

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Polaris Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 920 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure the transfer or discharge of 1 resident (#1), out of 4 residents reviewed for transfer and discharge requirements, met the requirements of 42 CFR S483.15(c). Specifically, after determining Resident #1 would not return to the facility following hospitalization, the facility failed to establish and document the basis for the discharge, identify the specific resident needs the facility could not meet, document the facility's attempts to meet those needs, and identify the services available at the receiving facility to meet the resident's needs. This deficient practice placed the resident at risk of inappropriate discharge and disruption in continuity of care necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being Findings:.Record review on 6/11/26 revealed Resident #1 was admitted to the facility with diagnoses that included pneumonia (an infection that inflames air sacs in one or both of the lungs) due to methicillin resistant staphylococcus aureus (MRSA - a type of antibiotic resistant bacteria), chronic obstructive pulmonary disease and acute and chronic respiratory failure with hypoxia (low level of oxygen in the body tissues). Review of the Physician Order, dated 4/30/26, revealed: Psychiatry: May see psychiatry prn [as needed] for psychiatric related issues. Status: Active. Review of Resident #1's ADVANCE DIRECTIVE ACKNOWLEDGMENT FORM, signed on 5/4/26, revealed the resident had no advance directive and no durable power of attorney for medical decisions. Review of Social Service Summary, dated 5/6/26, revealed: .BIMS [Brief Interview of Mental Status] is 14 indicating [Resident #1] is cognitively intact. Review of facility's N [Nursing] ADV[Advance] Skilled Evaluation, dated 5/20/26, revealed: .Mood and Behavior.Resident is currently experiencing unwanted behavior(s). Delusions: Chronic. Resists care: Chronic. Mood and Behavior Note: Resident verbally abusive when not getting what he/she wants and when staff follow rules. Review of Nurses Progress Notes, dated 5/21/26 at 3:16 PM, revealed: Social Worker. and PT [Physical therapist] . were present in resident's room talking about his/her transfer to PTC [Polaris Transitional Care]. This writer [nursing staff] walked up to the room in time to hear him/her telling them that he/she has 'shot someone before & [and] when they popped back up, he/she shot them 5 more times'. I walked away at that point with the ADON [Assistant Director of Nursing] to start his/her send out to the ED [Emergency Department]. Review of the Social Services Notes, dated 5/21/26 at 3:30 PM, revealed: .Resident [#1] reported severe pain, stating pain level 'over 20'. Nursing staff offered PRN [as needed] pain medication.resident refused.During [the] discussion about increasing therapy participation, resident expressed interest in 'doing more therapy.' As an accommodation [sic], I offered the option of relocating to a room closer to the therapy area to support his/her goal. Resident initially appeared agreeable; however, after a room was identified, resident became visibly irritated and escalated verbally. Resident stated: 'You're an idiot if you think I am doing this on your terms and your time.' 'You can't corner me like my mom did.' Staff reassure[d] resident that relocation was optional and intended to support his/her stated goals. Resident became increasingly agitated and made verbal threats, stating: 'I will kill you, you're lucky,' (repeated twice) . Resident also made suicidal statements, indicating to act on his/her own terms. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Transfer to emergency room Review of the Nurse Practitioner (NP) #1's Order, dated 5/21/26 at 3:43 PM, revealed: Send to ER [Emergency Room] for evaluation and treatment for suicidal ideation/homicidal ideations (plan verbalized) and uncontrolled pain (20/10). During an interview on 6/11/26 at 1:04 PM, NP #1 stated the Director of Nursing (DON) called her about Resident #1's threats to harm himself/herself, and to other people. NP #1 further stated she came to see the resident before the decision was made to transfer Resident #1 to the emergency room. During the same interview, NP #1 stated Resident #1 was aggressive, and she felt there was an emergency need for psychiatric evaluation. When asked if the facility can take care of Resident #1's behavior, she answered: no way. The NP stated in her experience, people can be alert and oriented with silly psychotic at the same time and do things because their brain just gets to be way over overwhelmed. Review of IDT (interdisciplinary) Notes, dated 5/21/26 at 4:30 PM, revealed: IDT consisting of Assistant Administrator [AA], DON, ADON, and