

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025018	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Polaris Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 910 Compassion Circle Anchorage, AK 99504	
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 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 under proper sanitary conditions in the North Dining Room resident/family refrigerators. This failed practice placed all residents who were able to consume food by mouth (based on a census of 39) at risk for foodborne illness. An observation on 11/18/25 at 1:00 PM, of the resident/family refrigerator revealed: - an unlabeled large yellow-lidded plastic food container holding a thick white liquid that had condensation/frost buildup. The container did not contain a date of preparation, resident identifier, or a discard date. The food container was stored directly on top of an unlabeled and undated clamshell container of grapes. An observation on 11/18/25 at 1:10 PM of the resident/family mini-refrigerator, revealed: - an undated and unlabeled white Styrofoam takeout container containing leftover food (rice with visible yellow residue/sauce). The container had no resident name, no date of preparation, and no discard date. The container lid was partially open, exposing the food to the refrigerator environment. - an unlabeled and undated plastic soup-type container containing a thick yellowish liquid or food product. The container showed no indication of the date it was placed in the refrigerator or when it should be discarded. During an interview on 11/19/25 at 10:00 AM, the Food Service Supervisor (FSS) stated every container in the resident/family refrigerators should have been labeled with a patient identifier, received date, and open date. The FSS also confirmed that the food items that were found presented a risk for contamination. Review of the facility provided policy Food and Nutrition Services, last reviewed on 3/2025, revealed: .food(s) brought to a resident by family/visitors must be stored and served in accordance with food safety professional standards. All foods shall be labeled with the resident name, location and date. Review of an FDA article titled Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, accessed at: https://www.fda.gov/media/127796/download#:~:text=Section%203%2D501.17%20specifies%20ready,C%20 revealed: .Section 3-501.17 specifies ready-to-eat, time/temperature control for safety (TCS). and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises. or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. These time/temperature parameters are intended to help control for growth of <i>Listeria monocytogenes</i>.		

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

FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 025018	If continuation sheet Page 1 of 16
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. .Based on record review, interview and observation, the facility failed to ensure care and services were provided in accordance with professional standards of practice and the comprehensive person-centered care plans for 3 residents (#12, #18, and #68) out of 43 residents (total census). Specifically, the facility failed to follow standards, care plan interventions, and physician's order directing staff not to obtain blood pressure measurements in the residents' compromised arms. This deficient practice resulted in the potential for compromised circulation, pain, and lymphedema. Resident #12: Record review from 11/17-21/25 revealed Resident #12 was admitted to the facility with diagnoses that included fracture of the right acetabulum (a break in the socket of the right hip joint where the head of the femur sits) and dependence on renal dialysis (medical treatment that filters waste, toxins, and excess fluid from the blood when the kidneys can no longer perform these functions effectively). Review of the physician's orders dated 10/14/25, revealed: AV SHUNT [surgical vascular access] OLD SITE: right upper arm- MONITOR FOR REDNESS, BLEEDING, SKIN BREAKDOWN, EDEMA every shift. [ORDER DATE] 10/14/2025. Further review of the orders revealed: NO NEEDLE STICKS, B/P [blood pressure], NO TIGHT CLOTHING OR JEWELRIES ON right arm old SHUNT. Can only take BP to left lower leg. Can do blood draw to left upper arm (s/p mastectomy [surgical removal of breast tissue]) every shift. [Order Date] 10/14/2025. Review of Resident #12's care plan, initiated on 10/14/25, revealed: NO BP to the right/left upper, take BP to left lower left only and blood draw only to left UE [upper extremity]. Review of Resident #12's Blood Pressure Summary revealed blood pressures entries documented on the left arm on 10/19/25, 10/25/25, 10/26/25, 10/30/25, 11/4/25, 11/12/25, and 11/16/25. Further review revealed blood pressure entries documented on the right arm, where Resident #12 has his/her old AV fistula (surgically created connection between an artery and a vein that provides reliable access for dialysis) site on 10/17/25, 10/22/25, 10/24/25, 10/30/25, and 11/8/25. During an interview on 11/20/25 at 1:54 PM, Resident #12 stated sometimes his/her blood pressure was read falsely low when measured on the leg, so he/she had told staff to measure the blood pressure on his/her left wrist. An observation on 11/20/25 at 1:54 PM revealed a sign above Resident #12's head of bed that read: CAN ONLY DO BP TAKING TO LEFT LOWER. Only use left UE for Blood draw. Resident #18: Record review on 11/17-21/25 revealed Resident #18 was admitted to the facility with diagnoses that included pulmonary fibrosis (lung-scarring disease), end-stage renal disease (kidneys permanently failed - dialyses required), dependence on renal dialysis, immunodeficiency associated with other specified major defects (severe immune deficiency), muscle weakness, difficulty walking and need for assistance with personal care. Review of the physician's orders last reviewed 10/30/25, revealed: .SHUNT/DIALYSIS SITE: Left AVF [arteriovenous fistula]. Review of Resident #18's Kardex (used by Certified Nurse Assistants (CNAs) for a quick access to resident's care plan), revealed: . Do not draw blood or take B/P in left arm with graft. An observation on 11/18/25 at 2:07 PM of Resident #18's room revealed a sign attached to a wooden door that read: NO BP. NO BLOOD DRAWS TO LEFT UPPER ARM. Review of Resident #18's Blood Pressure Summary from 10/28/25-11/18/25, revealed one entry where staff documented a blood pressure reading obtained in the left arm on 11/17/25. Resident #68: Record review on 11/17-21/25 revealed Resident #68 was admitted to the facility with diagnoses that included heart failure (a chronic condition in which the heart cannot pump blood effectively), insomnia, and pain. Review of the physician orders dated 9/27/25, revealed: NO BP'S, LABS, IV's (intravenous access) ON RUE (right upper extremity) - h/o (history of) RIGHT MASTECTOMY. An observation on 11/17/25 of Resident #68's room, revealed a sign posted at the head of the bed that read: NO BP. NO IV. NO LABS. ON THE RIGHT ARM. Review of Resident #68's Blood Pressure Summary from 9/26/25-11/14/25, revealed five separate entries where staff documented blood pressure readings obtained in the right arm on 10/3/25, 10/5/25, 10/17/25 (3:37 AM), 10/17/25 (8:50 AM) and 11/13/25. During interview on 11/21/25 at 8:50 AM, when asked how blood pressure readings (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be assessed on Resident #68, Licensed Nurse (LN) #2 stated: Place the cuff on his/her arm and take the BP. you can use either arm, he/she doesn't have any restrictions. