STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Extended Care	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. . Based on record review, observation, and interview, the facility failed to ensure residents' rights were honored. Specifically, the facility failed to provide care in a manner that promoted dignity and respect for 2 sampled residents (#19 and #51), out of 21 sampled residents, and 1 unsampled resident (#74). This failed practice had the potential to cause psychosocial harm and placed the residents at risk of not attaining or maintaining the highest practicable physical, mental, and psychosocial well-being. Findings: Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included multiple sclerosis (chronic autoimmune disease where the immune system attacks the protective covering of nerve cells), neuromuscular dysfunction of the bladder (a condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (mood disorder characterized by persistent feeling of sadness and loss of interest in activities). Review of the Resident #19's Care Plan Report, initiated 4/29/25, revealed: .Focus: [Resident 19] has a foley catheter [a medical device that helps drain urine from the bladder leading to a drainage bag] r/t [related to]: NEUROMUSCULAR DYSFUNCTION OF BLADDER . Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door . Check for catheter privacy bags to bed/wc [wheelchair] Q shift [once a shift]. Replace as needed . An observation on 5/19/25 at 9:34 AM, revealed Resident #19's urinary catheter drainage bag was covered with a transparent trashcan liner and was hung on a handle on the upper left side of his/her bed. An observation on 5/20/25 at 10:34 AM, revealed Resident #19's urinary catheter drainage bag was covered with a transparent trashcan liner and hung on a trash bin by the lower left side of his/her bed, which was visible upon entrance to Resident's room. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 10:38 AM, Resident #19 stated he/she just took a shower and after completing assistance with ADLs (Activities of daily living), Certified Nursing Assistant (CNA) #1 hung the catheter drainage bag on the trash bin. He/she stated, this happens all the time, and would be corrected when found by staff later in the day, or if he/she asked. Resident #19 further stated he/she used to have cloth privacy bags for the drainage bag. He/she further added, I had two and it got washed, then I never got them back . During an interview on 5/20/25 at 10:42 AM, Licensed Nurse (LN) #3 stated urinary catheters were assessed each shift which included the positioning of the bag and ensure it was free of kinks. LN #3 further stated the catheter drainage bags were to remain off the floor by hanging it on the side of the bed or placed in a wash bin. He/she stated catheter drainage bags should be not hung on the trash bin. During an interview on 5/20/25 at 10:50 AM, CNA #1 stated Resident #19 used to have privacy bags and he/she had not seen Resident #19's privacy bags for a while now. CNA #1 further stated drainage bags were to be hung on the side of the bed. He/she added there was a handle on the bed to attach it to and the drainage bags should not be hung on a trash bin. During an interview on 5/22/25 at 8:15 AM, LN #3 stated Resident #19 had two privacy bags that were his/her own and had specific designs. LN #3 stated trashcan liners were not to be used as a standard privacy bag. LN #3 then stated he/she had notified the supervisors. During an interview on 5/22/25 at 8:52 AM, LN #3 stated the Assistant Director of Nursing (ADON) had found a privacy bag to provide Resident #19. During an interview on 5/21/25 at 1:55 PM, the Infection Preventionist (IP) stated the facility was auditing residents' catheter use including catheter care, making sure urinary tubing was not kinked, drainage bag was off the floor and/or placed inside a privacy bag to promote dignity. The IP also stated the trashcan liner was not considered as a privacy bag and placing the drainage bag in the trashcan liner was an infection control concern. Review of the facility's policy Indwelling Urinary Catheter Care, last revised 3/2025, revealed: .14. Cover the drainage bag with a privacy bag to maintain dignity . Review of the facility's policy, Patient Rights, undated, revealed: .Right to .be treated with consideration, respect, and dignity . Resident #51 Record Review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses that included hemiplegia (paralysis of one side of the body), atrial fibrillation (a condition characterized by an irregular and often rapid heart rate that could lead to poor blood flow), and dementia (a decline in memory and cognitive functioning that interferes with daily life). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/21/25 at 10:25 AM, revealed CNA #3 was positioned on the resident's right side and attempted to turn Resident #51 onto his/her left side following an incontinence episode. CNA #3 was observed bending at the waist, lowered his/her upper torso to the resident's hip, then placed both hands on Resident #51's right hip and forcefully rotated the resident. While being turned, Resident #51's face grimaced. Review of Resident #51's Resident Daily Care Plan (RDCP), dated 2/21/25, revealed: Use lifting sheet when moving me in bed to prevent skin shearing. Review of Resident #51's Care Plan Report, revised 2/18/25, revealed: My goal is to feel comfortable, have no signs of pain in my facial expressions . I need my aides to be extra gentle with me . ask me if I hurt. Resident #74 Record review on 5/18-22/25 revealed resident #74 was admitted to the facility with diagnoses that included Cerebrovascular Accident (CVA - also known as a stroke, when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel) and hemiplegia or hemiparesis (weakness or paralysis of one side of the body). A continuous observation on 5/20/25 at 9:26 AM to 1:01 PM, revealed Resident #74 had an episode of incontinence and stated he/she needed to be changed. Further observation revealed: - At 9:26 AM: the resident pushed the call light; - At 9:50 AM: [NAME] #1 came into the resident's room. Resident #74 informed [NAME] #1 he/she needed to be changed. [NAME] #1 informed Resident #74 they would let the Nurse or CNA know; - At 9:53 AM: [NAME] #1 verbally informed LN #10 of the Resident #74's request. LN #10 informed [NAME] #1 that CNA #4 would help the resident; - At 1:01 PM, CNA #4 went into Resident #74's room and performed incontinence care and a brief change. Resident #74 waited a total of 3 hours and 35 minutes for cares. During an interview on 5/20/25 at 11:06 AM, while waiting for staff to come in for cares, Resident #74 stated staff would tell the resident he/she, pushed the call light too much and that made the resident feel like he/she, did not belong. During an interview on 5/22/25 at 2:33 PM, the Director of Nursing (DON) stated he was not sure of exact timeframe incontinence care was supposed to be carried out once staff was notified, but added, As soon as caregiver is aware. The DON further stated if a CNA was not available, a nurse could perform cares, . as long as they are not in the middle of med pass but even then they are expected to coordinate this. When asked if one hour and forty-five minutes was an acceptable timeframe to wait, he replied, no. When asked if four hours was an acceptable timeframe to wait, the DON also replied, no. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy ADL, Services to carry out, reviewed on 3/2025, revealed: Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain . Personal Hygiene include . Toileting . among others . Review of the facility's policy Residents Rights, revised on 3/20/25, revealed: It is the policy of this facility that all resident rights be followed per State and Federal guidelines as well as other Regulatory Agencies. The Resident has the right: to be treated with consideration, respect, and a full recognition of his or her dignity and individuality. .

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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. . Based on record review and interview, the facility failed to fully inform a Resident Representative in advance, of the care to be provided and treatment options for 1 resident (#343), out of 21 sampled residents. This failed practice violated the resident's and resident representative's right to be fully informed and to participate in the resident's treatment. Findings: Resident #343 Record review on 5/18-22/25 revealed Resident #343 was admitted to the facility with diagnosis that included spinal stenosis of lumbar region with neurogenic claudication (narrowing of the lower spine causing pain), vascular dementia, severe, with mood disturbance (brain damage from blood vessel issues, severe, with mood changes), obstructive sleep apnea (breathing issues during sleep), overactive bladder (frequent need to urinate), and major depressive disorder (severe sadness). Due to his/her dementia diagnosis Resident #343 was not able to complete an interview. During an interview on 5/19/25 at 9:05 AM, Resident #343's Representative stated that after Resident #343's admission, he/she was pressured to sign a Medicare-related form without adequate explanation, leaving him/her unaware of its purpose, or the right to appeal the decision to not pursue skilled services. He/she added, the facility did not clearly communicate the care plan post-admission, leading to a misunderstanding about resident's eligibility for skilled therapy versus long-term care. The Representative stated that he/she was told he/she: had to sign this form or [Resident #343] would lose their placement at the facility due to insurance related problems. According to the Representative, he/she came in person twice to seek clarification and was turned away without concrete answers. Resident #343's Representative stated Resident #343 needed skilled care so he/she couldn't understand why they were being pressured to sign this form for long term care instead. During an interview on 5/21/25 at 2:00 PM, the Admissions Coordinator (AC) was asked about the specific form signed after the admission process. Resident #343's Representative had reported to the AC that Licensed Nurse (LN) #9, a former discharge planner, sent him/her the form and pressured him/her to sign it without clear explanation, leaving the Representative confused and feeling coerced/pressured to sign this form. According to the AC, the title of the form was Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), the AC stated that this form was for Medicare skilled criteria, coverage, and billing. He/she further stated that LN #9's responsibility was to provide the form and explain to the residents and/or their representatives its purpose. Additionally, the AC stated that Resident #343's Representative had expressed frustration over a lack of communication about resident's care related to the form, particularly the decision to transition Resident #343 to long-term care instead of pursuing skilled nursing therapies under Medicare. The AC also stated they had previously addressed Resident #343 Representative's concerns by offering to file a grievance on their behalf on 5/16/25. Record review throughout the survey revealed this grievance had not been addressed and Resident #343's Representative had not been contacted. The official grievance log had no evidence of this complaint been logged or addressed. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25 at 3:35 PM, the Grievance Officer #1 stated he/she had contacted the family of Resident #343 on 5/22/25, after this surveyors' inquiry. He/she received an email on Friday 5/16/25 but did not realize it was there, because he/she preferred to be told in person by the staff about potential complaints. During an interview on 5/19/25 at 9:05 AM, Resident #343's Representative stated that the facility had admitted Resident #343 with the expectation of skilled therapy. Due to confusion with the form and miscommunication with the rehab team, who assumed long-term care was the goal, it led to the misunderstanding of the family's expectations. Review of Resident #343's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN), dated 5/5/25, revealed the form informs [Resident #343] that Medicare is unlikely to cover his/her inpatient skilled nursing care starting on 5/5/25 because he/she no longer meets the necessary Medicare coverage criteria, such as requiring daily skilled nursing care, physical therapy, or occupational therapy. The estimated cost for his/her continued care is $500 per day plus ancillaries. The form outlines three options: he/she could choose to have the facility bill Medicare to confirm coverage (Option 1), agree to pay for the care himself/herself if Medicare denies coverage (Option 2), or decline the care entirely (Option 3). Handwritten information under Additional information read: 5/1/25 - reached out to family about coming in to sign forms . they agreed to come in and sign but never showed up 5/5/25 called and representative came in and signed forms. The form was signed by Resident #343's Representative on 5/5/25. Resident's Representative stated he/she was denied a copy of the paper he/she had signed, when he/she requested it from LN #9. Representative also stated they were at the facility twice to ask for explanations and LN#9 was, too busy to meet. Review of the facility's Resident Rights - Know Your Rights, undated, revealed: .The Right to Be Fully Informed of available services and the charges for each service, facility rules and regulations, including a written copy of resident rights .Residents have a right to receive information in a language they understand (Spanish, Braille, etc.) . the right to participate in one's own care .participate in their own assessment, care planning, treatment and discharge . be free of charge for services covered by Medicaid or Medicare. .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. . Based on record review, interview, and observation, the facility failed to ensure reasonable accommodation of needs were maintained for 1 resident (#28), out of 21 sampled residents. Specifically, the facility failed to ensure the resident's call light device was within reach. This failed practice placed the resident at risk for not being able to call for help if needed. Findings: Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non-Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), and Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination). Review of Resident #28's MDS (Minimum Data Set- a federally required nursing assessment) annual assessment, dated 2/20/25, revealed the resident had limited range of motion in the upper and lower extremities and required substantial/maximal physical assistance for bed mobility, transfers, personal hygiene, and toileting. Further review revealed Resident #28 used a wheelchair for mobility. During an interview at 5/18/25 at 12:06 PM, Resident #28 stated he/she was unable to reach the call light at least once a week. An observation on 5/19/25 at 9:55 AM, revealed Resident #28 in his/her room alone yelling for help. Resident #28 was turned towards his/her right side and his/her call light was on his/her left side on the edge of the bed out of his/her vision and reach. Occupational Therapist (OT) #4 responded to the yelling and resident requested that OT #4 place call light within his/her reach. During an interview on 5/22/25 at 2:53 PM, the Director of Nursing (DON) stated staff should always ensure the call light were within reach of the resident before leaving the room. Review of the facility policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE, last revised 12/2024, revealed: .Keep the call light within reach. .

