her as the person they would talk to if there was a problem. Residents did not clearly identify him/her as the facility's designated grievance officer and appeared unfamiliar with the formal grievance process.During the discussion, residents indicated they were not aware of a formal grievance system or how to submit complaints in writing. Resident #14 further stated, When I first came. I didn't say anything because I didn't know what they were talking about and I didn't know what was going on. The Resident continued by saying they were not informed about how to raise concerns and explained, I didn't know there was complaints. I did not tell questions or make any comments. Residents suggested they would typically report concerns verbally to staff rather than through a formal grievance process.During the same interview, Residents #1 and #14 also stated that some individuals may be hesitant to report concerns. Resident #14 reported that another resident had missing items but was reluctant to report it, stating, He/She said they were missing things, but they were scared to ask.Review of the procedure titled on Resident's Rights and Responsibilities, last reviewed on 2/2/22, revealed: .In accordance with these standards and Yukon Kuskokwim Health Corporation (YKHC) Corporate Policies and Procedures each resident possesses certain rights while receiving treatment. Per Centers for Medicare & Medicaid Services (CMS) these include the resident's right to: a dignified existence, self-determination, and individuality; and communication with and access to persons and services inside and outside the facility. All residents will be treated with respect and dignity, recognizing their individuality and rights as US citizens.Review of the procedure titled on LTC [Long Term Care] Concerns/Grievances (LTC-057), last reviewed on 3/2/25, revealed: .YK Elder's Home supports each resident's right to voice concerns/grievances. 1. Concerns/grievances may be presented verbally or in writing and may include such items as: a. Treatment, b. Care, c. Lost personal items, d. Management of funds, e. or violation of rights.YK Elder's Home will actively seek resolution to concerns/grievances and attempt to keep the resident or griever updates on progress toward resolution.YK Elder's Home will uphold the resident's. right to voice customer concerns/grievances or file anonymous concerns/grievances without discrimination or reprisal.The Social Worker will assure that residents or legal representative(s) receive a written copy and review of their rights and responsibilities upon admission . The Activities Director/Designee will complete a grievance form when a global issue is raised at a Resident Activities Council Meeting . The Social Worker will log all concerns/grievances received onto the facility grievance log.Review of the Policy LTC Abuse Prevention Policy, reviewed 11/7/24, revealed: .E. Residents, families and staff shall be provided feedback regarding any incidents, concerns, and/or grievances upon completion of facility investigation. F. Incident/Accident (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Investigations shall be done according to the Facility Incident/Accident Investigation policy & procedures. G. Grievance Investigations will be done according to the Facility Grievance policy & procedures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. .Based on observation, interview and record review the facility failed to ensure food was stored, labeled, and prepared in accordance with professional standards of practice for food safety. Specifically, the facility failed to ensure: 1) foods were properly labeled and dated; 2) expired foods were removed and discarded; and 3) food items were stored in a manner that maintained the required clearance from sprinkler heads to promote temperature distribution.These failed practices had the potential of causing or spreading foodborne illness to all residents (based on a census of 18), who received food from the kitchen .Findings:.Main KitchenAn observation, during the initial main kitchen tour, on 3/2/26 at 3:01 PM, revealed:1) Meal Prep Area Refrigerator:One half-gallon carton of open Glenview Farms - Grade A Ultra-Pasteurized 40% Milkfat milk was unlabeled, with a use-by date of 3/9/26.2) Walk-in Freezer:One clear plastic bag containing hot dogs, unlabeled, with a date of 3/1/26.One clear plastic bag containing Salisbury steak, unlabeled, with no best-used-by or expiration date3) Dry Storage:Twenty-six packages of Gran Grape Ocean Spray Grape Cranberry Juice Drink (4 Fl oz [fluid ounces] / 118 mL [milliliters]), with a best-by date of 2/15/26.4) Wing B Kitchen:One plastic bag containing an unidentified food item resembling white