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: .Don't measure blood pressure in an extremity that's affected by. mastectomy. because doing so can compromise lymphatic circulation and worsen edema. Likewise, don't take a blood pressure measurement on the same arm as an arteriovenous fistula or hemodialysis shunt, because blood flow through the vascular device might become compromised.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 obtain informed consent prior to the initiation and use of psychotropic medications for 1 resident (#47) out of 12 sampled residents. Specifically, the facility administered multiple psychotropic medications without documented informed consent from the resident or the resident representative. This failure denied the resident and/or resident representative the right to be informed of the risks, benefits, and alternatives of psychotropic medications and the right to participate in care planning and decision-making. Past Noncompliance: During a recertification, licensure and complaint survey conducted on 11/21/25 past noncompliance was identified at F552. The last standard recertification survey was conducted on 11/1/24. The state agency verified that the facility took appropriate corrective actions for noncompliance found at F552 with a correction date of 8/20/25 Record review on 11/17-21/25 revealed Resident #47 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (injury to the brain caused by a complete lack of oxygen, leading to the death of brain cells and potentially severe, long-lasting neurological impairments), bipolar disorder (mental health condition characterized by alternating periods of elevated and depressed mood, affecting energy, behavior, and daily functioning), and hemiplegia and hemiparesis following a cerebral infarction (weakness or inability to use one side of the body) affecting the left non-dominant side. Review of the current physician orders revealed the following: 1. QUETiapine Fumarate Oral Tablet 150 MG [milligram] (Quetiapine Fumarate) Give 1 tablet by mouth in the evening for TBI [traumatic brain injury], agitation, combativeness, yelling, aggression. [Start Date 8/20/25] [Quetiapine is an antipsychotic medication used to treat conditions such as schizophrenia, bipolar disorder, and depression by helping balance certain neurotransmitters in the brain.] 2. LORazepam Oral Tablet 2 MG (Lorazepam) Give 2 mg by mouth three times a day for TBI, cognitive impairment with aggression, combativeness. [Start Date 8/20/25] [Lorazepam is a benzodiazepine medication used to reduce anxiety, treat seizures, and provide sedation by calming activity in the brain and nervous system]. 3. hydrOXYzine HCl [hydrochloride] Oral Tablet (Hydroxyzine HCl) Give 25 mg by mouth three times a day for anxiety. [Start Date 7/28/25] [Hydroxyzine is an antihistamine medication used to treat anxiety, allergies, nausea, and insomnia by reducing activity in the central nervous system and blocking histamine]. Review of the facility's psychotropic consent form Psychotherapeutic Medications Facility Verification of Resident Informed Care, dated 8/1/25 revealed: . I have obtained informed consent from the resident/surrogate decision-maker for the use of: Hydroxyzine 25 mg PO [by mouth] 3x daily for anxiety. Lorazepam 2 mg PO BID [twice a day] for anxiety Lorazepam 1 mg PO [every] 4 as needed for anxiety. [signed by Resident Representative (RR)]. Review of the facility's psychotropic consent form Psychotherapeutic Medications Facility Verification of Resident Informed Care, dated 8/20/25 revealed . I have obtained informed consent from the resident/surrogate decision-maker for the use of: Lorazepam 2 mg PO TID [three times a day] for anxiety Quetiapine 150 mg daily in the evening. [VERBAL CONSENT VIA PHONE]. Psychotropic consents prior to 8/2025 were requested by the surveyor on 11/19/25. Review of the facility provided documents revealed: Consents for lorazepam 0.5 mg PRN [as needed] signed on 1/29/25 and 2/12/25. There were no informed consents for quetiapine, hydroxyzine, or olanzapine, despite these medications being administered prior to 8/2025. Review of Resident #47 ?s medication administration record (MAR) from 3/2025-8/2025 revealed the following psychotropics were administered without resident or the resident representative's consent: 1. hydrOXYzine HCl Oral Tablet 25MG (Hydroxyzine HCl) Give 1 tablet by mouth every 6 hours as needed for Anxiety -Order Date-03/06/2025 1551 -D/C [discontinued date] Date-07/28/2025 1254. The resident received a total of 122 doses from 3/12/25-7/28/25. 2. QUETiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for traumatic brain injury with behavioral disturbance attempted wean-Order Date-04/23/2025 0959-D/C Date-08/20/2025 1010. The resident received a (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	total of 223 doses from 4/23/25 to 8/20/25.3. ZyPREXA Oral Tablet 5 MG (Olanzapine) Give 1 tablet by mouth every 12 hours as needed for agitations, [aggression][MT2] , combativeness -Order Date- 04/25/2025 1710 -D/C Date- 05/02/2025 1145. The resident received a total of 8 doses from 4/25/25-5/1/25.4. OLANZapine Oral Tablet 5 MG(Olanzapine) Give 5 mg by mouth every 8 hours as needed for agitation/aggression-Order Date-05/02/2025 1118-D/C Date-05/07/2025 1620. The resident received a total of 10 doses from 5/2-7/25.5. ZyPREXA Oral Tablet 5 MG(Olanzapine) Give 5 mg by mouth every 8 hours for TBI with aggression/agitation-Order Date-05/07/2025 1623-D/C Date-05/17/2025 0933. The resident received a total of 27 doses from 5/1-16/25.6. ZyPREXA Oral Tablet 5 MG (Olanzapine) Give 1 tablet by mouth three times a day for [aggression], agitation, combativeness, TBI, Korsakoff syndrome [chronic