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	025036	A. Building B. Wing	05/22/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 4 residents (#s 4, 19, 40, and 48), out of 21 sampled residents, were given the opportunity to make choices about aspects of his/her life that were significant to them. Specifically, the facility failed to ensure residents had the opportunity to: 1) receive a shower and/or a bath; 2) be transferred in and out of bed when requested; and 3) go outside and participate in activities as specified in the plan of care. These failed practices had the potential to affect the resident's quality of life and increase feelings of frustration. Findings: Resident #4 Record review on 5/18-22/25 revealed Resident #4 was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), rheumatoid arthritis (autoimmune disorder that affected the joints), and depression. During an interview on 5/18/25 at 12:45 PM, Resident #4 stated the facility was so short-staffed that he/she only received 1 shower a week, instead of the two scheduled showers that was care planned for. During an interview on 5/19/25 at 3:57 PM, Certified Nursing Assistant (CNA) #1 stated that due to being short-staffed, residents were unable to get the care that they deserve. He/she confirmed that Resident #4 was scheduled for showers on Wednesdays and Saturdays but added that if staff was unable to give showers on the scheduled days, .they would have to wait until the next shower day . During an interview on 5/21/25 at 10:36 AM, Resident #4's POA (Power of Attorney) stated he/she was concerned due to the resident's reports of inadequate showers. Review of Resident #4's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: -During the month of March, the resident received a shower twice on 3/19 and 3/26; -During the month of April, the resident received a shower twice on 4/9 and 4/30 and; -Between 5/01-21/25, he/she received a shower on 5/7, 5/14, and 5/21. Review of Resident #4's Minimum Data Set (MDS - a federally required assessment) quarterly assessment, dated 1/7/25, revealed Resident #4 had an impairment of the upper limbs. Resident #4 was dependent on staff for his/her shower transfers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's Care Plan Report, initiated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Fatigue . Goal: Will maintain current level of function in .Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: . BATHING (SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Wednesday and Saturday . Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included multiple sclerosis (chronic autoimmune disease where the immune system attacks the protective covering of nerve cells), type 2 diabetes mellitus with diabetic polyneuropathy (Type 2 DM: non-insulin-dependent diabetes, with nerve damage complications), neuromuscular dysfunction of the bladder (condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (MDD: mood disorder characterized by persistent feeling of sadness and loss of interest in activities). During an interview on 5/18/25 at 8:42 AM, Resident #19 stated he/she would only get showers once a month, and . maybe sometimes two if I guilt them into doing it . During an interview on 5/19/25 at 3:58 PM, CNA #1 confirmed Resident #19 is scheduled for showers on Tuesday and Friday. Record review of Resident #19's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: -During the month of March, the resident received a shower five times on 3/7, 3/11, 3/18, 3/25, and 3/31; -During the month of April, the resident received a shower four times on 4/11, 4/15, 4/22, and 4/28, and; -Between 5/01-21/25, the resident received a shower four times on 5/6, 5/13, 5/14 and 5/20. Review of Resident #19's MDS quarterly assessment, dated 1/31/25, revealed Resident #19 had an impairment on one side of the upper and lower limbs. Resident #19 was dependent for his/her shower transfers. Review of Resident #19's Care Plan Report, initiated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Activity Intolerance . Goal: Will maintain current level of function in . Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: .BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Tuesday and Friday . Resident #40 Record review on 5/18-22/25 revealed Resident #40 was admitted to the facility with diagnoses that included coronary artery disease, morbid obesity (disease characterized by a BMI [Body Mass Inde] of 40 or higher), heart failure, hypertension, end stage renal disease (ESRD - a condition in which kidney function is less than 10% of normal; the kidneys can no longer remove wastes, concentrate urine, and regulate electrolytes), and diabetes mellitus. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/18/25 at 1:06 PM, Resident #40 stated he/she was unable to brush his/her teeth when requested. Resident #40 stated staff was not available to gather his/her supplies. Resident #40 further stated that he/she could not get to the toilet independently so he/she would often have episodes of incontinence. Resident #40 stated that he/she had to wait 1 hour and 45 minutes for staff to come and provide perineal care after he/she pressed the call light. Resident #40 further stated he/she had not received a shower for 1 ½ months due to not enough staff. Resident #40 stated it required two CNAs to transfer him/her out of bed. During an interview on 5/19/25 at 8:20 AM, CNA #2 stated Resident #40 was showered about 2 months ago. CNA #2 further stated Resident #40 was transferred to the shower by the ceiling lift and required two staff members to complete a safe transfer. CNA #2 stated he/she did not always have a second staff member to assist. During an interview on 5/20/25 at 1:40 PM, the MDS Coordinator (MC) reviewed Resident #40's care plan. She stated that the number of staff required for a ceiling lift transfer depended on the staff member's comfort level. Review of Resident #40's Documentation Survey Report. Task Only, dated March 2025, revealed from 3/1/25 -3/31/25; - No showers were documented as successfully completed; - Oral Hygiene- was only documented on three days: 3/3/25, 3/17/25 and 3/19/25, and; - Personal Hygiene- was only documented on the following days: 3/3/25, 3/11/25, 3/16-19/25. Review of Resident #40's Documentation Survey Report . Task Only, dated April 2025, revealed from 4/1-30/25, tub/shower transfer occurred on two occasions. Review of Resident #40's Task: Bathing, dated 5/1-20/25, revealed . 5/17/25 . Shower. No other showers were documented as successfully completed. During an interview on 5/20/25 at 3:10 PM, CNA #2 stated he/she provided Resident #40 a shower with the assistance of a hospitality aide. CNA #2 stated the hospitality aide was able to assist with the transfer of Resident #40 out of bed to the shower. During an interview on 5/22/25 at 2:15 PM, Resident #40 smiled and stated he/she received a shower two days ago. Resident #40 stated when he/she did not receive a shower over the past 2 months, he/she felt uncomfortable. Resident #40 further stated he/she felt down because there was not enough help and I just cry and go to sleep. During an interview on 5/22/25 at 3:30 PM, Physical Therapist (PT) #1 stated when operating a ceiling lift, one to two staff members were required. When PT #1 was asked how many staff members were required to transfer Resident #40 out of bed, PT #1 stated one to two staff members. PT #1 stated if Resident #40 requested two staff members or the staff member operating the lift did not feel comfortable operating the lift alone, then the transfer required an assist of two staff members. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #40's MDS quarterly assessment, dated 3/11/25, revealed Resident #40 had an impairment of the lower limbs and required wheelchair transportation. Resident #40 was dependent for his/her shower transfers. Review of Resident #40's Care Plan Report, dated 4/15/25, revealed . BED MOBILITY (ROLL LEFT AND RIGHT, SIT TO LYING, LYING TO SITTING ON SIDE OF BED): Requires 1-2 people providing more than half the effort. PERSONAL HYGIENE/ORAL CARE (ORAL HYGIENE): SET UP ASSIST . I need my aides to help me brush . Resident #48 Record review on 5/18-22/25 revealed Resident #48 was admitted to the facility with diagnoses that included, Type 2 DM, ESRD, hemiplegia (a condition in which half of the body is paralyzed) and hemiparesis (partial paralysis of one side of the body) following unspecified cerebrovascular disease (damage to the blood vessels in the brain) affecting right dominant side, MDD and post-traumatic stress disorder (PTSD - a mental health condition caused by a traumatic event that affects the ability to function daily). During an interview on 5/18/25 at 12:53 PM, Resident #48 stated that he/she cannot get transferred in and out of bed when requested. Resident #48 further stated he/she had to make the decision to get out of bed or just stay in bed because there were not enough CNAs available. Resident #48 stated he/she had missed frequent activity events because he/she was not able to get out of bed or staff did not wake him/her up. Resident #48 stated he/she was frustrated. Resident #48 further stated, Staffing is an issue every day and has gotten worse. You get a good one [CNA], and the facility burns them out and they leave. During an interview on 5/22/25 at 9:05 AM, the Activity Coordinator (AC) stated the only documentation for activity participation was completed in the MDS upon admission, quarterly, and the annual assessments. During an interview on 5/22/25 at 2:39 PM, the Director of Nursing (DON) stated if a resident requested to be transferred out of bed, the resident should be transferred out of bed. The DON further stated a resident should receive requested care as soon as possible. Random observations from 5/18-22/25 of Resident #48's bedroom door revealed a sign that advised staff to wake up Resident if sleeping. Review of Resident #48's MDS annual assessment, dated 9/20/24, revealed it was very important for Resident #48 to go outside to get fresh air when the weather was good, to attend activities, do things with groups of people and to be able to do his/her favorite activities. Resident #48 had an impairment on one side with limited range of motion and was dependent for his/her transfers. During an interview on 5/18/25 at 8:35 AM, CNA #2 stated he/she was the only CNA in the Deshka cottage. CNA #2 further stated from 3:30 PM to 7:00 PM on 5/18/25, he/she had to cover the Kenai cottage while covering the Deshka cottage, because there was not enough staff. CNA #2 stated he/she was concerned about how all residents would be cared for timely. CNA #2 stated there were two residents in the Deshka cottage that required feeding assistance and would be required to wait longer for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE, dated 12/2024, revealed . AM CARE (EVERY MORNING): Hands and face washed, Toilet & Peri Care. Oral Care. H.S. [bedtime] CARE (EVERY HS AT BEDTIME): Hands and face washed, Toilet & Peri Care. Oral Care. BEFORE MEAL CARE: Toileting and Peri care. PERIODIC CARE: Shower/Bath as scheduled. Provide a complete bed bath if scheduled shower cannot be given. ONGOING CARE: . Call lights: work as team to meet the goal of answering regular within 5-10 minutes. Provide peri care after voids . Promote resident choice and personal preference . Review of the facility's policy Services to carry out ADL [Activity of Daily Living], dated 3/2025, revealed: . 2. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain: Good nutrition, Grooming, Personal hygiene, Oral hygiene, Bathing, Showering, Toileting . Review of the facility's policy Safe Transfer of a Resident, dated 3/2025, revealed: .Mechanical lift transfers are usually used for resident who are very large or extremely dependent .Safe and secure mechanical lift transfers may require the help of one, two, or three caregivers depending on the resident's condition . Review of the facility's policy Comprehensive Resident Centered Care Plan, dated 3/2025, revealed: . Resident's Goal-refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning . Person-centered care- means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Review of the facility's policy Adequate Staffing, dated 3/2025, revealed: . 2. The facility maintains adequate staff on each shift to assure that the resident's needs are met . Review of the facility's policy Patient Rights, undated, revealed: . Receive adequate and appropriate care. To be free from mental . abuse . Reasonable accommodation of one's needs and preferences . Right to Dignity, Respect, and Freedom. To be treated with consideration, respect, and dignity . .