bread, unlabeled, with no best-used-by or expiration date.Random observations conducted during the main kitchen tour on 3/2/26 at 3:01 PM revealed the walk-in freezer and refrigerator contained multiple rows of tightly stacked cardboard boxes stored on metal wire shelving from the floor up to the ceiling (approximate 1-3 inches between the top box and the ceiling. The storage areas appeared congested and cluttered, with limited spacing between items. Several boxes were observed in very close proximity to two large industrial cooling fans.During an interview on 3/5/26 at 9:00 AM, the Kitchen Manager (KM) explained that staff were expected to write the name, store it, and routinely check refrigerators, freezers, and dry storage areas for proper labeling and dating, further stating there was a pretty high turnover and that new staff were simply shown the process upon hire. When asked about expired or mislabeled items described above, he/she confirmed such items would be discarded. During the interview, the KM reported that staff training was primarily conducted through verbal instruction and demonstration. The KM further stated I just show them what to do. indicating the absence of a formalized or structured training process.The KM further stated that the facility followed a storage policy requiring items to be kept 18 inches from the ceiling to maintain proper clearance and safety. He/she explained that staff were instructed not to store items on top shelves, noting, I tell them about it, which indicated that training on storage and fire safety practices had been provided verbally rather than through formal or documented processes.During a concurrent interview on 3/5/26 at 9:00 AM, the Dietitian reported that the facility served 18 residents and followed therapeutic diet guidelines dictated by our diet manual, while incorporating preferences gathered during admission and care planning. He/she emphasized ongoing communication through care conferences and interdisciplinary meetings. Regarding food safety, he/she noted he/she was available as a resource but currently works remotely and does not have a direct hands-on capability to ensure compliance. He/she further identified inconsistencies in labeling practices, training, and monitoring, alongside resource and staffing limitations impacting food safety compliance.He/she added that while he was ServSafe (food safety certification) certified and available as a resource for additional trainings, he/she did not have direct oversight of daily kitchen operations. It was also noted that only one staff member held a ServSafe certification, while other dietary staff-maintained Alaska State food handler cards.Review of the document titled YKHC [Yukon-Kuskokwim Health Corporation] Fire Protection, Sprinkler Heads, and Storage of Supplies, reviewed 2/2/24, revealed: . A. The minimum vertical clearance between sprinklers and material(s) below shall be 18-inches (45.7 cm [centimeters]). The 18-inch applies only to areas that have sprinklers installed. 1. Example: Picture a horizontal plane parallel to the ceiling that is 18 inches below the sprinkler heads. Nothing should be in that area between the (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to monitor the effectiveness of its performance improvement activities to ensure that improvements were sustained. Specifically, the facility had no evidence of tracking, trending or monitoring the decolonization (a medical intervention aimed at eliminating antimicrobial-resistant microorganisms) program. This failed practice placed all residents (based on a census of 18) at risk of receiving an ineffective decolonization intervention and at potential risk for adverse effects .Findings:.Residents' Medical Record ReviewRecord review on 3/2-6/26 of the quarterly Minimum Data Set (MDS - a federally required nursing assessment), revealed 15 residents had antibiotics checked as is taking with indication noted in the following MDS:Resident #1's MDS dated [DATE];Resident #2's MDS dated [DATE], 1/15/26;Resident #3's MDS dated [DATE], 2/9/26;Resident #4's MDS dated [DATE], 10/26/25, 12/18/25;Resident #5's MDS dated [DATE] and 3/2/26;Resident #6's MDS dated [DATE], 2/11/26;Resident #7's MDS dated [DATE], 1/26/26;Resident #9's MDS dated [DATE], 1/12/26;Resident #10's MDS dated [DATE];Resident #11's MDS dated [DATE], 12/22/25;Resident #14's MDS dated [DATE];Resident #15's MDS dated [DATE], 2/9/26;Resident #16's MDS dated [DATE];Resident #17's MDS dated [DATE]; andResident #21's MDS dated [DATE]Record review from 3/2-6/26 of Residents #1, #2, #3, #4, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #21 medical diagnosis list included preventive measure clinical diagnosis Encounter for