Social Services convened [the] following notification that resident verbalized uncontrolled pain rate '20/10,' along with statements indicating suicidal and homicidal ideation. Based on presentation and reported symptoms, the team determined that resident's current care needs exceeded the facility's capability to provide safe and appropriate management. ARNP [Advanced Registered Nurse Practitioner] was consulted and concurred with recommendation for transfer to a higher level of care, order obtained to transfer resident to the emergency department for further evaluation and management. Further review of the IDT notes revealed chart review was conducted by the Long Term Care (LTC). The review identified that personality, delusional and mood disorders were not disclosed at the time of admission on [DATE] from PAMC (Providence Alaska Medical Center). Transfer Notice Provided to Resident #1 Before the Emergency Visit Review of Nurses Progress Notes, dated 5/21/26 at 4:44 PM, revealed: . Resident declined to sign transfer notice and declined bed hold. Resident transferred to Providence ER [Emergency Room] at 1614 [4:14 PM] via EMS [Emergency Medical Service]. Review of the NOTICE OF PROPOSED TRANSFER/DISCHARGE, dated 5/21/26, revealed the facility provided the residents with a notice of transfer/discharge. The reasons for transfer/discharge were: .2) The transfer/discharge is necessary for your welfare and your needs cannot be met in the facility (a) the specific needs that cannot be met are care, behavior/safety, uncontrolled pain.3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident (a) Reasons the safety of others in the Facility are endangered include: Resident threats to kill staff. Further review revealed Resident #1 declined to sign the notice on 5/21/26. Resident Not Accepted Back to Return to LTC After emergency room Visit During an interview on 6/11/26 at 12:16 PM, the Social Services Director (SSD) stated on 5/21/26, two hours after Resident #1 was transferred, that the hospital called her asking why the resident was not accepted back to the facility. The SSD explained that the Resident was unsafe to himself/herself and others. The SSD stated she documented the conversation with the hospital's mental health specialist (MHS) on the chart on 5/22/26. Review of the SSD's notes, dated 5/22/26, revealed: Spoke with. (Mental Health Specialist Providence) regarding concerns about [Resident #1] and Providence's inquiry about. [Resident #1's] discharge and potential return. [MHS] asked why [Resident #1] is not being accepted back to the facility. I explained that [Resident #1] is currently unsafe to himself/herself and others based on recent observed behaviors and direct statements. Specifically, he/she verbalized suicidal ideation, stating he/she intended to shoot himself/herself. He/she also made direct threats to staff. The facility has an obligation to ensure a safe environment for all residents and staff and to prevent abuse, neglect, or foreseeable harm. [Resident #1's] explicit threats toward staff and statements of self-harm represent credible safety risks requiring immediate intervention and exceed[ed] what can be safely managed within this setting. Retaining a resident whose needs cannot be met safely places the facility at risk of noncompliance with federal requirements related to resident safety, supervision, and quality of care. Further review of the SSD's notes revealed: Accurate and complete information at the time of admission is necessary to determine appropriate placement and develop an effective care (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan. The absence of clearly communicated behavioral health history and the lack of alignment with PASRR [Pre-admission Screening and Resident Review] related screening raises concern regarding the adequacy of pre-admission evaluation and the appropriateness of placement in a non-psychiatric facility. Additionally, when a resident exhibits acute psychiatric instability, including threats of harm to self or others, transfer to a higher level of care for evaluation and stabilization is consistent with standards of care and federal expectations regarding appropriate placement and access to necessary medical and psychiatric services. Review of Resident #1's hospital medical record, dated 5/21/26, revealed Resident #1 was admitted on [DATE] in the emergency department [ED] with a chief complaint of suicidal thoughts. Review of the hospital's Care Management Initial Assessment notes, dated 5/22/26, revealed: Social work [SW #1] was consulted to see if pt [patient] can return to Polaris SNF [Skilled Nursing Facility] rather than being admitted to hospital. Per chart review, psych[psychiatric] ED clinician was initially consulted, who had cleared pt and had reached out to Polaris, which as of yesterday [5/21/26] declined to accept pt back. Pt was advised that LCSW [Licensed Clinical Social Worker] is working on trying to see if he can be discharged back to Polaris, though if this is not possible he/she will need to be admitted so care team can work on an alternative discharge plan. Message sent to psych clinician. [name of clinician], whose note from 5/21/[26] indicates pt needs further assessment, to confirm when pt will be cleared so social work can either call SNF to see if pt can return, possibly under a behavioural[sic] contract or needs to be admitted pending alternative placement. Per discussion with attending, it was clarified that pt has been cleared by psych and LCSW will now call Polaris to discuss this and if pt can return to its facility. Further review of the SW notes revealed: LCSW called Polaris and spoke with . [name of the head of nursing], who reported that pt has had an ongoing issue with behaviours[sic] at its SNF and as a result is not seeking to accept pt back. Social work asked if a 30[-]day notice had been given, however, per later discussion with leadership, this may not be needed for this facility. She states pt has had 'multiple incidents of SI[suicidal ideation]/HI [homicidal ideation]' and may have untreated borderline personality disorder, which is 'hard' on its staff. She is concerned that, were pt to be discharged, his/her behaviours[sic] would increase and he/she would 'boomerang' back to hospital. She acknowledged pt's concern for pain, which had initially been uncontrolled as he/she had been discharged to Polaris without this[sic] medications. She will discuss pt's case with other staff and will follow up with LCSW. The SW #1 notes also revealed: LCSW received call from .[name of social services director] and [name of assistant administrator (AA)] at Polaris. AA confirmed that facility is not prepared to accept pt back, indicating concern for possible undiagnosed bipolar disorder and would benefit mental health treatment for this. She was advised that psych ED clinician had ruled this out as a diagnosis. She also expressed concern that the PASS-R sent to Polaris prior to discharge had not identified pt's behavioural[sic] issues. Attending was advised of outcome of social work's conversation and will reach out to request that pt be admitted. During an interview on 6/11/26 at 12:16 PM, the SSD stated she was expecting the hospital to call her for an updated PASSR, but she did not hear anything from the hospital since their last conversation on 5/21/26. Record review on 6/11/26, revealed there was no other documented communication between the LTC and the hospital aside from the SSD notes on 5/22/26. During an interview on 6/12/26 at 12:56 PM, the Administrator stated the facility transferred Resident #1 to the hospital because staff believed the resident required a psychiatric evaluation and treatment beyond the facility's capabilities. The Administrator stated the facility attempted to obtain mental health services before the hospitalization and believed important information regarding the resident's psychiatric history had not been disclosed before admission. The Administrator stated that after the hospital informed the facility the resident had been evaluated and was ready for discharge, the facility did not believe it was safe for the resident to return because staff continued to have concerns regarding the resident's behaviors. The Administrator further stated the admission PASSR had not been completed correctly, diagnoses had been omitted, and the omitted information could have resulted in a Level II PASSR evaluation. The Administrator acknowledged the (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility recognized significant psychiatric concerns as the resident's stay progressed but did not identify any attempt by the facility to complete a corrected PASSR screening or request a Level II PASSR evaluation after those concerns were identified. When asked about communication with the hospital after the facility declined to readmit Resident #1, the Administrator stated the facility did not follow up with the hospital and acknowledged communication between the facility and hospital essentially ceased. The Administrator stated she did not know why the facility failed to reestablish communication regarding the resident's disposition. Lack of Discharge Notice From LTC After Resident #1's emergency room Visit Record review on 6/11/26 revealed there was no documented second discharge notice provided to Resident #1 after the facility determined that the resident could not return to the facility due to facility's inability to manage Resident #1's aggressive behavior. During an interview on 6/11/26 at 3:43 PM, the Quality Director (QD) stated the facility issued a transfer notice before Resident #1's emergency room visit and that the