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. . Based on record review and interview, the facility failed to ensure resident funds were deposited into the resident's trust account for 1 resident (#31), out of 21 sampled residents. This failed practice resulted in the resident not having access to their personal funds which violated the resident's right to manage his/her financial affairs. Findings: Record review from 5/18-22/25 revealed Resident #31 was admitted to the facility with diagnoses that included legal blindness. During an interview on 5/18/25 at 1:10 PM, Resident #31 stated the last time money was put into his/ her account, he/she had not been able to access it. The resident further stated the funds were deposited over a month ago. When Resident #31 asked about the funds, the facility assured him/her that it was available. Review of Resident #31's Receipt, dated 3/27/25, revealed: Deposit to trust fund, for $200.00. Review of Resident #31's Trust Statement, dated 3/31/25, revealed no deposit of $200.00 was listed. Review of Resident #31's Resident Fund Management Service Statement, with a statement period of 2/20/25 to 5/21/25, revealed no deposit of $200.00. During an interview on 5/21/25 at 9:49 AM, the Business Office Manager (BOM) stated Resident #31's father brought in a check for $200.00 but could not remember exactly when it was brought in. After reviewing Resident #31's record, the BOM did not see the $200.00 and stated more research was needed. During an interview on 5/21/25 at 3:23 PM, the BOM stated Resident #31's $200.00 was deposited into a general account. The check was received on 3/27/25. The BOM stated this was an error and she was working on moving the money into Resident #31's account along with any interest owed. The BOM stated Resident #31's money would be available on 5/22/25. Review of the facility-provided policy Resident Trust Account, effective on 3/2023, revealed: . The facility maintains accurate accounting systems for each individual resident's trust account . .

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	025036	A. Building B. Wing	05/22/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview, observation, and record review, the facility failed to ensure: 1) Residents were provided with clear instructions on how to file a grievance; and 2) Consistent and accurate information about the grievance officer's identity was provided. This failed practice denied all residents (based on a census of 91) and their representatives the ability to exercise their rights to file grievances correctly and receive written resolutions of the investigation by the grievance officer. Findings: During an interview on 5/21/25 at 2:01 PM, members of the Resident Council (Residents #'s 18; 20; 28; 34; 35; 47; 48; 68; and 87) shared their concerns about grievances, they highlighted a lack of transparency and clarity in the process. They noted that under the new management (Polaris), Residents were unaware of the grievance official's identity or the procedure for filing complaints, leading to a lack of confidence that issues were being addressed. When told by the surveyors of the identity of the Grievance Officer (GO), resident council unanimously stated, we've never heard of such person, never seen him or her . we have no idea who you are talking about. Additionally, they expressed fears of retaliation for raising concerns, perceiving the administration as unprofessional and lacking accountability, a situation worsened by the transition to Polaris, with no resident input or ongoing dialogue with Polaris' administration to address these systemic issues. Resident #28 stated the only grievance officer he/she has ever seen was the state long-term care ombudsman. Resident #47 further added, we don't even know if the grievance official is a he or she, it [the grievance officer] is non-existent. When surveyors informed the resident council of the name of the grievance officer, Resident #47 stated he/she did come around the other day [to Resident #47's room] asking how things are going, but they didn't tell me who they were .so this [grievance official] is news to all of us. Random observations on 5/18-22/25 in all cottages revealed the existence of a framed sign on the counter next to the entryway of the cottages, featuring a wooden frame with a Suggestions label on the bottom left. The sign had a blue and orange header with the text caring reliably in white. Below the header, it read: Thank you for your feedback. If you have any concerns or feedback about your care, please fill out a concern/feedback form and either give it to a caregiver or drop it here [referring to a locked wooden box nearby]. You may also call the grievance official at 212.9250 or e-mail pec_grievance_official@providence. org. Note: you may submit a concern anonymously, however, we will not be able to follow up with you directly if you do. Further follow up on the email address pec_grievance_official@providence.org led to an incorrect address, and the phone number 212.9250, aside from being incomplete, when called, connected to the Assistant Administrator (AA), who confirmed the email was inaccurate and stated the phone number should instead lead to the grievance officer. During an interview on 5/20/25 at 8:25 AM, the AA also added that they (the Grievance Officer and the Assistant Administrator) worked together on addressing grievances, but the sign needed to be changed. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the document titled Meet our grievance officer, undated, introduced Grievance Officer #1 as the grievance officer, noting their over 35 years of experience in long-term care, their advocacy for residents and families, and their dedication to addressing concerns with respect and care. It provided contact information for Grievance Officer #1, including an email (GrievanceOfficial1@ensignservices.net) and a phone number (907-212-9237), encouraging individuals to reach out with any concerns. These documents were discovered throughout the cottages in various locations. The email and phone number listed in this form contained inaccurate and inconsistent information when compared to the instructions provided in the wooden framed sign described above. Record review of the Resident admission Agreement, undated, revealed the following grievance procedure: (A). Generally. If the Resident or Resident Representative believes that the Resident is being mistreated in any way or the Resident's rights have been or are being violated by staff or another resident, the Resident or Resident Representative shall make his/her complaint known to the Facility's Director of Nursing or Administrator. The Facility will review and investigate the complaint and provide a response to the Resident or Resident Representative. A copy of the Facility's grievance policy and procedure regarding any complaints about Facility practices is attached to this Agreement and available upon request. During an interview on 5/21/25 at 6:16 PM, the Director of Nursing (DON) stated that he was not the grievance officer, and that the admission paperwork was incorrect, as it should specify DON or designee as the point of contact for grievances. During a separate interview on 5/22/25 at 3:25 PM, the DON reported recently having addressed a grievance submitted via the facility's complaint hotline by Resident #19. The grievance concern was of insufficient shower frequency for Resident #19 and other residents. The DON stated that he neither documented nor logged the grievance officially. The DON pointed out the Hotline number as the way to file a complaint and provided surveyors with a copy of the Hotline grievance process form. The DON further stated, Flyers with the Grievance Officer's picture and grievance information were posted, and staff were informed to share this with residents. I'm not sure if every resident received this directly Addressing fear of retaliation is tough-if residents don't voice it, it's hard to address, but we can discuss it at the next council meeting. Record review of the document titled Accountability, undated, revealed a notice that emphasized accountability and standards of care. It prominently featured a hotline phone number, [PHONE NUMBER], encouraging reporting of grievances or concerns to this number, which was available 24 hours a day, 7 days a week. Record review of the Resident admission Agreement, undated, revealed the following: (A). Retaliation. The Facility shall not retaliate or discriminate against a Resident, a family member, or guardian or any other person because the Resident, the resident's family member or guardian, or any other person: (1) makes a complaint or files a grievance concerning the Facility; (2) reports a violation of law, including a violation of laws or regulations regarding nursing facilities; or (3) initiates or cooperates in an investigation or proceeding of a governmental entity relating to care, services, or conditions at the Facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/25 at 3:25 PM, when asked about what training do staff receive to support resident council rights and handle grievances, the DON stated the grievance officer role was discussed in staff meetings, Either I or the Administrator reviews every grievance to ensure compliance. The grievance officer, doesn't directly report to me, so I'd need to confirm their oversight structure. During an interview on 5/21/25 at 3:05 PM, Grievance Officer #1 stated they do not have an official process to track grievances and that not all grievances would be found in the grievance log, because they would rather have their staff verbally inform them of the grievances. She explained that this informal approach allows for quicker communication and resolution. During a separate interview on 5/22/25 at 4:30 PM, Grievance Officer #1 who is also the Quality Assurance Coordinator stated resident concerns brought up during resident council have not been identified in Quality Assurance and Performance Improvement (QAPI) meetings. Review of the policy and procedure Resident Rights - Grievances, revised 11/23/21, revealed the framework for addressing resident concerns in a facility. The policy emphasizes the facility's commitment to establishing a grievance process that addresses concerns without fear of discrimination or reprisal. It encourages residents to make prompt efforts to resolve grievances, ensuring their rights are protected. The procedure detailed steps such as the role of a grievance officer in overseeing the process, residents' rights to file grievances anonymously or in writing, and the use of specific Grievance Resolution Forms. It also highlighted concerns can be raised at meetings, with the grievance officer tasked with investigating, taking action, and resolving issues within three working days while reporting any severe violations as required by state law. A notable gap in the policy and procedure is the absence of the grievance official's name, despite a designated field for it under the procedure section. The document also lacked the official's business address, phone number, and email. .