Prophylaxis.Record review 3/2-6/26 of the residents' medication orders, revealed 17 residents had the following order: Order name: Mupirocin topical, Status: completed, Details: 1 app [application], nasal, both nares [nostrils], form Ointment, BID [twice a day], M-F [Monday to Friday].Further review of the medical record revealed the following:Resident #1 had 10 weeks of completed ointment application from 11/16/25 to 2/26/26;Resident #2 had 12 weeks of completed ointment application from 9/27/25 to 2/26/26;Resident #3 had 17 weeks of completed ointment application from 7/13/25 to 2/26/26;Resident #4 had 5 weeks of completed ointment application from 12/14/25 to 2/26/26;Resident #5 had 7 weeks of completed ointment application from 12/15/25 to 2/26/26;Resident #6 had 17 weeks of completed ointment application from 7/1/25 to 2/26/26;Resident #7 had 8 weeks of completed ointment application from 11/16/25 to 2/22/26;Resident #8 had 4 weeks of completed ointment application from 1/11/26 to 2/26/26;Resident #9 had 15 weeks of completed ointment application from 8/11/25 to 2/26/26;Resident #10 had 13 weeks of completed ointment application from 9/8/25 to 2/26/26;Resident #11 had 8 weeks of completed ointment application from 11/24/25 to 2/26/26;Resident #12 had 10 weeks of completed ointment application from 10/19/25 to 2/26/26;Resident #13 had 18 weeks of completed ointment application from 6/29/25 to 2/26/26;Resident #14 had 9 weeks of completed ointment application from 11/10/25 to 2/26/26;Resident #15 had 13 weeks of completed ointment application from 9/8/25 to 2/26/26;Resident #16 had 2 weeks of completed ointment application from 2/8/26 to 2/26/26; andResident #17 had 10 weeks of completed ointment application from 10/27/25 to 2/26/26.During an interview on 3/4/26 at 5:38 PM, when asked why those residents mentioned above were prescribed Mupirocin 2% topical ointment antibiotic, the Medical Director (MD) stated the Mupirocin was used for the facility's decolonization protocol. He explained the facility had been using Chlorhexidine gluconate as soap substitute during residents' shower days and every other week the residents received Mupirocin 2% topical ointment nasal swab. When asked the rationale for the decolonization protocol, the MD stated to remove bacteria in the nose and the skin. When asked if the decolonization protocol was experimental research, the MD stated it was not, but it was considered the facility's performance improvement initiative. Quality Assurance and Performance Improvement (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025037	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yukon Kuskokwim Elder's Home	1100 Chief Eddie Hoffman Hwy Bethel, AK 99559

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(QAPI) Committee InterviewDuring an interview on 3/6/26 at 9:59 AM, the Administrator stated the facility's Quality Assurance and Performance Improvement (QAPI) committee was working on projects such as pressure injuries. She stated that QAPI was tracking and trending the project and if the plan was not working, they would discuss and plan again.When asked if the QAPI committee was aware of the facility's decolonization program, the QAPI committee stated the decolonization program was implemented through the infection control and that it was not discussed in QAPI meetings. The Chief Nursing Executive (CNE) provided a historical background to the project. She stated the MD implemented the decolonization program. When asked if the decolonization program was one of QAPI's performance projects, the CNE did not directly answer the question but stated that the MD reported it to QAPI. When asked what the timeframe of the program was, the committee had not provided the information and that the MD was collaborating with the Infection Preventionist. The CNE further stated the MD had been tracking and trending the program but had not submitted to QAPI. Infection Preventionist interviewDuring an interview on 3/5/26 at 11:08 AM, when asked about the decolonization program of the facility, the Infection Preventionist stated she was aware that Chlorhexidine was used as soap for the residents and the facility was initiating nasal swab. She further stated she was not up to date on the program; she was only recently made aware of it. When asked if she was monitoring the program, she stated she had not and she was not actively involved in the decolonization program, other than knowing about it.During the same interview, when asked if the decolonization program was discussed in the Infection Prevention and Control (IPC) meeting, she stated it could have been discussed but she could not say for sure.Review of the IPC meeting minutes dated 4/23/25, revealed