memory disorder, usually caused by severe thiamine (vitamin B1) deficiency often related to long-term alcohol misuse] -Order Date- 05/17/2025 0933 -D/C Date-06/23/2025 2021. The resident received a total of 111 doses from 5/17/25 to 6/23/25.Review of the LN [Licensed Nurse] Psychoactive Medication Evaluation, dated 3/27/25 at 2:25 PM revealed Enter the name and dose of the psychoactive medication(s) used within the last 7 days. LORazepam, traZODone HCL, Hydroxyzine HCl .V. Informed Consent Obtained a. 0. Yes.Review of the LN Psychoactive Medication Evaluation, dated 8/4/25 at 8:52 AM revealed Enter the name and dose of the psychoactive medication(s) used within the last 7 days. quetiapine 50 mg BID [Twice daily] Olanzapine 5 mg TID [3 times a day].V. Informed Consent Obtained a. 0. Yes.Review of the LN Psychoactive Medication Evaluation dated 5/5/25 at 4:30 PM revealed Enter the name and dose of the psychoactive medication(s) used within the last 7 days. LORazepam Tablet 0.5 MG *Controlled Drug* BID, LORazepam Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug*Give 2 tablet by mouth every 6 hours as needed for aggression, combativeness traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 50 mg TID QUetiapine Fumarate Oral Tablet 50 MG Give 1 tablet BID OLANZapine Oral Tablet 5 MG Give 5 mg by mouth every 8 hours PRN.V. Informed Consent Obtained a. 9. Unable to Determine.During an interview on 11/21/25 at 11:30 AM, the Administrator stated that the psychotropic consents for lorazepam were the only consents on file prior to 8/2025.Review of facility policy Psychotropic Medication Management, dated 3/2025, revealed: 8. Upon initial comprehensive assessment, the SSD [social services director] designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. The facility's Interdisciplinary Team (IDT) will review to ensure. Informed consent was obtained prior to medication use. 9. Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication or if the dosage of an existing psychoactive medication increases.Corrective ActionsThe facility has since corrected this noncompliance as of 8/20/25, implementing the following:On 8/1/25, the facility obtained psychotropic consent for Hydroxyzine 25 mg, Lorazepam 2 mg and Lorazepam 1 mg from the RR.On 8/20/25, the facility obtained psychotropic consent for Lorazepam 2 mg and Quetiapine 150 mg from the RR		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. .Based on record review, interview, and observation, the facility failed to ensure 1 resident (#18), out of 12 sampled residents, was given the opportunity to make choices about aspects of his/her life that were significant to him/her. Specifically, the facility failed to ensure the resident had the opportunity to receive a shower and/or a bath according to his/her preferences. This failed practice had the potential to affect the resident's quality of life and sense of well-being Resident #18Record review on 11/17-21/25 revealed Resident #18 was admitted to the facility with diagnoses that included pulmonary fibrosis (lung-scarring disease), end-stage renal disease (kidneys permanently failed - dialyses required), dependence on renal dialysis (Kidney failure requiring dialysis), immunodeficiency associated with other specified major defects (severe immune deficiency), muscle weakness, difficulty walking and need for assistance with personal care.During an interview on 11/18/25 at 9:26 AM, Resident #18 stated he/she would like to take a shower on Tuesdays or Wednesdays and/or weekends. The resident further stated that sometimes he/she asked for it but was told no by staff, who told Resident #18 that was not on his/her schedule. Resident #18 added: because of the dialysis days I am supposed to be resting the days staff wants me shower.Minimum Data SetReview of Resident #18's Minimum Data Set (MDS - a federally required assessment), dated 10/30/25, revealed Resident #18 needed assistance with bathing, dressing. Resident needed partial assistance from another person to complete any activities. E. Shower/bathe self. substantial/maximal assistance. Further review of this document under Section F - Preferences for Routine and Activities, dated 11/4/25, when asked How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Resident #18 answered Very important.During an interview on 11/19/25 at 11:30 AM, the MDS Nurse stated that resident preferences for showers or baths were documented in Section F of the MDS. She further explained that the activities department should have obtained these preferences at the time of the resident's admission. She also stated that these preferences should have been included in the care plan; however, for Resident #18, this information was not documented.Care Plan and Kardex (Resident Daily Care Plan)Review of Resident #18's IDT Care Plan Review - V 2, dated 10/30/25, revealed: .Dialysis M (Monday), W (Wednesday), F (Friday) .[he/she] has dialysis 3 times a week, prefers to rest when [he/she] comes back to facility.Further review of the care plan revealed Resident # 18's shower preference or schedule were not included.Review of the Kardex, dated 11/19/25 revealed Resident # 18's shower preference or schedule were not included.During an interview on 11/19/25 at 11:40 AM, Certified Nursing Assistant (CNA) #1 stated that the facility maintained a daily assignment schedule for resident showers, with each resident typically receiving two scheduled showers per week. CNA #1 explained that Resident #18, was assigned nighttime showers. When asked whether residents may independently choose their own shower times, CNA #1 clarified that the facility followed a set schedule for all residents.During an interview on 11/19/25 at 12:00 PM, CNA #2 stated that some residents refused their scheduled showers, and when refusals occur, CNAs documented them directly in the electronic record. CNA #2 further stated: residents cannot choose to shower on days outside their assigned schedule, as staffing levels and workload make it difficult to accommodate unscheduled showers. While this CNA tried to provide showers, when possible, he/she emphasized that it cannot be promised on a resident's preferred day, and the facility generally adhered strictly to the pre-established shower schedule.During an interview on 11/19/25 at 11:11 AM, the Director of Nursing (DON) stated that she had direct oversight of CNAs, managed their schedule, and coordinated competencies and staff education. DON also stated activity preferences were gathered by the activity staff, while shower preferences were expected to be obtained by the admitting nurse and added to the appropriate shift's shower schedule and care plan, with