LTC would not issue another discharge notice when the facility determined the resident could not return to the LTC after hospitalization. During a joint interview on 6/11/26 at 4:11 PM with the ADON and the QD, the ADON stated the transfer/discharge was initiated by the facility because they couldn't manage Resident #1's pain, suicidal ideation and aggressive behavior. The ADON stated the facility had no other transfer/discharge notice provided to the resident aside from the notice the facility had provided before the resident transferred to the hospital on 5/21/26. Review of the facility's Discharge or Transfer policy, dated 11/2019, revealed: It is the policy of this facility to provide the Resident with a safe organized structured transfer or discharge from the facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical, and psychosocial well being. A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies .1. Transfer/discharge: Emergency, and 2. Transfer/discharge: Other Healthcare Facility (planned). Further review revealed both discharges required C. Complete transfer/discharge form.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to provide and document a discharge notice to 1 resident (#1) out of 4 sampled residents after determining that Resident #1 would not be permitted to return to the facility following hospitalization. Specifically, after determining Resident #1 would not be permitted to return to the facility following hospitalization, the facility failed to provide a discharge notice that included the effective date of the discharge, the specific location to which the resident was to be discharged , an explanation of the resident's right to appeal the discharge, the name, mailing address, email address, and telephone number of the State entity that receives appeal requests, information on how to obtain an appeal form, information on obtaining assistance in completing and submitting an appeal request, and the name, mailing address, email address, and telephone number of the representative of the Office of the State Long Term Care Ombudsman (LTCO). The facility also failed to provide a copy of the discharge notice to the Office of the State LTCO. These failed practices deprived Resident #1 of the procedural protections required for an involuntary discharge, including timely written notice of the discharge decision, information regarding the right to appeal, and access to assistance from the Office of the State LTCO through timely notification of the discharge.Findings:.Record review on 6/11/26 revealed Resident #1 was admitted to the facility with diagnoses that included pneumonia (an infection that inflames air sacs in one or both of the lungs) due to methicillin resistant staphylococcus aureus (MRSA - a type of antibiotic resistant bacteria), chronic obstructive pulmonary disease and acute and chronic respiratory failure with hypoxia (low level of oxygen in the body tissues). Review of the Physician Order, dated 4/30/26, revealed: Psychiatry: May see psychiatry prn [as needed] for psychiatric related issues. Status: Active. Review of Resident #1's ADVANCE DIRECTIVE ACKNOWLEDGMENT FORM, signed on 5/4/26, revealed the resident had no advance directive and no durable power of attorney for medical decisions. Review of Social Service Summary, dated 5/6/26, revealed: .BIMS [Brief Interview of Mental Status] is 14 indicating [Resident #1] is cognitively intact. Review of facility's N [Nursing] ADV[Advance] Skilled Evaluation, dated 5/20/26, revealed: .Mood and Behavior.Resident is currently experiencing unwanted behavior(s). Delusions: Chronic. Resists care: Chronic. Mood and Behavior Note: Resident verbally abusive when not getting what he/she wants and when staff follow rules. Review of Nurses Progress Notes, dated 5/21/26 at 3:16 PM, revealed: Social Worker. and PT [Physical therapist] . were present in resident's room talking about his/her transfer to PTC [Polaris Transitional Care]. This writer [nursing staff] walked up to the room in time to hear him/her telling them that he/she has ?shot someone before & [and] when they popped back up, he/she shot them 5 more times'. I walked away at that point with the ADON [Assistant Director of Nursing] to start his/her send out to the ED [Emergency Department]. Review of the Social Services Notes, dated 5/21/26 at 3:30 PM, revealed: .Resident [#1] reported severe pain, stating pain level ?over 20'. Nursing staff offered PRN [as needed] pain medication.resident refused.During [the] discussion about increasing therapy participation, resident expressed interest in ?doing more therapy.' As an accommodation [sic], I offered the option of relocating to a room closer to the therapy area to support his/her goal. Resident initially appeared agreeable; however, after a room was identified, resident became visibly irritated