in the LTC (long term care) report, .CHG [unknown acronym] Bathing Program.There was no other information about the program in the meeting minutes (3/1/25 and 1/29/26) provided by the facility. Medical Director InterviewDuring an interview on 3/6/26 at 10:47 AM, the MD stated the decolonization program was implemented on 7/1/25. He stated that the program would be permanent because it seems to be helping the residents in preventing infection and hospitalization.When asked if he had data from the facility that led him to the implementation of the program, the MD stated he was tracking hospitalization due to congestive heart failure and in September (unknown year) there was a respiratory illness that was never identified. He stated that possibly there was an infection that had no test for.During the same interview, the MD stated he listened to a webinar on decolonization. The MD could not remember the title but stated he would provide the email he had sent to YKEH personnel about the decolonization program. He further stated that the webinar made him excited and anticipated that if the facility implemented the program, it would reduce the hospitalization per year.Review of the MD's email, dated 7/25/24, revealed the email was sent to several personnel in YKEH (Yukon Kuskokwim Elders Home). Further review revealed: Esteemed colleagues, I have just listened to webinar #13 on decolonization in the AHRQ [Agency for Healthcare Research and Quality] Safety Program for MRSA [Methicillin-Resistant Staphylococcus Aureus] Prevention. Subsequently, I read the attached November 2023 New England Journal of Medicine article entitled: Decolonization in Nursing Homes to Prevent Infection and Hospitalization, which describes a study which found that continuous, routine decolonization of nursing home residents significantly reduced the rate of hospitalization. The interventions were.1. substituting 4% rinse-off chlorhexidine gluconate (CHG) for soap during routine bathing [CHG binds to the proteins of the skin and has an effect duration of about 24 hours] AND 2. Nasal decolonization twice daily, 5 days per week [Mupirocin 2% ointment would be my choice].The number needed to treat to prevent one hospitalization (apparently over the 18 month study period) was 8.9, which is relatively low. The article concluded that the ?cost-benefit ratio is likely to be very favorable' . I am currently tracking Elders Home hospitalization, so we can easily assess for impact.this sounds like relatively easy intervention for us to implement.During an interview on 3/6/26 at 10:47 AM, the MD stated he was tracking and trending the decolonization program. When asked if he reported or updated the QAPI committee in the monthly meetings, he stated No. He stated that the full year data would be available (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025037	A. Building B. Wing	03/06/2026

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on 6/30/26, which he would then present it to QAPI. QAPI Minutes of the MeetingReview of the facility's QAPI minutes of the meeting dated 12/18/25, 1/15/26, and 2/19/26, revealed decolonization program was not discussed. QAPI PlanReview of the facility's QAPI Plan, dated 8/2025, revealed: .Monitoring and Evaluation Activities.Administrator, DON, and QAPI Committee participants monitor a number of ancillary activities which, when combined with the mandatory measures, provides YKHC [Yukon Kuskokwim Health Corporation] with data for an overall evaluation of quality of care and safety.The QAPI Committee reviews data on a monthly basis, and trends data quarterly.Further review of the plan revealed: .The Elder's Home team members will conduct Performance Improvement Projects (PIPs) designed to take a systematic approach to revise and improve care or services in areas that are identified as needing attention. Leadership will conduct PIPs that lead to change and guide corrective actions within our systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents residing at the Elder's Home. As PIPs are identified, we will focus on conducting those that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes and lead to greater staff, resident, and family satisfaction. An important aspect of our PIPs is in monitoring the effectiveness of the performance improvement activities to determine whether the improvement has been sustained. Ongoing monitoring of the PIP, will be documented. The team will report their progress to the QAPI committee on a regular basis. The QAPI committee, in turn, will ensure that the following individuals and groups are informed of the PIPs and other QAPI activities: Board members, Elder's Home Staff, Residents and their families, [and] Others.