updates made if a resident requested changes. In reviewing the case of Resident #18, the DON stated that no documented shower preference could be found in the (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission assessment, care plan, Kardex (staff reference sheet), or shower schedules. During the same interview, the DON further stated that she had not previously been informed of the resident's preference to avoid showers on dialysis days and agreed that this pattern should have prompted an adjustment to schedule showers on non-dialysis days to meet the facility's twice-weekly shower expectation. Review of the Treatment Administration Record (TAR) with the DON, on 11/19/25 at 11:11 AM, revealed Resident #18 had two showers marked, with multiple refusals recorded but without reasons consistently documented or supported by nurse progress notes. Review of Resident #18's Documentation Survey Report v2 [version] . Intervention/Task . Bathing ., revealed: period from 10/28/25 to 11/18/25, Resident #18 received a shower twice on 11/2/25 (Sunday) and 11/16/25 (Sunday). For the same period, Resident had 3 documented refusals respectively on 11/7/25 (Friday - dialysis day), 11/10/25 (Monday - dialysis day) and 11/14/25 (Friday - dialysis day). Random observations conducted from 11/17-21/25 of Resident #18's room revealed no signage of the resident's shower preference. Review of the facility's policy Routine Procedures - Residents' Bath, Shower, dated 2/2022, revealed: . It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. Residents will be assisted to have a shower or full bath at least 2x/week or resident preference. Review of the facility's policy PTC/PEC [Polaris Transitional Care/ Polaris Extended Care] STANDARDS OF CARE, updated 3/1/25, revealed: . AM CARE (EVERY MORNING)/ H.S. [bedtime] CARE (EVERY HS AT BEDTIME): Hands and face washed, Toileted & Peri Care. Maintain dignity. Oral Care. PERIODIC CARE: Shower/Bath as scheduled. Provide a complete bed bath and report to PCN [unknown] (.). ONGOING CARE: . Provide peri care after voids . APPROACHES . listen to resident. Affirm self-worth and dignity. Avoid controlling, negative words such as No, Don't, You can't. Promote resident choice and right to express concerns .		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure a resident's advance directive (AD) was obtained and maintained in the medical record and was readily accessible to staff for 1 resident (#47) of 12 sampled residents. Specifically, the facility did not obtain, verify, or properly file the resident's advance directive upon admission, resulting in staff being unaware of the resident's documented treatment preferences. This failure placed the resident at risk for receiving care or interventions inconsistent with the resident's expressed wishes and compromised the resident's right to request, refuse, and/or discontinue treatment. Record review on 11/17-21/25 revealed Resident #47 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (injury to the brain caused by a complete lack of oxygen, leading to the death of brain cells and potentially severe, long-lasting neurological impairments), bipolar disorder (mental health condition characterized by alternating periods of elevated and depressed mood, affecting energy, behavior, and daily functioning), hemiplegia and hemiparesis following a cerebral infarction (weakness or inability to use one side of the body) affecting the left non-dominant side. Review of the Quarterly MDS (Minimum Data Set- a federally required assessment used in long-term care facilities to collect information about a resident's health, functional status, and care needs to support care planning), dated 11/10/25, revealed Resident #47 was not screened with the Brief Interview for Mental Status due to rarely or never understanding. Further review revealed a staff-assessed cognitive score of 3-severely impaired-indicating the resident never or rarely made decisions regarding tasks of daily life. Review of the electronic health record (EHR) on 11/18/25 at 10:01AM revealed Resident #47's code status was documented as DNR [Do Not Resuscitate]/ Do Not Attempt Resuscitation. Review of Resident #47's EHR on 11/18/25 at 10:03 AM, under Misc (Miscellaneous) section, revealed no advance directive was present. Review of the Contacts section revealed Resident #47 was listed as the Care Conference Person Legal Representative Resident/Self. Further review identified Resident Representative (RR) #1 listed as an emergency contact and resident representative. Review of Resident #47's AD provided by the facility revealed the facility did not have Resident #47's AD until after the surveyor requested a copy on 11/19/25. Review of the admission Notes revealed the following: 1. [11/19/25 at 2:11 PM] Called ANMC [Alaska Native Medical Center] and spoke with CM [case manager] . regarding patient records at ANMC. Per [CM] there is no Advance Directive or POLST [Physician Orders for Life-Sustaining Treatment] on file at ANMC for [Resident #47]. 2. [11/19/25 at 2:22 PM] Spoke with case manager at Alaska Regional Hospital, regarding records during recent hospitalization for [Resident #47] in January. They do have an Advance Directive on file for [him/her] and will fax to Polaris today for continuity of care. 3. [11/19/2025 at 2:42 PM] Called [Resident #47's RR] and POA [Power of Attorney] .to arrange a time to sign admission [agreement], consent forms and Advance Directive Acknowledgement. Left a voice message for a return phone call. Review of the Advance Health Care Directive, faxed to the facility on [DATE] revealed the listed Health Care Agent did not match the name of RR #1. Further review revealed the document did not contain a signature, date, witness signature, or notary signature. During an interview on 11/19/25 at 4:15 PM, the Administrator stated the facility received Resident #47's advance directive via fax from Alaska Regional Hospital that day, and the facility did not have a copy of the advance directive prior to 11/19/25. During an interview on 11/21/25 at 9:24 AM, the Assistant Administrator (AA) stated the facility provided written information about advance directives upon admission and would document receipt of this information in the admission agreement. The AA further stated that the facility could not access the resident's original admission agreement. Review of the facility's policy Advance Directives and Associated Documentation, dated 3/2025 revealed: It is the policy of this facility that a residents' choice about advance directives will be recognized and respected. Further it is policy of this facility (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Polaris Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 910 Compassion Circle Anchorage, AK 99504	