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. . Based on record review, interview, and observation, the facility failed to protect the residents right to be from neglect for 3 sampled resident (#'s 40, 47, and 70), out of 21 sampled residents, and 1 unsampled resident (#56). Specifically, the facility failed to ensure provisions of goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress were provided: 1) Activities of Daily Living (ADLs - the skills of bathing, dressing, toileting, transferring, bed mobility, and eating) were completed and/or completed in a timely manner to meet the needs of 1 resident (#40); 2) Medications were available for administration as ordered 2 residents (#47 and #56); and 3) Appropriate, timely treatment for a possible urinary tract infection (UTI) for 1 resident (#70). This failed practice: 1) placed Resident #40 at risk for psychological harm and/or physical harm and a less-than-optimal environment that ensured the resident was able to maintain their highest practical well-being; 2) placed Residents #47 and #56 at risk of possible serious complications and hospitalization; and 3) left Resident #70 with UTI symptoms for over a month despite repeated requests for answers and possible treatment from the resident which resulted in continued pain and discomfort. Findings: Activities of Daily Living Resident #40 Record review on 5/18-22/25 revealed Resident #40 was admitted to the facility with diagnoses that included morbid obesity, coronary artery disease, heart failure, hypertension, end stage renal disease and diabetes mellitus. Review of Resident #40's Minimum Data Set (MDS - a federally required nursing assessment) annual assessment, dated 6/27/24, revealed showering, bed bath, or sponge bath were very important to Resident #40. Resident #40 required setup or clean-up assistance during oral care. Review of Resident #40's MDS quarterly assessment, dated 3/11/25, revealed Resident #40 had an impairment of the lower limbs and required wheelchair transportation, always incontinent of bladder and bowel, and at risk for pressure ulcers. Resident #40 required assistance for his/her shower transfers. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #40's Care Plan Report, dated 4/15/25, revealed .MY GOAL IS TO: . feel comfortable and safe, give me time to do tasks. ADL Self Care Performance r/t [related to] Cognitive deficit, Limited Mobility. Interventions/Tasks. TOILET USE (TOILET TRANSFER, TOLIET HYGIENE): Requires 1 person providing more than half the effort . BED MOBILITY. Requires 1-2 people providing more than half the effort. BATHING. Shower days: Tuesday day and Friday evening. PERSONAL HYGIENE/ORAL CARE (ORAL HYGIENE): SET UP ASSIST . I need my aides to help me brush.I HAVE: the potential to feel anxious, scared/fearful. WHEN I FEEL THIS WAY I: . feel down or depressed. MY GOAL IS TO: feel. safe and secure, participate in my care, make decisions about my daily routine. Offer me choices ask me how I am feeling today. During an interview on 5/18/25 at 8:35 AM, Certified Nurse Assistant (CNA) #2 stated he/she was the only CNA scheduled in the Deshka cottage. CNA #2 further stated from 3:30 PM to 7:00 PM on 5/18/25, he/she had to cover the Kenai cottage while covering the Deshka cottage because there was not enough staff. CNA #2 stated he/she was concerned how all residents would be cared for. CNA #2 stated there were two residents in the Deshka cottage that required feeding assistance and would be required to wait longer than normal. During an interview on 5/18/25 at 1:06 PM, Resident #40 stated he/she was unable to brush his/her teeth when requested. Resident #40 stated staff was not available to gather his/her supplies. Resident #40 further stated that he/she could not get to the toilet independently so he/she would often have episodes of incontinence. Resident #40 stated that he/she had to wait 1 hour and 45 minutes for staff to come and provide perineal care after he/she pressed the call light. Resident #40 further stated he/she had not received a shower for 1 ½ months due to not enough staff. Resident #40 stated it required two CNAs to transfer him/her out of bed. During an interview on 5/19/25 at 8:20 AM, CNA #2 stated Resident #40 was last showered about 2 months ago. CNA #2 further stated Resident #40 was transferred to the shower by the ceiling lift and required two staff members to complete a safe transfer. CNA #2 stated he/she does not always have a second staff member to assist. During an interview on 5/20/25 at 1:40 PM, the MDS Coordinator (MC) reviewed Resident #40's care plan. The MC stated Resident #40 required one or two staff to complete the transfer with the use of the ceiling lift based on their comfort level and ability. The MC further stated Resident #40's current weight on 5/13/25 was 278 pounds. Review of Resident #40's Documentation Survey Report. Task Only, dated March 2025, revealed from 3/1/25 to 3/31/25; - No showers were documented as successfully completed; - Oral Hygiene- was only documented on three days: 3/3/25, 3/17/25 and 3/19/25, and; - Personal Hygiene- was only documented on the following days: 3/3/25, 3/11/25, 3/16-19/25. Review of Resident #40's Documentation Survey Report . Task Only, dated April 2025, revealed from 4/1-30/25;Tub/shower transfer occurred on two occasions. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #40's Task: Bathing, dated 5/1-20/25, revealed . 5/17/25 [at] 00:01. Shower. No other showers were documented as successfully completed. During an interview on 5/22/25 at 2:15 PM, Resident #40 smiled and stated he/she received a shower two days ago. Resident #40 stated when he/she did not receive a shower over the past 2 months, he/she felt uncomfortable. Resident #40 further stated he/she felt down because there was not enough help and I just cry and go to sleep. During an interview on 5/22/25 at 3:30 PM, Physical Therapist (PT) #1 stated when operating a ceiling lift, one to two staff members were required. When PT #1 was asked how many staff members were required to transfer Resident #40 out of bed, PT #1 stated if Resident #40 requested two staff members or the staff member operating the lift did not feel comfortable alone, then the transfer required two staff members. Review of the facility's policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE, dated 12/2024, revealed: . AM CARE (EVERY MORNING): Hands and face washed, Toilet & Peri Care. Oral Care. H.S. [bedtime] CARE (EVERY HS AT BEDTIME): Hands and face washed, Toilet & Peri Care. Oral Care. BEFORE MEAL CARE: Toileting and Peri care. PERIODIC CARE: Shower/Bath as scheduled. Provide a complete bed bath if scheduled shower cannot be given. ONGOING CARE: . Call lights: work as team to meet the goal of answering regular within 5-10 minutes. Provide peri care after voids . Promote resident choice and personal preference . Lack of Medication Availability Resident #47 Record review on 5/18-22/25 revealed Resident #47 was admitted to the facility with diagnoses that included type 1 diabetes mellitus (insulin-dependent diabetes), chronic kidney disease stage IIIb (CKD - moderate to severe kidney function loss) and vascular insufficiency (impaired blood flow). During an interview on 5/19/25 at 8:33 AM, Resident #47 stated he/she had issues with not receiving his/her medication on 3/25/25. Resident #47 further stated his/her medication, Sodium Bicarbonate, was ordered three times per day and sometimes he/she would go days without receiving the medication due to staff not being able to locate it in the medication administration cart. During an observation and concurrent interview on 5/20/25 at 10:30 AM, LN #1 opened the medication administration cart in the Deshka cottage and removed a large white bottle with a pharmacy label for Resident #47's Sodium Bicarbonate medication. The pharmacy label documented that the medication was: . filled 2/25/25 . expires 8/24/25 . LN #1 further stated he/she was unsure why the medication was not available on 3/25/25. Review of Resident #47's Medication Administration Record (MAR), for March 2025, revealed: . Sodium Bicarbonate oral tablet 650 mg . Give 1 tablet by mouth three times a day for Metabolic Acidosis Associated with CKD-Order Date-11/17/2022. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Further review revealed the following doses of Sodium Bicarbonate were not given: 3/19/25 at 1:00 PM; 3/23/25 at 9:00PM; 3/24/25 at 9:00 PM; 3/25/25 at 9:00 PM; 3/26/25 at 9:00 AM; 1:00 PM; and 9:00 PM. Further review revealed all missed doses were documented as 2=Hold/See Nurse Notes or 7=Other/See Nurse Notes. Review of Resident #47's Provider Progress Note, dated 3/19/25 at 11:48 AM, revealed: . CKD stage IIIB . NaBicarb [Sodium Bicarbonate] 650mg TID . Review of Resident #47's eMAR [electronic MAR] Medication Administration Note, dated 3/19/25 at 12:37 PM, revealed: . Morning dose was given at 1240 skipping noon dose. Review of Resident #47's eMAR Medication Administration Note, dated 3/23/25 at 9:27 PM, revealed: Sodium Bicarb missing. Review of Resident #47's eMAR Medication Administration Note, dated 3/25/25 at 8:51 AM, revealed: not available. Review of Resident #47's eMAR Medication Administration Note, dated 3/26/25 at 9:02 AM, revealed: not available. Review of Resident #47's eMAR Medication Administration Note, dated 3/26/25 at 9:39 PM, revealed: not in stock. Review of the National Kidney Foundation, dated 2025, retrieved from: https://www.kidney.org/kidney-failure-risk-factor-serum-bicarbonate, revealed . sodium bicarbonate. can help keep kidney disease from getting worse . Resident #56 Record review on 5/18-22/25 revealed Resident #56 was admitted to the facility with diagnoses that included absence epileptic syndrome, not intractable, without status epilepticus, other sequelae of cerebral infarction (stroke), hemiplegia (weakness or paralysis of one side of the body) following cerebral infarction, long term (current) use of anticoagulants (blood-thinning medication) and unspecified hearing loss, bilateral. During an interview on 5/20/25 at 10:27 AM, Resident #56 stated he/she had epilepsy and missed several doses of Celotin (anti-seizure medication) medication. Resident #56 stated the facility ordered his/her medications and had run out multiple times. Resident #56 further stated, I cannot miss any doses as it is my lifeline. Resident #56 stated he/she reported the concern about the missed doses of Celotin but was not sure which member of staff was reported to. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/20/25 at 10:45 AM, LN #1 stated Resident #56's monthly medications were automatically filled by an out of state pharmacy contracted by the facility. LN #1 stated the medications were received and checked in by the nursing supervisors. LN #1 further stated if a medication was missing for administration, he/she would contact the nursing supervisor, and then the pharmacy would be notified. LN #1 stated that if the medication was needed right away, the facility would request the pharmacy to send a prescription to the local satellite pharmacy, so the patient could receive it that day. LN #1 further stated if a medication was ordered and not administered, then the resident, the resident's POA (Power of Attorney) and the provider must be notified. Review of Resident #56's Care Plan Report, dated 2/25/25, revealed: . Because I: History of . seizure disorder . Interventions/Tasks. I need my nurses to . give me my medications as ordered . notify MD [Medical Doctor] as needed . Review of Resident #56's MAR, dated March 2025, revealed Resident #56 missed: Celotin 300mg capsule BID for Seizure Disorder on 3/20-25/25. All missed doses documented as 2=Hold/See Nurse Notes or 7=Other/See Nurse Notes. Review of Resident #56's eMAR Medication Administration Note, dated 3/20/25 at 5:50 AM, revealed: Medication not available. Review of Resident #56's eMAR Medication Administration Note, dated 3/20/25 at 1:28 PM, revealed: Med was ordered 3/19/2025 in the NOC [night] shift. Has not been delivered yet. Review of Resident #56's eMAR Medication Administration Note, dated 3/21/25 at 5:08 AM, revealed: unavailable, ordered from pharmacy. Review of Resident #56's eMAR Medication Administration Note, dated 3/21/25 at 1:58 PM, revealed: unavailable. Review of Resident #56's Progress Note, dated 3/22/25 at 5:18 AM, revealed: RX [Celotin] unavailable, pharmacy contacted 3/20/25. Review of Resident #56's Progress Note, dated 3/22/25 at 6:10 AM, revealed: Resident POA called and upset that [his/her] [sibling] was not getting [his/her] seizure medication and why it has not been delivered . Review of Resident #56's Progress Note, dated 3/22/25 at 10:00 AM, revealed: Dilantin 100mg TID initiated until Celotin is available. Review of Resident #56's Provider Progress Note, dated 3/24/25 at 5:03 PM, revealed: . Chief Complaint: Nursing reports missing Celotin, pt [patient] started on Dilantin .Seizure. Celotin 300mg BID . Review of Resident #56's Progress Note, dated 3/26/25, revealed Celotin was restarted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #56's MAR, dated May 2025, revealed missed administrations of the following ordered doses for Celotin 300 mg: 5/1/25 at 6:00 AM, 5/5/25 at 6:00 AM, 5/7/25 at 2:00 PM, 5/8/25 at 6:00 AM, 5/10/25 at 6:00 AM, 5/11/25 at 6:00 AM, 5/14/25 at 2:00 PM and 5/17/25 at 6:00 AM. All missed doses were documented 2=Hold/See Nurse Notes. Review of Resident #56's Provider Progress Note, dated 5/1/25 at 9:53 AM, revealed . being seen today for f/u care . Seizure-Nonintractable absence epilepsy without status epilepsy-Methsuximide (Celotin) 300mg BID. Further review revealed there was no documentation noted regarding the unavailable Celotin medication. Review of Resident #56's eMAR Medication Administration Note, dated 5/5/25 at 5:05 AM, revealed Celotin 300mg capsule not available, reordered, given Ethosuximide [Zarontin - an antiseizure medicaiton]. This was the only documentation noted for any of the missed administrations of Celotin on 5/25. Review of Resident #56's Order Summary Report, dated 5/20/25, revealed . Celotin Oral Capsule 300MG Give 1 capsule by mouth two times a day for Seizure Disorder. Order Date 10/1/22 Start Date 3/1/25 . Ethosuximide Oral Capsule 250 MG Give 1 capsule by mouth as needed for Absence Seizures related to ABSENCE EPILEPTIC SYNDROME, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS (G40.A09) Give if resident runs out of Celotin. order date 5/2/25 start date 5/3/25. Review of the Epilepsy Foundation, dated 2024, retrieved from https://www.epilepsy.com/what-is-epilepsy/seizure-triggers/missed-medicines, revealed: . Missing doses of seizure medication is the most common cause of breakthrough seizures. Missed medicines can trigger seizures in people with both well-controlled and poorly controlled epilepsy. Missing doses of medicine can also lead to falls, injuries and other problems from seizures and changes in medicine levels . stopping seizure medication . suddenly, a person can have withdrawal symptoms. You could also have long seizures, cluster of seizures or status epilepticus, even if you've never had these problems before. If you're taking more than one seizure medicine, stopping one of the medicines could change the level or amount of another seizure medicine in your body. These sudden changes in drug levels can trigger seizures . During an interview on 5/22/25 at 1:50 PM, the Director of Nursing (DON) stated if a nurse was unable to locate an ordered medication, the nurse should check the emergency kit (ekit) for a dose. The nurse should contact the pharmacy for to the medication to be dispensed from the ekit. If the medication was not in the ekit, the pharmacy would send a prescription to the local satellite pharmacy to be dispensed right away. The DON further stated if a medication was omitted, the nurse should contact the physician, document in the medical record why the medication was not given, the steps taken to obtain the medication, the discussion held with the physician and if there was any harm to the resident. Review of the facility job description Licensed Vocational Nurse/Licensed Practical Nurse, dated 12/17/21, revealed .Prepare and administer medications as ordered by the physician . Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident . Review of the facility job description Registered Nurse, dated 12/17/21, revealed .Prepare and administer medications as ordered by the physician . Chart nurses' notes in professional and appropriate manner that timely, accurately and thoroughly reflects the care provided to the resident . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy Medication Administration, dated 3/25, revealed: . If a dose of regularly scheduled medication is withheld . the nurse shall document either in the Electronic Medication Administration Record . and enter an explanatory note. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition, book, published 2023, revealed: . To promote a culture of safety and to prevent medication errors, nurses must . adhere to the five rights of medication administration: .administer the medication by the right route . Safe Medication, Administration Practices . If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. Delay in UTI Treatment Resident #70 During an interview on 5/18/25 at 10:45 AM, Resident #70 stated he/she requested a urine analysis (UA- a lab test to see if there were any abnormalities in a urine sample) to be completed back in April for symptoms of a UTI he/she was having, mainly bladder pain and painful urination. Resident #70 stated there was a huge delay in getting a UA successfully completed, Once the nurse forgot to order the UA, the second time the UA was never sent to the lab, the third time the UA was contaminated, and the fourth sample is still at the lab. Resident #70 stated, currently, he/she continued to have UTI symptoms of flank pain (pain over the kidney area, near lower back) and painful urination, and has had no doctor come and talk to him/her about them. Resident #70 further stated that he/she usually used a purewick catheter (a flexible external catheter that used low pressure suction to wick urine away from the patient), however it was currently broken because a Certified Nursing Assistant (CNA) accidently threw a part away during cares and the facility had ordered the part but was waiting for its delivery to continuing using the catheter. Review of Resident #70's medical record, dated 4/16/25 to 5/22/25, revealed: 1) An order for a UA was written on 4/16/25 and documented it was completed, however a review of Resident #70's lab reports revealed this UA was never received or analyzed by the lab vendor. A review of Resident #70's progress notes revealed: - 4/20/25 at 6:48 PM: Resident #70 inquired about the results of last UA. - 4/27/25 at 4:51 PM: Ibuprofen (pain medication) was given resident complained of back pain. - 4/28/25 at 4:33 PM: Ibuprofen was given pain scale 5 (on a scale of 0 to 10), requested for back pain. - 4/29/25 at 8:31 AM: Ibuprofen was given complained of low back pain. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 4/29/25 at 12:03: Documentation of Phenazopyridine HCL [a pain reliever for the lower urinary tract, but not for UTIs] Oral Tablet 95mg . Give 2 tablet by mouth every 8 hours as needed for Urinary tract/Badder discomfort until [5/1/25 11:59 PM] three times a day. - 4/29/25 at 6:28 PM: Resident complaint of back pain, offered Morphine but refused. Requested Ibuprofen PRN [as needed], given and was effective. Pain scale was down to 3 [at] 1:44 PM . Resident wants to know last urine test result, will send message to ANP [advanced nurse practitioner]. - 5/1/25 at 12:00 AM: Provider progress note from ANP #3, Chief Complaint: urine/flank pain . [He/she] states [he/she] is generally not feeling well with urethral pain/burning/lack of urinary frequency . Labs/Radiology/Tests: Labs: Labs and imaging reviewed on Epic [electronic medical record] . Assessment and Plan: Urethral Pain. U/A C&S [urine analysis with culture and sensitivity - analyze the urine, culture it to determine sensitivity to antibiotics if indicated] . ICD [International Classification of Disease] Codes . N39.0 urinary tract infection, site not specified . 2) An order for a UA was written on 5/1/25 and documented it was completed, however a review of Resident #70's lab reports revealed this UA was never received or analyzed by the lab vendor. Further review of Resident #70's progress notes revealed: - 5/5/25 at 10:32 AM: Resident stated that [he/she] is having bladder pain . wanted to know [his/her] last urine test result . Message to [ANP #3] about the result, waiting . - 5/5/25 at 6:12 PM: Change of Condition: Symptoms or signs noted of condition change . pain in urination . Reported to primary care clinician [ANP #3] Date and time of clinician notification: [5/5/25] 1:00 PM. - 5/5/25 at 7:33 PM: Order from [ANP #3] for U/A, C&S if indicated transcribed . - 5/6/25 at 10:06 AM: Resident stated complained of bladder pain . Resident is waiting for the lab result of [his/her] urine, informed [him/her] it was sent by [night] nurse this morning . - 5/6/25 at 6:57 PM: At [3:04 PM] Resident check [his/her] lab result [through] MyChart wants result. Writer message [ANP #3] said she will order antibiotics. Waiting for actual [antibiotic] order . 3) An order for a UA was written on 5/6/25 and documented it was completed. A review of Resident #70's UA lab report from 5/6/25 revealed the following abnormalities: - Clarity: Turbid (cloudy or hazy urine, can be caused by bacteria, cells, or mucus) - Leukocyte Esterase: Moderate (increased number of leukocytes in urine, could indicate UTI) - [NAME] Blood Cells: 26-50 (normal range is 0-5, could indicate serious medical conditions like inflammation or infection) - [NAME] Blood Cell Clumps: Rare (could indicate an infection or inflammation) (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Further review revealed: Culture results: 10,000-50,000 CFU/ml mixed flora (multiple morphologies present) suggestive of superficial contamination/colonization. Suggest appropriate recollection with timely delivery to the laboratory, if clinically indicated. Further review of Resident #70's medical record revealed no re-order or re-collection of another UA took place after this report was received by the facility. Further review of Resident #70's progress notes revealed: - 5/6/25 at 7:47 PM: Diagnosis or Condition(s) being monitored: Pain in Urination . Pain originates from during urination located at bladder described as sharp nonpharmaceutical interventions include repositioning as tolerated . Genitourinary and renal: Urine is slightly darker yellow urine Active [symptoms] difficult/painful urination . offered pain medication was refused . encouraged to drink fluids. - 5/9/25 at 4:09 PM: Resident is requesting for another U/A C&S to be done due to [his/her] back pain 3-5/10 [3 to 5 out of 10]. Pain medication was offered. Resident refused. Resident's recent U/A C&S was reviewed by [ANP #3]. Per NP, [Resident #70's] UA C&S came back normal but if [he/she] would like to have another test then that's okay. Ordered noted and carried out. Resident aware . - 5/9/25 at 4:54 PM: Received a phone call from [Resident #70's] POA [Power of Attorney], at [1:55 PM] today. She was concerned about ongoing complaints to her from [Resident #70] about a UTI that was not being treated. This writer [Licensed Nurse (LN) #14] called [ANP #3] and learned that the UA C&S microscopic that resulted on 5/6/25 was [negative] for nitrates and growth, with moderate leukocytes. Electrolytes WNL [within normal limits]. The Macrobid [an antibiotic] that had been ordered prophylactically was withdrawn. After speaking with [Resident #70], I believe the results had not been explained to [him/her]. The current problem is the resident still has complaints of intermittent kidney pain. I called the Provider again who said to get a new UA with C&S and microscopic if indicated if the resident was good with that plan. [Resident #70] agreed & the order was entered. The [Registered Nurse] in Matanuska will obtain the sample via sterile straight cath. Just before the time of this note, this writer called the POA back to update her on the above events. Will continue to monitor. 