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	025037	A. Building B. Wing	03/06/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. .Based on record review, observation, and interview, the facility failed to provide an ongoing program of individualized, meaningful activities designed to meet the interests and needs of residents for 2 of 18 sampled residents (Residents #7 and #10). Specifically, the facility failed to: 1. implement activities consistent with residents' assessed preferences and care plan goals,2. ensure activities were actually provided as scheduled, and3. maintain effective oversight and evaluation of the activity program.These deficient practices placed residents at risk for social isolation, decreased psychosocial well-being, and diminished quality of life Findings:.Resident #7Record review from 3/2-6/26 revealed Resident #7 was admitted to the facility with diagnoses that included heart failure (mildly reduced heart pumping ability) with associated hemiparesis (weakness on one side of the body), hyperlipidemia (high blood fats/cholesterol), hypertension (high blood pressure), insomnia (difficulty sleeping), and colorectal cancer (cancer of the colon or rectum).During an interview with Resident #7's Representative on 3/3/26 at 1:12 PM, he/she stated that there was a lack of meaningful and consistent activities provided to residents. The representative reported that although an activities calendar was posted with scheduled events, such as baking and other programs, many of those activities did not actually occur, with bingo identified as the only activity consistently offered. He/she stated that when concerns were raised, activity offerings temporarily improved but were not sustained. Additionally, he/she stated that outings were infrequent, though a recent trip to a local high school was well received due to its rarity. The representative also reported that while an Eskimo dance group practices within the facility, residents were not informed or invited to participate or observe. Overall, he/she described the residents' daily routine as repetitive, consisting primarily of medications, meals, and bedtime, with little variation, including on weekends and holidays.Review of Resident #7's Activities Evaluation, dated 11/11/25, revealed: Activity Interests: Cards and Games Interest: Card games. Crafts and Art Interest: Hand crafts, Sewing, Other: tying fishing nets and other related items to subsistence lifestyle. Physical Activity Interest: Ball catching, Walking. Music Interest: Listen to music: Ball, Live music, Other: old school like Elvis. Spirituality and Religious Interest: Attend worship, Read Bible . Outing Interest: Movies, Seasonal events, Sightseeing.Review of the plan of care for Long Term Activities, last updated on 11/21/24, revealed: Resident #7 will participate in group activities x5/wk [week].will be involved with individual activities daily. (GOAL).Interests: Country and gospel music, Yup'ik radio call in shows, TV/movies, outings.Storytelling, working on fishing nets, Alaska Native culture, socials and sports.Review of Resident #7 Minimum Data Set (MDS - a federally required nursing assessment), Section F: Preferences for Customary Routine and Activities, dated 11/10/24 revealed Resident #7 responses to the importance of various activities while in this facility, coded on a scale where 1 is Very important, 2 is Somewhat important, and 3 is Not very important: A. How important is it to you to have books, newspapers, and magazines to read? [coded] 2 (Somewhat important); B. How important is it to you to listen to music you like? [coded] 2 (Somewhat important); C. How important is it to you to be around animals such as pets? [coded] 3 (Not very important); D. How important is it to you to keep up with the news? [coded] 1 (Very important); E. How important is it to you to do things with groups of people? [coded] 1 (Very important); F. How important is it to you to do your favorite activities? [coded] 2 (Somewhat important); G. How important is it to you to go outside to get fresh air when the weather is good? [coded] 2 (Somewhat important); H. How important is it to you to participate in religious services or practices? [coded] 2 (Somewhat important).Review of the Activity Detail Report - [Caretracker] for January, February, and March 2026 for Resident #7 revealed multiple entries for activities such as television viewing, music, exercise, socialization, and group programming. However, the documentation did not align with the posted activity calendar, as recorded activities did not correspond with scheduled events or times. Additionally, entries reflected generalized or repetitive activity types without clear evidence of individualized, meaningful engagement based on (continued on next page)