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. It is policy of this facility to implement the resident decisions and directives that are in compliant [compliance] with State and/or Federal Law and the policies of this facility. Definitions: Advance directive: A written instruction that related to the provision of health care when the individual is incapacitated, such as a Living Will, Durable Power of Attorney for Health Care or the Natural Death Act. These documents allow the individual to identify choices related to their medical treatment or designate someone to make treatment choices for them should they lose decision making capacity for themselves. Procedure: 1. Prior to, or immediately after admission, a facility staff member shall: a. Provide the resident/family or responsible agent written information, in a manner easily understood by the resident or resident representative, regarding the right to accept to refuse to formulate Advance Directives. 4. If the resident is incapacitated and not capable of independent decision-making at the time of admission: a. Inform the surrogate decision maker to document their desire to initiate an advance directive and their knowledge that this decision is in the resident's best interest or is to comply with resident's known desires, when this need arises. b. If the surrogate decision-maker is a family member, not identified on an Advanced Directive document, all members of the immediate family with equal relationship to the resident will need to agree and sign the document. i. In the event opinions differ among family members, the Advance Directives will not be implemented until a resolution is achieved. 6. Obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. .Based on record review and interview, the facility failed to report to the State Survey Agency (SSA) and Adult Protective Services (APS) an allegation of resident neglect no later than 24 hours after the allegation was made as required by 42 Code of Federal Regulation (CFR) S483.12(c)(1), for 1 resident (#69), out of 3 unsampled residents reviewed for compliance with reporting requirements. This failed practice placed Resident #69 at risk for ongoing neglect, unaddressed care concerns, and further exposure to mistreatment and/or mental anguish Record review on 11/17-21/25, revealed Resident #69 was admitted to the facility with diagnoses that included unspecified abnormalities of gait and mobility (gait and mobility impairment), wedge compression fracture of lumbar vertebra (vertebral collapse fracture), COPD (chronic obstructive pulmonary disease) and osteoporosis (bone-thinning disease). Resident #69 was also legally blind and had documented past medical history of frequent falls. Record review of the facility's Resident Concern & Feedback [Grievance] Form, dated 6/15/25, revealed an email from Resident #69's Representative, dated the same day, describing multiple incidents he/she believed constituted neglect. Further review of the grievance revealed the Representative reported that Resident #69 received high doses of narcotic pain medication during the early weeks of admission, despite documented cautions from two prior facilities regarding the resident's history of opioid-induced delirium. The Representative stated this resulted in significant delirium and confusion, which prevented Resident #69 from participating meaningfully in therapy. According to the grievance, skilled-nursing coverage was denied on 4/23/25 due to lack of progress, after which the resident became a private-pay resident. The Representative's communication further alleged multiple care concerns since the denial of coverage, including:- Repeated preventable falls, including one in early June 2025 after a recent kyphoplasty (surgical procedure with balloon-assisted vertebral cement augmentation). He/she stated that the fall occurred when call-light requests for toileting assistance were not addressed, resulting in a new acute L4 compression fracture.- Failure to notify family of the falls and of the newly sustained fracture.- Failure to provide an escort or pre-medication for diagnostic imaging appointments despite residents' pain and blindness.- Neglect of meal assistance, with meals reportedly being placed at the bedside without description, un-covering, or feeding assistance for a legally blind resident.- Pain-medication delays routinely exceeding one hour.- Repeated loss of personal laundry.- Refusal to release medical records to a receiving facility in anticipation of the resident's transfer.- Exposure to an aggressive co-resident who allegedly broke windows and yelled into other residents' rooms, creating an unsafe environment.- Minimal or absent communication from physicians, nurse practitioners, and nursing staff regarding the resident's condition, treatment, or care needs. The Representative stated he/she believed the environment was unsafe and neglectful, urging for an immediate transfer for Resident #69. Review of Resident #69's medical record from 11/17-21/25 revealed no documentation was found showing the facility reported these allegations of neglect to the SSA or APS, as required. During an interview on 11/21/25 at 11:00 AM, Quality Director (QD) stated that when she assumed her role, she reviewed all existing grievances and was surprised by several findings. She implemented staff re-education and began addressing systemic issues, recognizing that follow-up on grievances had not been handled appropriately prior to her arrival. QD explained that although previous staff had submitted a report of the resident's fall, the Resident Representative's four-page complaint had not been included in any documentation or in the final report, which suggested a communication breakdown within social services at that time. QD further stated regarding APS reporting, that she did not know whether the case had been reported at the time because no formal APS reporting system existed then; she later identified this as a deficiency and implemented a system for social services compliance, revised grievance forms, provided staff education, and reset expectations for grievance handling. She continued stating that prior to her arrival, grievances were not consistently captured, and that QD now (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviews and signs every grievance, with final sign-off occurring only after resolution with the resident or family. She concluded: I would have erred on the side of caution and reported the allegation as possible neglect. Review of the facility's policy Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, last revised 3/2025, revealed: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but:- Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury- Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. The Administrator of the Facility; b. The State Survey Agency; c. Adult Protective Services (as appropriate) .3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that the results of all investigations are reported within five (5) working days of the incident to: a. The Administrator and b. The State Survey Agency 5. Ensure that, if the alleged violation is verified, appropriate corrective action is taken. 