4) An order for a UA was written on 5/9/25 and documented it was completed, however a review of Resident #70's lab reported revealed this UA was never received or analyzed by the lab vendor. - 5/14/25 at 8:34 AM: Received new order from [ANP #3] to resume the order for Phenazopyridine HCL oral tablet 95mg PRN for bladder discomfort . - 5/14/25 at 4:40 PM: Writer [LN #15] spoke with [Resident #70] and updated [him/her] of an order for a Urology consult obtained from yesterday . also I asked [him/her] if [he/she] has any urinary difficulties and would like to have a UA done, 'I still have random discomfort after peeing, yes, I would like to have it done.' UA C&S with micro if indicated was entered in PCC [Point Click Care - electronic medical record] for tomorrow's collection at [6:00 AM]. POA is aware that UA will be done tomorrow. - 5/14/25 at 5:12 PM: Spoke with [Resident #70] and let [him/her] know that [night] nurse will collect urine from [him/her] tomorrow early morning and [he/she] agreed . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 5/15/25 at 7:02 AM: UA C&S with micro [microscope analysis] if indicated. One time only for 1 day collected at [6:50 AM]. 5) An order for a UA was written on 5/15/25 and documented it was completed. A review of Resident #70's UA lab report from 5/15/25 revealed the following abnormalities: - Specific Gravity: high at 1.031 - Protein: 20mg/dL (normal range is 0-14mg/dL. Could be indicative of kidney disease or dehydration) - Leukocyte Esterase: Small - [NAME] Blood Cells: 11-15 Further review of Resident #70's progress notes revealed: - 5/18/25 at 2:13 AM: Phenazopyridine was administered. With an effective reassessment at 2:41 AM. - 5/18/25 at 12:24 PM: Phenazopyridine was administered, resident requested for bladder pain and discomfort. Stated [his/her] pain scale was 7. Had an effective reassessment at 6:42 PM (over 6 hours after having administered it). - 5/18/25 at 7:50 PM: . Resident complain of [bladder] pain and symptoms. Pain scale of 7. Check on Resident went down to 2 as stated . - 5/21/25 at 9:34 AM: Phenazopyridine was administered, per requested for urinary pain. During an interview on 5/21/25 at 10:21 AM, after reviewing Resident #70's UA lab reports from 5/6/25 and 5/15/25, the Medical Director stated there were some abnormalities to both lab reports. When asked to review Resident #70's medical record to see if any provider had assessed Resident #70 after these samples were received, the Medical Director stated no one had seen him/her for these concerns. The Medical Director stated he was taking over resident care this week and would assess Resident #70. Further review of Resident #70's progress notes revealed antibiotics were started after the Medical Director's assessment. - 5/21/25 at 1:47 PM: . Nitrofurantoin Macrocrystal Capsule 100mg give 1 capsule by mouth two times a day for cystitis [An inflammation of the urinary bladder, often caused by a bacterial infection. It's a common type of UTI] for 7 days . - 5/22/25 at 1:24 PM: . Received order to change [Nitrofurantoin Macrocrystal] to Macrobid BID [for] 7 days . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/22/25 at 5:30 PM, after having reviewed Resident #70's medical record, the Director of Nursing and Infection Preventionist both stated they could not find documentation that a Provider followed up with Resident #70's symptoms of UTI and they could not explain why three of the five UAs obtained did not make it to the lab for analysis. Review of the facility's policy Patient Rights, undated, revealed: . Receive adequate and appropriate care . Be informed of all changes in medical condition . participate in their own assessment, care-planning, treatment, and discharge . To be treated with consideration, respect, and dignity . Reasonable accommodation of one's needs and preferences . Review of the facility's policy ADL, Services to carry out, reviewed on 3/2025, revealed: Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain . Personal Hygiene include . Toileting . among others. Review of the facility's policy titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, dated 3/2025, revealed, It is the policy of this Facility that each resident has the right to be free from abuse, neglect . Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress . .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to implement their abuse, neglect, and exploitation screening policy accordingly. Specifically, the facility failed to ensure individuals who had direct contact with residents, their medical or financial records, or control over or impact on the financial well-being of residents had a valid criminal history check conducted under 7 Alaska Administrative Code (AAC) 10.900-10.990. This resulted in 37 employees and 18 contracted staff working in the facility without valid clearance from the Alaska Background Check program. This failed practice placed all residents (based on a census of 91) at risk for abuse and neglect. Findings: New Employees During an interview on [DATE] at 1:03 PM, the HR (Human Resources) Manager stated the hiring process of new employees included the completion of a State of Alaska background check application, that included fingerprinting after the employee accepted the job. The HR Manager further stated the facility waited for the receipt of an eligible background check before the facility started the onboarding process, which included orientation training, shadow time on the floor, and then starting work independently. Record review on 5/18-22/25 of the facility-provided active employee list, undated, revealed the following new hire employees started their orientation/training, and/or direct resident care without a valid and/or appropriately associated State of Alaska background check: 1) Licensed Nurse (LN) #100 LN #100 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #100's eligible background check was not obtained until [DATE] (31 days after work was already started). 2) LN #101 LN #101 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #101's eligible background check was not obtained until [DATE] (29 days after work was already started). 3) Social Worker #1 Social Worker #1's first day of employment was [DATE]. The Social Worker's eligible background check was not obtained until [DATE] (24 days after work was already started). 4) LN #102 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LN #102 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #102's eligible background check was not obtained until [DATE] (27 days after work was already started). 5) LN #103 LN #103 started orientation on [DATE]. LN #103's eligible background check was not obtained until [DATE] (24 days after work was already started). 6) Business Office Staff #1 Business Office Staff #1's first day of employment was [DATE]. Business Office Staff #1's eligible background check was not obtained until [DATE] (22 days after work was already started). 7) LN #106 LN #106 started orientation on [DATE]. LN #106's eligible background check was not obtained until [DATE] (18 days after work was already started). 8) Certified Nursing Assistant (CNA) #202 CNA #202 started orientation on [DATE]. CNA #202's eligible background check was not obtained until [DATE] (25 days after work was already started). 9) LN #110 LN #110 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #110's eligible background check was not obtained until [DATE] (58 days after work was already started). 10) Physical Therapy (PT) Tech #1 PT Tech #1 started orientation on [DATE]. PT Tech #1's eligible background check was not obtained until [DATE] (50 days after work was already started). 11) LN #111 LN #111 started orientation on [DATE]. LN #111's eligible background check was not obtained until [DATE] (54 days after work was already started). 12) LN #112 LN #112 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #112's eligible background check was not obtained until [DATE] (36 days after work was already started). 13) Hospitality Aide #90 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hospitality Aide #90 started orientation on [DATE] and the first day working directly with residents was [DATE]. Hospitality Aide #90's eligible background check was not obtained until [DATE] (36 days after work was already started). 14) Maintenance Staff #40 Maintenance Staff #40 started orientation on [DATE]. Maintenance Staff #40's eligible background check was not obtained until [DATE] (50 days after work was already started). 15) HR Payroll Representative The HR Payroll Representative started orientation on [DATE]. The HR Payroll Representative's eligible background check was not obtained until [DATE] (64 days after work was already started). 16) Dietician #8 Dietician #8 started employment on [DATE]. Dietician #8 had no eligible background check for the facility during time of the survey. Further review revealed Dietician #8 had a background check for another LTC (Long Term Care) facility associated with the owner, dated [DATE], but this was not associated with the current facility at time of the survey. 17) LN #116 LN #116 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #116 had no eligible background check for the facility at time of the survey. Further review revealed LN #116 had a background check for another LTC facility associated with the owner, dated [DATE], but this was not associated with the current facility at time of the survey. 18) Hospitality Aide #91 Hospitality Aide #91 started orientation on [DATE] and the first day working directly with residents was [DATE]. Hospitality Aide's eligible background check was not obtained until [DATE] (34 days after work was already started). 19) LN #117 LN #117 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #117's eligible background check was not obtained until [DATE] (38 days after work was already started). 20) Hospitality Aide #92 Hospitality Aide #92 started orientation on [DATE] and the first day working directly with residents was [DATE]. Hospitality Aide #92's eligible background check was not obtained until [DATE] (31 days after work was already started). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	21) CNA #207 CNA #207 started orientation on [DATE] and the first day working directly with residents was [DATE]. CNA #207 had no eligible background check for the facility during the survey. Further review revealed CNA #207 had a background check for another LTC facility associated with the owner, dated [DATE], but this was not associated with the current facility at time of the survey. 22) LN #118 LN #118 started orientation on [DATE] and the first day working directly with residents was [DATE]. LN #118's eligible background check was not obtained until [DATE] (31 days after work was already started). Established Employees During an interview on [DATE] at 1:03 PM, the HR Manager stated when the new owner took over, on [DATE], the facility attempted to get the old background check eligibility letters that were associated with the old owner and facility name, for employees who remained through the change in ownership. The letters for these established employees were never obtained. The HR Director further stated, due to not having the old eligibility letters, the new owners assumed all established employees had a valid background check to continue working until their new eligibility letters, under the new owners and facility name, were obtained. Record review on 5/18-22/25 of the facility-provided active employee list, undated, revealed the following established employees worked without a valid and/or appropriately associated State of Alaska background check: 1) Administrator During an interview on [DATE] at 1:03 PM, the HR Manager stated the Administrator was working under the old owner and name prior to the change of ownership. Review of the State of Alaska Background Check database revealed the Administrator never had an eligible background check under the old owner and name. The Administrator took on the full-time duties of this role when the new owner took over the facility on [DATE]. A background check application was only first submitted for the Administrator on [DATE] (72 days after assuming the role) and an eligible background check was obtained on [DATE]. (A total of 80 days without an eligible background check). 