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	025037	A. Building B. Wing	03/06/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's assessed interests and care plan goals. Due to these inconsistencies, the documentation did not provide sufficient evidence that activities were implemented as planned. Random observations conducted throughout the survey from 3/2-6/26 revealed Resident #7 was consistently observed in his/her room and was not observed participating in or being offered scheduled group or individual activities. Despite a posted activity calendar indicating ongoing programming, there was no observed evidence of Resident #7's engagement in activities during the survey period. These observations were not consistent with the Resident's assessed interests and care plan goals for regular participation in both group and individualized activities.Resident #10Record review from 3/2-6/26 revealed Resident #10 was admitted to the facility with diagnoses that included low back pain (chronic lower back discomfort), microalbuminuria (small amounts of albumin in urine), osteoarthritis (joint degeneration and pain), pressure ulcer of coccyx (bed sore over tailbone area), and dementia (progressive cognitive decline).During an interview with Resident #10 on 3/2/26 at 4:48 PM, when asked about the activities that had been offered, he/she stated: Only Bingo but we haven't had that for a while.it's pretty boring, we don't do much.Review of Resident #10's Activities Evaluation, dated 1/30/26, revealed: Activity Interests: Cards and Games Interest: Bingo. Crafts and Art Interest: Hand crafts. Physical Activity Interest: Cooking: Low impact exercise, Hand crafts. Music Interest: Listen to music. Reading and Writing Interest: Mail. Spirituality and Religious Interest: Attend worship. Outing Interest: Movies, Seasonal events, Sightseeing . Interest in Social Conversation: Family/Friends, Other residents, Staff, Volunteer. Review of the plan of care for Long Term Activities, last updated on 7/23/24, revealed Resident #10 will participate in group activities x5/wk [week].will be involved with independent activities of choice daily. (GOAL).interests: Bingo, cooking, crafts, exercise, music/radio, church, tv/movies, van rides., community events, Native Alaskan Culture, socializing, mail. Review of Resident #10 MDS, Section F: Preferences for Customary Routine and Activities, dated 4/9/25, revealed Resident #10 responses to the importance of various activities while in this facility, coded on a scale where 1 is Very important, 2 is Somewhat important, and 3 is Not very important: A. How important is it to you to have books, newspapers, and magazines to read? [coded] 2 (Somewhat important); B. How important is it to you to listen to music you like? [coded] 3 (Not very important); C. How important is it to you to be around animals such as pets? [coded] 3 (Not very important); D. How important is it to you to keep up with the news? [coded] 3 (Not very important); E. How important is it to you to do things with groups of people? [coded] 3 (Not very important); F. How important is it to you to do your favorite activities? [coded] 2 (Somewhat important); G. How important is it to you to go outside to get fresh air when the weather is good? [coded] 1 (Very important); H. How important is it to you to participate in religious services or practices? [coded] 3 (Not very important).Review of the Activity Detail Report - [Caretracker] for January, February, and March 2026 for Resident #10 included documented entries for activities such as television viewing, music, exercise, socialization, and occasional group programming, including bingo. However, the documentation did not align with posted activity calendar, as recorded activities lacked correlation with scheduled events, specific times, or structured programming. Entries were generalized and did not clearly demonstrate individualized or goal-directed activity implementation based on the resident's assessed preferences. As a result, the documentation did not provide sufficient evidence that an ongoing, meaningful activity program was consistently provided.Random observations conducted throughout the survey from 3/2-6/26 revealed Resident #10 was primarily observed in his/her room and was not observed participating in scheduled activities, with the exception of one instance of participation in a Bingo activity. Despite a posted activity calendar indicating ongoing programming, there was limited observed evidence of consistent engagement in activities. These observations were not consistent with the Resident's assessed interests and care plan goals participation in both group and individualized activities.During an interview on 3/4/26 at 2:10 PM, with the Resident Council, Residents (#1, #2, #4, #8, #10, #14) stated they had very limited activity options, reported no activities and when asked what they do during the day, responded, (continued on next page)