and escalated verbally. Resident stated: ?You're an idiot if you think I am doing this on your terms and your time.' ?You can't corner me like my mom did.' Staff reassure[d] resident that relocation was optional and intended to support his/her stated goals. Resident became increasingly agitated and made verbal threats, stating: ?I will kill you, you're lucky,' (repeated twice) . Resident also made suicidal statements, indicating to act on his/her own terms. Resident #1's Transfer to emergency room Review of the Nurse Practitioner (NP) #1's Order, dated 5/21/26 at 3:43 PM, revealed: Send to ER [Emergency Room] for evaluation and treatment for (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suicidal ideation/homicidal ideations (plan verbalized) and uncontrolled pain (20/10). During an interview on 6/11/26 at 1:04 PM, NP #1 stated the Director of Nursing (DON) called her about Resident #1's threats to harm himself/herself, and to other people. NP #1 further stated she came to see the resident before the decision was made to transfer Resident #1 to the emergency room. During the same interview, NP #1 stated Resident #1 was aggressive, and she felt there was an emergency need for psychiatric evaluation. When asked if the facility can take care of Resident #1's behavior, she answered: no way. The NP stated in her experience, people can be alert and oriented with silly psychotic at the same time and do things because their brain just gets to be way over overwhelmed. Review of IDT (interdisciplinary) Notes, dated 5/21/26 at 4:30 PM, revealed: IDT consisting of Assistant Administrator [AA], DON, ADON, and Social Services convened [the] following notification that resident verbalized uncontrolled pain rate ?20/10,' along with statements indicating suicidal and homicidal ideation. Based on presentation and reported symptoms, the team determined that resident's current care needs exceeded the facility's capability to provide safe and appropriate management.ARN [Advanced Registered Nurse Practitioner] was consulted and concurred with recommendation for transfer to a higher level of care, order obtained to transfer resident to the emergency department for further evaluation and management. Further review of the IDT notes revealed chart review was conducted by the Long Term Care (LTC). The review identified that personality, delusional and mood disorders were not disclosed at the time of admission on [DATE] from PAMC (Providence Alaska Medical Center). Transfer Notice Provided to Resident #1 Before the Emergency Visit Review of Nurses Progress Notes, dated 5/21/26 at 4:44 PM, revealed: . Resident declined to sign transfer notice and declined bed hold.Resident transferred to Providence ER [Emergency Room] at 1614 [4:14 PM] via EMS [Emergency Medical Service]. Review of the NOTICE OF PROPOSED TRANSFER/DISCHARGE, dated 5/21/26, revealed the facility provided the residents with a notice of transfer/discharge. The reasons for transfer/discharge were: .2) The transfer/discharge is necessary for your welfare and your needs cannot be met in the facility (a) the specific needs that cannot be met are care, behavior/safety, uncontrolled pain.3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident (a) Reasons the safety of others in the Facility are endangered include: Resident threats to kill staff. Further review revealed Resident #1 declined to sign the notice on 5/21/26. Resident Not Accepted Back to Return to LTC After emergency room Visit During an interview on 6/11/26 at 12:16 PM, the Social Services Director (SSD) stated on 5/21/26, two hours after Resident #1 was transferred, that the hospital called her asking why the resident was not accepted back to the facility. The SSD explained that the Resident was unsafe to himself/herself and others. The SSD stated she documented the conversation with the hospital's mental health specialist (MHS) on the chart on 5/22/26. Review of the SSD's notes, dated 5/22/26, revealed: Spoke with. (Mental Health Specialist Providence) regarding concerns about [Resident #1] and Providence's inquiry about. [Resident #1's] discharge and potential return. [MHS] asked why [Resident #1] is not being accepted back to the facility. I explained that [Resident #1] is currently unsafe to himself/herself and others based on recent observed behaviors and direct statements. Specifically, he/she verbalized suicidal ideation, stating he/she intended to shoot himself/herself. He/she also made direct threats to staff.The facility has an obligation to ensure a safe environment for all residents and staff and to prevent abuse, neglect, or foreseeable harm. [Resident #1's] explicit threats toward staff and statements of self-harm represent credible safety risks requiring immediate intervention and exceed[ed] what can be safely managed within this setting. Retaining