6. Guidelines for Facility Compliance: In order to comply with the Facility's obligations as set forth in 42 CFR 483.12, it will: a. Make all staff aware of the applicable reporting requirements upon hire and annually. b. Educate all staff on the definitions of abuse, neglect, mistreatment, exploitation, and misappropriation of resident property .Review of the facility's Policy/Procedure Grievances, last revised 11/23/21, revealed: 5. The Grievance Official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property to the Administrator; and as required by State law.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to ensure the drug regimen for one resident (#41), out of 12 sampled residents, was free from unnecessary medication. Specifically, the facility failed to prevent duplicate drug therapy by continuing a maintenance dose concurrently with a high-dose of prednisone (corticosteroid medication used to reduce inflammation and suppress the immune system) without a documented clinical rationale confirming the benefits of maintaining both doses of the medication. This failed practice placed Resident #41 at risk for potential adverse effects from unnecessary medication administration related to excessive corticosteroid exposure. Record review on 11/17-21/25, revealed Resident #41 was admitted to the facility with diagnoses that included aftercare following joint replacement surgery and dislocation of the internal right hip prosthesis (artificial components of a right hip replacement move out of their normal position, causing loss of joint alignment, pain, and impaired mobility) and chronic obstructive pulmonary disease (COPD- a long-term lung condition that causes airflow blockage and breathing difficulties). Review of the physician progress notes, dated 10/17/25, revealed: [Resident #41] has been coughing since [he/she] got here with shortness of breath has had COPD exacerbations [sudden worsening of COPD symptoms-such as increased shortness of breath, coughing, and mucus production-often triggered by infection or environmental irritants] in the past [plus] sputum production . COPD: steroid burst [short course of high-dose corticosteroids such as prednisone used to quickly reduce inflammation during acute flare-ups of COPD] and taper. Review of Resident #41's Consultant Pharmacist's Medication Regimen Review [MRR] October 2025 revealed Resident [#41] has two orders for prednisone for COPD; one order is a 5 mg tablet dose once daily for COPD and the second order is for a 15-day taper using the 20 mg tablet. Please confirm if the once daily 5 mg tablet dose is to start after the conclusion of the taper (and is so annotate it as such) or if that order needs to be discontinued. Further review revealed a handwritten note signed by the ordering physician reading: Correct 5 mg is maintenance, kept so wouldn't get lost #1 Burst + Taper prednisone #2 Taper extended d/t [due to] severe COPD. [signature of MD] 11/5/25. Review of Resident #41's medication administration record (MAR) of October 2025 and November 2025 revealed the following: 1. predniSONE Oral Tablet 5 MG (Prednisone) Give 1 tablet by mouth in the morning for copd. [Order Date] 10/08/2025. Administered since 10/9/25. 2. predniSONE Oral Tablet 20 MG (Prednisone) Give 3 tablet by mouth one time only for COPD exacerbation for 1 Day [Order Date] 10/17/2025. Administered on 10/17/25. 3. predniSONE Oral Tablet 20MG (Prednisone) Give 3 tablet by mouth in the morning for copd exacerbation for 2 Days. [Order Date] 10/17/2025. Administered on 10/18/25 and 10/19/25. 4. predniSONE Oral Tablet 20 MG (Prednisone) Give 2 tablet by mouth in the morning for copd exacerbation for 3 Days [Order Date] 10/17/2025. Administered 10/20-22/25. 5. predniSONE Oral Tablet 20 MG (Prednisone) Give 2 tablet by mouth one time [NAME] for copd exacerbation for 5 Days [Order Date] 10/22/2025. Administered 10/23-27/25. 6. predniSONE Oral Tablet 20 MG (Prednisone) Give 1 tablet by mouth one time a day for copd exacerbation for 5 Days [Order Date] 10/22/2025. Administered 10/28/25-11/1/25. 7. predniSONE Oral Tablet 20 MG (Prednisone) Give 0.5 tablet by mouth one time a day for copd exacerbation for 5 Days [Order Date] 10/22/2025. Administered 11/2-6/25. Further review of the MAR revealed between 10/18/25-11/6/25, a total of 19 days, Resident #41 received between 15 mg to 65 mg of prednisone daily, reflecting the addition of the 5 mg maintenance dose to the steroid burst and taper. During an interview on 11/19/25 at 7:10 AM with Pharmacist #1, he/she stated part of his/her duties at the facility was to conduct monthly medication regimen review for the entire facility. He/she further stated, he/she emailed the facility and documented in the facility's EHR (electronic health record) a recommendation to clarify the prednisone 5 mg dose after the prednisone burst and taper course. He/she stated when a physician prescribed a steroid burst and taper of prednisone, the maintenance dose of prednisone if prescribed, is typically discontinued during the (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	duration of that burst and taper. Pharmacist #1 stated he/she did not verify the orders of prednisone when orders were entered by the physician but that the EHR alert system would have flagged for duplicate medication. Pharmacist #1 stated he/she would have double checked with the prescriber whether the maintenance dose of prednisone should be continued or not. Pharmacist #1 stated when medication orders were entered by the physician, the physician would be able to modify the medication administration start time if they wished, for example enter an order for Resident #41's maintenance dose of prednisone 5 mg with a future start time in one or two weeks. During an interview on 11/19/25 at 10:15 AM, the Administrator stated she would receive an email from Pharmacist #1 of all the monthly medication reviews then a printed copy of the recommendation would be handed to the physician. The physician would review the