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	025037	A. Building B. Wing	03/06/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nothing. Residents stated that just bingo was the only activity they were aware of, with no other consistent programming. When asked about activities occurring that day, residents reported no activities were offered. Residents expressed interest in having more variety, including outings in the summertime, as well as activities such as knitting, dancing, and cultural programs, indicating current activity offerings were minimal, lacked variety, and did not meet their interests.During an interview on 3/5/26 at 2:45 PM, Certified Nurse Assistant (CNA) #9 stated staff did not have an effective way to accurately track or log activities and reported that ?CareTracker' often did not reflect actual resident participation. CNA #9 stated the system did not allow staff to free-type notes and did not accurately reflect the activities that were actually provided, resulting in documentation that did not match what occurred. CNA #9 further described attempts to engage residents in activities such as crocheting, sewing, games, movies, and group exercises; however, residents frequently declined participation due to discomfort, lack of interest, or returning to their rooms after meals, and at times during Resident Council, residents expressed that activities were boring, making consistent engagement challenging. CNA #9 further added staff were not able to document refusals, since one cannot add those to ?Caretracker'.During an interview with the Activities Director (AD) on 3/5/26 at 2:00 PM, she stated she had been overseeing the activity program remotely from Minnesota and reported limited direct interaction with residents, stating, I haven't been out there since COVID, and that she was not able to complete face-to-face visits, relying instead on chart review and staff input. She stated, I rely on the staff quite a bit, and further explained, I'm remote, and it's not ideal. When asked about oversight of activity implementation, she stated she was dependent on knowing who's in the building doing the job and reported she was not responsible for creating the activity calendar, stating, I'm not the one making it because I'm not there. Regarding weekend programming, she stated, We don't have weekend coverage that I'm aware of. it's mostly what nurses can do, and described scheduled weekend activities as probably lacking. When asked about discrepancies between the activity calendar and documentation, she stated, That's why I need a copy of the calendar so I can check it against ?CareTracker', and added, I'm not there, so I can only do what I'm sent. She also stated she completed audits and QAPI (Quality Assurance Performance Improvement) reviews but had fallen off doing those lately, and reported, I would say they probably want more. it's obvious there are things we're missing. When asked the AD could not provide evidence the facility evaluated or revised the activity program in response to resident dissatisfaction.Review of the document titled Yukon Kuskokwim Health Corporation - Activity Director Job Description, revealed: . Position Summary: responsible for coordinating, directing, planning, and conducting the life enrichment activity programs, and this position will also work closely with community volunteers; . Position Responsibilities: .2. Designs a creative and exciting life enrichment program to meet group and individual needs and interests of the residents; 3. Plans and implements a life enrichment calendar each month that includes life skills, education, wellness, recreational, and spiritual programming, while providing individualized calendars for each resident, his or her families, and friends, and posting calendars throughout the facility; 4. Provides one-to-one programming for residents who cannot participate in a group setting; 5. Provides transportation for resident medical appointments and recreational outings; 6. Coordinates the holiday decorations with the help of residents and coordinating volunteers to help with events, as well as coordinating the help of other staff as necessary to bring residents to and from activities and events located on campus; 7. Maintains life enrichment budget, equipment, and supplies.Record review of the facility policy LTC [Long Term Care] Activity Evaluation & Care Plan, reviewed 5/2/23, revealed: .It is YKHC [Yukon-Kuskokwim Health Corporation] Elder's Home policy to assess each resident's physical, mental, spiritual, cultural, and leisure choices as well as each resident's preferences for participation in activities. This assessment will occur on admission, quarterly, and with condition changes per the Minimum Data Set (MDS) schedule. PURPOSE: To assure that the facility delivers an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025037	A. Building B. Wing	03/06/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of each resident. This may be achieved through group participation, independent activity, individual visits, and/or independent activity.