a resident whose needs cannot be met safely places the facility at risk of noncompliance with federal requirements related to resident safety, supervision, and quality of care. Further review of the SSD's notes revealed: Accurate and complete information at the time of admission is necessary to determine appropriate placement and develop an effective care plan. The absence of clearly communicated behavioral health history and the lack of alignment with PASRR [Pre-admission Screening and Resident Review] related screening raises concern regarding (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the adequacy of pre-admission evaluation and the appropriateness of placement in a non-psychiatric facility. Additionally, when a resident exhibits acute psychiatric instability, including threats of harm to self or others, transfer to a higher level of care for evaluation and stabilization is consistent with standards of care and federal expectations regarding appropriate placement and access to necessary medical and psychiatric services. Review of Resident #1's hospital medical record, dated 5/21/26, revealed Resident #1 was admitted on [DATE] in the emergency department [ED] with a chief complaint of suicidal thoughts. Review of the hospital's Care Management Initial Assessment notes, dated 5/22/26, revealed: Social work [SW #1] was consulted to see if pt [patient] can return to Polaris SNF [Skilled Nursing Facility] rather than being admitted to hospital. Per chart review, psych[psychiatric] ED clinician was initially consulted, who had cleared pt and had reached out to Polaris, which as of yesterday [5/21/26] declined to accept pt back. Pt was advised that LCSW [Licensed Clinical Social Worker] is working on trying to see if he can be discharged back to Polaris, though if this is not possible he/she will need to be admitted so care team can work on an alternative discharge plan. Message sent to psych clinician. [name of clinician], whose note from 5/21/[26] indicates pt needs further assessment, to confirm when pt will be cleared so social work can either call SNF to see if pt can return, possibly under a behavioural[sic] contract or needs to be admitted pending alternative placement. Per discussion with attending, it was clarified that pt has been cleared by psych and LCSW will now call Polaris to discuss this and if pt can return to its facility. Further review of the SW notes revealed: LCSW called Polaris and spoke with . [name of the head of nursing], who reported that pt has had an ongoing issue with behaviours[sic] at its SNF and as a result is not seeking to accept pt back. Social work asked if a 30[-]day notice had been given, however, per later discussion with leadership, this may not be needed for this facility. She states pt has had 'multiple incidents of SI[suicidal ideation]/HI [homicidal ideation]' and may have untreated borderline personality disorder, which is 'hard' on its staff. She is concerned that, were pt to be discharged, his/her behaviours[sic] would increase and he/she would 'boomerang' back to hospital. She acknowledged pt's concern for pain, which had initially been uncontrolled as he/she had been discharged to Polaris without this[sic] medications. She will discuss pt's case with other staff and will follow up with LCSW. The SW #1 notes also revealed: LCSW received call from .[name of social services director] and [name of assistant administrator (AA)] at Polaris.AA confirmed that facility is not prepared to accept pt back, indicating concern for possible undiagnosed bipolar disorder and would benefit mental health treatment for this. She was advised that psych ED clinician had ruled this out as a diagnosis. She also expressed concern that the PASS-R sent to Polaris prior to discharge had not identified pt's behavioural[sic] issues. Attending was advised of outcome of social work's conversation and will reach out to request that pt be admitted. During an interview on 6/11/26 at 12:16 PM, the SSD stated she was expecting the hospital to call her for an updated PASSR, but she did not hear anything from the hospital since their last conversation on 5/21/26. Record review on 6/11/26, revealed there was no other documented communication between the LTC and the hospital aside from the SSD notes on 5/22/26. During an interview on 6/12/26 at 12:56 PM, the Administrator stated the facility transferred Resident #1 to the hospital because staff believed the resident required a psychiatric evaluation and treatment beyond the facility's capabilities. The Administrator stated the facility attempted to obtain mental health services before the hospitalization and believed important information regarding the resident's psychiatric history had not been disclosed before admission. The Administrator stated that after the hospital informed the facility the