recommendations and acknowledged the pharmacist's recommendation by affixing his signature. During an interview on 11/19/25 at 10:34 AM, when asked what the clinical rationale for maintaining maintenance dose and burst and taper dose, the Medical Director (MD) stated that he left the maintenance dose of prednisone 5mg on the MAR because he didn't want the maintenance dose to get lost as it has happened in the past. MD further stated he discussed keeping the maintenance dose with Resident #41 in which the resident consented. MD stated he may or may not have gotten a notification from the verifying pharmacist when entering orders for the prednisone burst and taper regarding whether to continue the maintenance dose. Record review of the facility's Pharmacy Service Agreement Review, undated, revealed (a) On a monthly basis, during the previously scheduled visit to the Customer, a Consultant Pharmacist shall perform a medication regimen review (MRR) for each Resident on active Customer census on the visit date (b) Within 48 hours after conducting the MRR, the Pharmacy or Consultant Pharmacist shall provide the MRR report to Client's Administrator/Executive Director and Director of Nursing. When irregularities are noted, the MRR report documenting such irregularities will be provided to Client's Administrator/Executive Director and Director of Nursing. Electronic delivery of the report is an appropriate alternative to hard copy.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview, and record review, the facility failed to ensure the electronic health record (EHR) of 1 resident (#3), out of 12 sampled residents, was maintained in a manner to ensure confidentiality from unauthorized access. Specifically, Licensed Nurse (LN) #1 left the medication cart computer screen unlocked and unattended in a hallway. This failed practice had the potential to place the resident's medical record at risk for unauthorized access and use. An observation on 11/18/25 at 11:21 AM, revealed the nurse's medication cart for the Iliamna Hall was located in front of the clean utility room of the south hall unattended. Further observation revealed the cart's computer screen was not locked and access to resident records was available. During an interview on 11/18/25 at 11:21 AM, the Business Office Manager (BOM) stated the computer should not have been left open and accessible. The BOM located an LN (unidentified) and requested them to lock the computer. An observation on 11/19/25 at 9:03 AM, revealed LN #1 was preparing for medication administration for Resident #3. While preparing the medication, he/she checked the Medication Administration Report (MAR) in Point Click Care (PCC-facility's EHR). After the medication preparation, LN #1 minimized the PCC without locking the computer screen then proceeded to Resident #3's room and administered the medications to the resident. Further observation revealed the medication cart was left in the hallway unattended. During an interview on 11/19/25 at 9:30 AM, when asked if anybody can access resident's medical record when the computer screen was not locked, LN #1 stated, yes. The LN further stated that he/she would have locked the PCC screen by clicking the lock icon. However, that time he/she forgot to lock the screen. During the same interview, LN #1 stated he/she had been trained on how to lock the computer. Review of LN #1's HIPAA (Health Insurance Portability and Accountability Act) training certificate revealed he/she completed the training on 3/25/25. Review of the facility's New Hire HIPAA Training module, undated, revealed: .Securing Protected Health Information in HIPAA terms, secured means that Protected Health Information (PHI) is safeguarded from access by unauthorized individuals. We log off computers when not in use. During an interview on 11/20/25 at 1:13 PM, the Director of Staff Development (DSD) stated all nurses were trained in HIPAA. When asked how staff secure PHI, she stated the staff should keep the screen off or log-off and make sure the computer was locked. When informed about LN #1 not locking the computer screen during the medication administration, she stated [he/she] should not have done that. The DSD further stated the PCC MAR had a lock icon that the LN should have used to lock the computer screen. Review of the facility provided [NAME] (facility's service provider) HIPAA Compliance Policy and Procedure, revision date 3/24/16, revealed: . Accessing, using, and/or disclosing PHI will be limited to the minimum necessary to accomplish the intended purpose. the Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclose PHI.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. .Based on record review and interview, the facility failed to maintain its Infection Prevention and Control Program (IPCP). Specifically, the facility failed to:Maintain a system for consistent preventing, identifying, reporting, investigating, and controlling infections, such as occupational bloodborne pathogen (infection spread in the blood) exposures.Maintain a system for recording occupational bloodborne pathogen exposures and documenting the corrective actions taken by the facility.Formalized reporting and communication of infection control issues across departments and committees, including Quality Assurance and Performance Improvement (QAPI) and Human Resources (HR), to monitor trends and implement preventive actions.These failed practices had the potential for ineffective Infection Control Program and increased the potential risk for development and transmission of disease and/or infection in all residents (based on a census of 43) and staff. Review of the facility document titled Infection Control Tracking Spreadsheet, (undated, modified 11/20/25), revealed the following entry:- On 8/3/25, Certified Nurse Assistant (CNA) #4 reported an occupational exposure while performing a blood-sugar finger stick. After pricking the resident's finger with a lancet and squeezing to obtain blood, blood splashed into CNA #4's right eye.- CNA #4 was wearing a face mask and gloves but no eye protection.- The CNA rinsed the eye with saline and notified the charge nurse the same day.- The Infection Preventionist (IP) was not notified until 8/5/25.- The record marked yes for completion of an employee injury report and receiving bloodborne pathogens education.Further review of the tracking sheet, revealed:- No details of the education provided were documented.- No follow-up treatment was recorded after the CNA declined initial medical evaluation.