resident had been evaluated and was ready for discharge, the facility did not believe it was safe for the resident to return because staff continued to have concerns regarding the resident's behaviors. The Administrator further stated the admission PASSR had not been completed correctly, diagnoses had been omitted, and the omitted information could have resulted in a Level II PASSR evaluation. The Administrator acknowledged the facility recognized significant psychiatric concerns as the resident's stay progressed but did not identify any attempt by the facility to complete a corrected PASSR screening or request a Level II (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Polaris Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 920 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.			
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASSR evaluation after those concerns were identified. When asked about communication with the hospital after the facility declined to readmit Resident #1, the Administrator stated the facility did not follow up with the hospital and acknowledged communication between the facility and hospital essentially ceased. The Administrator stated she did not know why the facility failed to reestablish communication regarding the resident's disposition. Lack of Discharge Notice From LTC After Resident #1's emergency room Visit Record review on 6/11/26 revealed there was no documented second discharge notice that contained the following:a. The effective date of the discharge;b. The specific location to which the resident is to be discharged ;c. An explanation of the right to appeal the discharge to the State;d. The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;e. Information on how to obtain an appeal form;f. Information on obtaining assistance in completing and submitting the appeal hearing request; andg. The name, address (mailing and email), and phone number of the representative of the Office of the State LTCO.provided to Resident #1 after the facility determined that the resident could not return to the facility due to facility's inability to manage Resident #1's aggressive behavior. During an interview on 6/11/26 at 3:43 PM, the Quality Director (QD) stated the facility issued a transfer notice before Resident #1's emergency room visit and that the LTC would not issue another discharge notice when the facility determined the resident could not return to the LTC after hospitalization. During a joint interview on 6/11/26 at 4:11 PM with the ADON and the QD, the ADON stated the transfer/discharge was initiated by the facility because they couldn't manage Resident #1's pain, suicidal ideation and aggressive behavior. The ADON stated the facility had no other transfer/discharge notice provided to the resident aside from the notice the facility had provided before the resident transferred to the hospital on 5/21/26. During an interview on 6/12/26 at 12:56 PM, the Administrator stated that after the hospital informed the facility, Resident #1 had been evaluated and was ready for discharge, the facility determined the resident could not safely return because of continued concerns regarding the resident's behaviors. The Administrator further stated the facility did not reestablish communication with the hospital regarding the resident's disposition after declining the resident's return. In addition, the Administrator confirmed no discharge notice was provided to the resident after the hospital's attempt to discharge the resident back to the long-term care facility. Review of the facility's Discharge or Transfer policy, dated 11/2019, revealed: It is the policy of this facility to provide the Resident with a safe organized structured transfer or discharge from the facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical, and psychosocial well being. A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies .1. Transfer/discharge: Emergency, and 2. Transfer/discharge: Other Healthcare Facility (planned). Further review revealed both discharges required.C. Complete transfer/discharge form. Notification of the Long-Term Care Ombudsman's Office During an interview on 6/11/26 at 9:30 AM, the QD stated per the LTCO instruction, the facility should report discharge notice every month including an emergency transfer/discharge. Review of the facility's monthly discharge report to the LTCO, dated 5/2026, revealed Resident #1's transfer to the hospital on 5/21/26 was included. Record review on 6/11/26, revealed there was no other documented Resident #1's discharge notification of the LTCO after the facility determined the resident could not be accepted back to return to the LTC. Review of the facility's Discharge or Transfer policy, dated 11/2019, revealed the policy did not include the process of notifying the LTCO of resident's discharges		