- and the employee's phone number was not recorded.Review of the Employee Statement of Accident, dated 8/6/25 revealed the employee later sought medical treatment on an undisclosed date, inconsistent with earlier documentation that no follow-up treatment was given. During an interview on 11/20/25 at 5:00 PM, the IP nurse stated that the only documentation the facility had for the blood-to-eye exposure involving CNA #4 was the employee's self-report form, the supervisor's accident/exposure form, and his/her own IP tracking spreadsheet. She further stated although CNA #4 initially refused treatment, CNA #4 later informed the charge nurse-not the IP-that he/she had gone to his/her primary care provider. The IP added that she reviewed the source resident's chart and found no documented history of HIV or hepatitis, noting that the facility usually checks history rather than drawing source labs unless there was a specific concern. The IP further described the facility's exposure-evaluation process, which includes first-aid guidance, collecting incident details, documenting the event, providing bloodborne pathogen education, and referring employees for initial and follow-up testing when indicated.During the same interview, the IP nurse further stated that root-cause analyses were typically reserved for more serious exposures, such as needle-stick injuries. Regarding the facility's corrective actions for the blood exposure incident, the IP counseled the employee on using appropriate PPE-such as a face shield-to prevent future splashes, documenting this only on her spreadsheet. The IP nurse stated she did not forward the incident to the QAPI committee but did verbally notify the administrator, noting that QAPI typically reviews resident infections, while Human Resources (HR) oversees most employee injuries unless they involve bloodborne pathogen exposure.During an interview on 11/21/25 at 10:30 AM, the Administrator stated that the facility managed infections and communicable diseases among staff through daily morning stand-up meetings where the IP would report any new illnesses, precautions, or potential outbreaks. She explained that communication was primarily verbal. She further stated the IP was supposed to maintain her own tracking log and providing written infection-control updates monthly during QAPI meetings.Regarding occupational exposures such as the blood-to-eye incident involving CNA #4, the Administrator explained that the process would begin with the supervisor completing an incident report, which would be sent to HR and workers' compensation. HR then would communicate the case to the IP, who was expected to track, investigate, and follow up with the employee, including (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintaining written documentation. The Administrator stated she learned about this exposure during morning stand-up the day after it occurred but did not recall any further discussion with the IP about follow-up. She also verified that the exposure was not documented in QAPI minutes for neither August or September of 2025. The Administrator stated that there appeared to be a breakdown in communication between the IP, HR, administration, and QAPI. During the same interview, the Administrator further stated that she would oversee infection control through daily stand-up updates, monthly QAPI reports, and one-on-one meetings with leadership, including the IP: in this case, the system failed to ensure proper tracking, follow-up, or communication regarding the bloodborne pathogen exposure and that the facility lacked documentation of the IP's investigation or staff education. During an interview on 11/21/25 at 12:30 PM, the Medical Director (MD) stated: that although he was responsible for coordinating resident care and supporting infection-control processes, he was not aware of the bloodborne pathogen exposure in which CNA #4 received blood in his/her eye. After reviewing his messages, he confirmed he had not been notified of this incident and had not reviewed the source resident nor ordered any related labs. He explained that, in general, the IP nurse was supposed to consult with him regarding exposures, source-patient testing, and any needed post-exposure protocols. He added that he would meet formally with the IP nurse once a month, with occasional additional informal check-ins, but had no other routine oversight role beyond these interactions. Review of the facility-provided Bloodborne Pathogens Exposure Control Plan (ECP), undated, revealed: . Record keeping . In the event of an exposure incident, the following records will be kept in the employee's medical file:- The results of any examination, medical testing, and follow-up procedures.- A copy of the treating physician's written opinion to the employer.- A copy of all information provided by the employer to the health care professional regarding the exposure incident. Record every needlestick on the OSHA [Occupational Safety and Health Administration] 300 Log and/or the Sharps Injury Log. Record all other exposure incidents that result in medical treatment, (e.g., gamma globulin, hepatitis B immune globulin, hepatitis B vaccine, etc.) on the OSHA 300 log. Retain these records for five years. Plan evaluation and review the exposure control plan and update it at least annually. Review of the document Job Description- Infection Preventionist, signed on 3/1/25 revealed: Assist all departments in evaluating and classifying routine and job-related functions to ensure that tasks involving exposure to blood/body fluids are properly identified. Monitor infection control practices and procedures to ensure that personnel are implementing our standard operating procedures for tasks involving exposure to blood/body fluids. Further review of this document revealed: Prepare monthly summaries of all facility/resident/personnel infections, corrective action taken, and the results of the corrective action. Submit copies to the Administrator and Director of Nursing Services. Maintain a written record of all residents and employees who have nosocomial infections. Provide personnel with information concerning the facility's policies governing hepatitis B vaccinations. Report occupational exposures to blood, body fluids, infectious materials, and hazardous chemicals in accordance with the facility's policies and procedures governing accidents and incidents. According to the Centers for Disease Control (CDC) and Prevention (https://www.cdc.gov), an effective infection prevention and control program includes systems to promptly identify, report, and investigate potential sources of infection, ensure proper use of personal protective equipment, manage exposures to blood and body fluids, and implement corrective measures to reduce transmission risks in healthcare settings		