2) Director of Nursing (DON) The DON's prior eligible background check for the old owner expired on [DATE]. The DON was hired for the role on [DATE]. A background check application was only first submitted for the DON on [DATE] (72 days after assuming the role) and an eligible background check was obtained on [DATE]. (A total of 81 days without an eligible background check). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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	025036	A. Building B. Wing	05/22/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11) [NAME] #32 Cook #32 was a past employee prior to when the new owner took over the facility on [DATE]. [NAME] #31 had no eligible background check for the facility during time of the survey. Further review revealed [NAME] #32 had a background check for another LTC facility associated with the owner, dated [DATE], but this background check was not associated with the current facility at time of the survey. 12) [NAME] #33 Cook #33's prior eligible background check for the old owner expired on [DATE]. Further review revealed that [NAME] #33's background check application, under the new owner and name, was still in process at time of survey. [NAME] #33 was working without an eligible background check. 13) Laundry Staff #20 Laundry Staff #20's prior eligible background check for the old owner expired on [DATE]. Further review revealed that Laundry Staff #20's background check application, under the new owner and name, was still in process at time of survey. Laundry Staff #20 was working without an eligible background check. 14) Clergy #6 Clergy #6's prior eligible background check for the old owner expired on [DATE]. Further review revealed that Clergy #6's background check application, under the new owner and name, was still in process at time of survey. Clergy #6 was working without an eligible background check. 15) CNA #211 CNA #211's prior eligible background check for the old owner expired on [DATE]. An eligible background check was obtained on [DATE]. (A total of 76 days without an eligible background check). Travel Staff During an interview on [DATE] at 1:03 PM, the HR Manager stated that travel employees were hired and processed through The [NAME] Group, Inc. (the new owner) and not the facility. The HR Manager stated that she informed The [NAME] Group, Inc. that travel staff required an Alaska State background check prior to working at the facility, but currently, there were no travel staff that had a State of Alaska eligible background check. When asked for a list of all active travel staff currently working for the facility, the following list was provided: 1) LN #104: Started contract for employment on [DATE]. The contract ends on [DATE]. 2) LN #107: Started contract for employment was not listed. The contract ends on [DATE]. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of 7 AAC 10.900(b) at https://www.akleg.gov/basis/aac.asp#7.10.900, the 34th Legislature (2025-2026), revealed: . Each individual who is to be associated with a provider in a manner described in this subsection must have a valid background check conducted under 7 AAC 10.900 - 7 AAC 10.990 if that individual is 16 years or older and will be associated with the provider as (1) an administrator or operator; (2) an individual service provider; (3) An employee, an independent contractor, an apprentice, an unsupervised volunteer, or a board member if that individual as (A) regular contact with recipients of services; (B) access to personal or financial records maintained by the provider regarding recipients of services, including access to (i) personal identifying information, financial information, treatment information, or medical records .(4) an officer, a director, a partner, a member, or a principal of the business organization that owns an entity, if that individual has (A) regular contact with recipients of services; (B) access to personal or financial records maintained by the provider regarding recipients of services, including access to (i) personal identifying information, financial information, treatment information, or medical records . .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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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: 1) Provide written information related to bed holds at the time of transfer for 2 residents (#'s 48 and 90), out of 4 residents assessed for hospitalization; and 2) Document a physician's order for discharge for 1 resident (#90), out of 3 closed records reviewed. These failed practices: 1) had the potential for the residents to be displaced from their room or incur charges they would not be aware of from the facility; and 2) created an incomplete medical record. Findings: Resident #48 Record review on 5/18-22/25 revealed Resident #48 was admitted to the facility with diagnoses that included type 2 diabetes mellitus (non-insulin-dependent diabetes), end stage renal disease (a condition in which kidney function is less than 10% of normal; the kidneys can no longer remove wastes, concentrate urine, and regulate electrolytes), hemiplegia (a condition in which half of the body is paralyzed) and hemiparesis (partial paralysis of one side of the body) following unspecified cerebrovascular disease (damage to the blood vessels in the brain) affecting right dominant side, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, affects how one feels, think and behaves) and post-traumatic stress disorder (mental health condition caused by a traumatic event that affects the ability to function daily). During an interview on 5/18/25 at 1:24 PM, Resident #48 stated he/she was not provided with a bed hold notification when he/she was sent to the hospital on 4/21/25 and was admitted . Resident #48 further stated he/she was informed by the hospital that he/she could only stay at the hospital for 3 days or would lose his/her long-term care bed. During an interview on 5/19/25 at 11:50 AM, Licensed Nurse (LN) #1 stated Resident #48 was sent to the hospital on 4/21/25. LN #1 stated bed holds were completed by the supervisor when a resident was sent to the hospital. LN #1 could not locate a bed hold notice for Resident #48's 4/21/25 hospitalization when asked. Review of Resident #48's Minimum Data Set (MDS - a federally required assessment) quarterly assessment, dated 3/7/25, revealed Resident #48 was admitted to the facility on [DATE] with a BIMS (Brief Interview for Mental Status) score of 13 (a score of 13-15 indicated the resident was cognitively intact). A copy of Resident #48's Bed Hold Notification from 4/21/25 was requested on 5/20/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25 at 10:25 AM, the Director of Community Liaison stated she would provide the documentation. By the end of the survey on 5/22/25, the requested documentation was not received. During an interview on 5/22/25 at 2:14 PM, the Director of Nursing (DON) stated the State Ombudsman was not informed of Resident #48's discharge to the hospital on 4/21/25. The DON further stated the facility only reported resident incidents and residents who had discharge concerns to the State Ombudsman. Resident #90 Record review on 5/18-22/25 revealed Resident #90 was admitted to the facility with diagnoses that included a wedge compression fracture of the fourth lumbar vertebra (this occurs when one side of spine collapses and creates a wedge shape), type 2 diabetes mellitus, and nonalcoholic steatohepatitis (a severe form of nonalcoholic fatty liver disease). Review of Resident #90's MDS admission assessment, dated 3/19/25, revealed Resident #90 was admitted to the facility on [DATE] with a BIMS score of 15. Review of Resident #90's MDS discharge assessment, dated 3/26/25, revealed Resident #90 was discharged on 3/26/25. Review of Resident #90's medical record revealed no physician's order to discharge the resident on 3/26/25. Review of Resident #90's Progress Note, dated 3/26/25 at 5:40 PM, revealed: Resident was assessed by nurse supervisor. Provider notified on resident altered mental status trend and agreed on sending resident out to ER . Review of Resident #90's Progress Note, dated 3/28/25 at 2:52 PM, revealed: .Late Entry- Nurse supervisor notified on [of] resident and advising to send [him/her] out, even after given orders. Resident wellbeing seemed concerning and felt [he/she] needed acute care, nurse supervisor agreed to send [him/her] out. Provider was made aware and gave orders to transfer to ER. During an interview on 5/20/25 at 3:35 PM, the Medical Records Supervisor (MRS) stated that all records for Resident #90 should be in the current electronic medical record. When asked if she could locate the physician's discharge order, she could not. During an interview on 5/22/25 at 1:45 PM, the DON stated there should be a bed hold notice and physician discharge order for Resident #90's 3/26/25 transfer and then discharge. When asked if he could locate these items, he stated that he could not find them in the resident's record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Bed Hold, dated 3/1/25, revealed: . It is a policy of this facility to inform the resident or resident's representative in writing of the right to exercise the bed hold provision of three (3) days upon admission and provide a second notice before transfer to a general acute care hospital. In the event of an emergency transfer, the second notice will be provided within 24 hours. Bed hold - Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . Procedure: 1. The resident, or the resident's representative shall be informed in writing of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital . Review of a blank facility Bed Hold Notification form, dated 3/1/25, revealed: . Medicaid will not cover the cost of the bed hold. Medicaid beneficiaries are responsible for reasonable costs for each day of the bed hold . If you desire this option, the Facility must be notified within 24 hours of transfer. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, interview, and observation, the facility failed to develop and/or implement a comprehensive care plan for 6 Residents (#s 4; 19; 51; 60; 89; and 492), out of 21 sampled residents. Specifically, the facility failed to: 1) implement showers scheduled as care planned; 2) provide adequate supervision and/or assistance to a resident who utilized a ceiling lift; 3) reposition residents and maintain skin integrity as care planned; and 4) develop a care plan for a resident's diagnosis of chronic obstructive pulmonary disease (COPD). These failed practices placed the residents at risk of not receiving necessary care and services to address the individual's needs. Findings: Shower Schedule Resident #4 Record review on 5/18-22/25 revealed Resident #4 was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), rheumatoid arthritis (autoimmune disorder that affected the joints), and depression. During an interview on [DATE] at 12:45 PM, Resident #4 stated the facility was so short-staffed that he/she only received one shower a week, instead of the two scheduled showers that was care planned for him/her. During an interview on [DATE] at 10:36 AM, Resident #4's POA (Power of Attorney) stated he/she was concerned due to the resident's reports of inadequate showers. During an interview on [DATE] at 3:57 PM, Certified Nurse Assistant (CNA) #1 stated that due to being short-staffed, residents were unable to get the care that they deserve. He/she confirmed that Resident #4 was scheduled for showers on Wednesdays and Saturdays but added that if staff was unable to give showers on the scheduled days, .they would have to wait until the next shower day . Review of Resident #4's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., reviewed on [DATE], revealed: -During the month of [DATE], the resident received a shower twice on 3/19 and 3/26; -During the month of [DATE] , the resident received a shower twice on 4/9 and 4/30 and; -Between 5/1-21/25, he/she received a shower on 5/7, 5/14, and 5/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's Minimum Data Set (MDS - A federally required assessment) quarterly assessment, dated [DATE], revealed Resident #4 had an impairment of the upper limbs. Resident #4 was dependent on staff for his/her shower transfers. Review of Resident #4's Care Plan Report, initiated on [DATE], revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Fatigue . Goal: Will maintain current level of function in . Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: . BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Wednesday and Saturday . Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included multiple sclerosis (chronic autoimmune disease where the immune system attacks the protective covering of nerve cells), type 2 diabetes mellitus with diabetic polyneuropathy (non-insulin-dependent diabetes with nerve damage complications), neuromuscular dysfunction of the bladder (condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (mood disorder characterized by persistent feeling of sadness and loss of interest in activities). During an interview on [DATE] at 8:42 AM, Resident #19 stated he/she would only get showers once a month, and .maybe sometimes two if I guilt them into doing it . During an interview on [DATE] at 3:58 PM, CNA #1 confirmed Resident #19 was scheduled for showers on Tuesday and Friday. Record review of Resident #19's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., reviewed on [DATE], revealed: -During the month of [DATE], the resident received a shower five times on 3/7, 3/11, 3/18, 3/25, and 3/31; -During the month of [DATE], the resident received a shower four times on 4/11, 4/15, 4/22, and 4/28, and; -Between 5/1-21/25, the resident received a shower four times on 5/6, 5/13, 5/14 and 5/20. Review of Resident #19's MDS quarterly assessment, dated [DATE], revealed Resident #19 had an impairment on one side of the upper and lower limbs. Resident #19 was dependent for his/her shower transfers. Review of Resident #19's Care Plan Report, initiated on [DATE], revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Activity Intolerance . Goal: Will maintain current level of function in .Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: .BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Tuesday and Friday . During an interview on [DATE] at 2:55 PM, the Director of Nursing (DON) stated it was the expectation for staff to follow the resident's care plan, including showers. Supervision and/or Assistance for Ceiling Lift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #60 Record review on 5/18-22/25 revealed Resident #60 was admitted to the facility with diagnoses that included non-traumatic subarachnoid (the space in the brain where cerebrospinal fluid circulates) hemorrhage, hemiplegia (paralysis of one side of the body), and hemiparesis (one sided muscle weakness). Review of Resident #60's Care Plan Report, initiated on [DATE], revealed Resident #60 Requires assistance . for transferring from one position to another r/t [related to]: Cognitive deficit, Decreased strength Provide two persons for supervision/physical assist with mechanical aid or transfer belt. An observation on [DATE] at 11:05 AM, revealed Resident #60 was lying in bed. CNA #7 provided Resident #60's personal care. During the cares, CNA #7 inserted a ceiling lift sling behind the Resident. After the sling was placed, CNA #7 hooked the sling to the ceiling lift. Then, the CNA pressed the lift button to transfer the Resident from the bed to the wheelchair. While the ceiling lift moved from bed to wheelchair, the ceiling lift stopped working. The CNA stated the cord was pulled out, pointing at the red button (emergency button) with a cord hanging from the ceiling lift. During the same observation, CNA #7 continued to point at the red button while the Resident was suspended in the ceiling lift sling. Then, the CNA pushed the call light. While waiting for help, the CNA rushed towards the door leaving the Resident suspended in the air, alone and out of sight of the CNA. As CNA #7 opened the door, Licensed Nurse (LN) #12 went inside the room followed by Hospitality Aide (HA) #1. LN #12 reached and pushed the red button back while HA #1 and CNA #7 were guarding the Resident. Then, CNA #7 continued to lower the Resident into the wheelchair. During an interview on [DATE] at 10:00 AM, when asked what was meant if the resident's care plan stated two-person physical assist, mechanical lift or transfer, the Nurse Supervisor (NS) stated it should be two-person assist. During a follow-up interview on [DATE] at 8:55 AM, the Dirctor of Nursing DON stated the CNA should have used a radio transmitter to ask for help. The DON stated there should have been somebody else in the room and to not leave the Resident suspended in the air alone. DON stated CNAs will be educated. Review of the facility's policy Transfer of a Resident, Safe, dated 3/2025, revealed: .safe and efficient transfers are combination of resident's ability and perceptual capacity, proper equipment and proper techniques and good planning.transfers may involve.mechanical lift. Review of the Maxi Sky 2 (the ceiling lift used by the certified nurse aide to transfer a resident from bed to wheelchair), INSTRUCTIONS FOR USE, revised date 6/2024, revealed: .Actions Before Every Use Note: The need for a second attendant to support the patient must be assessed in each individual case. WARNING: Before an attempt is made to attempt to move a patient, a clinical assessment of the patient's suitability for transfer must be carried out by a qualified professional considering that, among other things, the transfer may include substantial pressure on the patient's body. Repositioning and Skin Integrity Resident #51 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses that included atrial fibrillation (an irregular heart rhythm), dementia (a decline in cognitive functioning affecting daily living), and hemiplegia. A continuous observation on [DATE], from 9:00 AM to 12:00 PM, revealed Resident #51 was positioned on his/her back with a slight left-sided tilt. During this time, Resident #51 remained in the same position without any repositioning interventions for a total of three hours. Review of Resident #51's Resident Daily Care Plan (RDCP), dated [DATE], revealed: Reposition me every 2 hours. Review of Resident #51's Care Plan Report, initiated on [DATE], revealed: . help me reposition at least every 1-2 hours while I'm in bed . Review of Resident #51's, Turns and Repositions log, for [DATE], revealed the resident was repositioned two times during that day, once at 2:01 PM and at 8:35 PM. During an interview on [DATE] at 2:31 PM, when asked about the repositioning log indicating only two repositioning interventions on [DATE] for Resident #51, LN #6 stated, From the charting that is correct. It's not realistic to expect the residents to be turned every two hours when you only have one nurse and one CNA working . It's an organization problem. An observation on [DATE] at 10:34 AM, revealed Resident #51's left hip had an oval shaped, 1.5 inch x 1 inch, bright-red wound with a shiny appearance. The resident's incontinence brief was observed rubbing directly against the wound. No dressing or protective intervention was in place for friction prevention. Review of Resident #51's Care Plan Report, initiated on [DATE], revealed: .MY GOAL IS TO: keep my skin healthy and intact . My nurses to reduce pressure and friction between myself and my bed . Review of Resident #51's Order Summary Report, dated [DATE], revealed: Left hip blister: cleanse with NS [normal saline], pat dry, cover with a dry dressing . Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Tailoring wound care to wound color . Cover a red wound, keep it moist and clean, and protect it from trauma . During an interview on [DATE] at 10:40 AM, when discussing interventions for wound healing, LN #6 stated, I leave it [the wound] open to air. When discussing the ordered intervention to cover the wound with a dry dressing, LN #6 stated, There should be a dry dressing in place. Resident #492 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/18-22/25 revealed Resident #492 was admitted to the facility with diagnoses that included depression, bipolar disorder (mental health condition characterized by alternating episodes of emotional highs and lows, significantly affecting mood, energy, and daily functioning), and atrial fibrillation. A continuous observation on [DATE], from 8:20 AM to 12:00 PM, revealed Resident #492 remained positioned supine (lying face up) in bed, without any staff entering the room to reposition the resident for a total of 3 hours and 40 minutes. Record review of Resident #492's Care Plan Report, initiated on [DATE], revealed: . Has the potential for pressure ulcer development r/t [related to] Generalized body weakness and impaired mobility . Out of bed unless contraindicated . Needs monitoring/reminding/assistance to turn/reposition. Review of the Resident #492's Turns and Repositions, log, dated [DATE], revealed the resident was turned or repositioned two times during that day, at 1:06 PM and 3:30 PM. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Pressure Injury Prevention .Turn and reposition the patient regularly and frequently . During an interview on [DATE] at 3:25 PM, when asked about the facility's policy for turning and repositioning of residents with impaired mobility, the Assistant Director of Nursing (ADON) stated, We expect the staff to turn [residents] every two hours and as needed. Developing a Care Plan for a Diagnosis Resident #89 Record review on 5/18-22/25 revealed Resident #89 was admitted to the facility with a diagnosis of COPD, unspecified (Chronic Obstructive Pulmonary Disease - a long-term lung condition that causes breathing difficulties due to airflow obstruction, without specific details provided about the type such as emphysema or chronic bronchitis, or severity). Record review on 5/18-22/25 revealed Resident #89 died on [DATE]. Review of the Resident #89's provider's orders revealed: -Drug: [Trelegy Ellipta] Fluticasone-Umeclidin-Vilant [a once daily inhalant medication used for the maintenance treatment of COPD] 100MCG [micrograms]/ACT [actuation, or per puff]-62.5MCG/ACT 25MCG/ACT Aerosol Powder Breath Activated Dose: (1 puff) Route: inhalation Frequency: daily Time: AM First Date: [DATE] Administration Instructions: Give 1 puff using inhaler once a day For: asthma/ Chronic Obstructive Pulmonary Disease . - Drug: Albuterol Sulfate (2.5 MG [milligrams]/3ML [milliliter]) 0.083% Nebulization Solution [nebulizer treatment: given through breathing in a mist of moisturized air and medication] Dose: (3 ml) Route: inhalation PRN Frequency: every 4 hours as needed First Date: [DATE] For: Chronic Obstructive Pulmonary Disease . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #89's last Care Plan Report, dated [DATE], did not include COPD. During an interview on [DATE] at 1:30 PM, when asked if a care plan for COPD should have been implemented for a resident with a COPD diagnosis, the DON stated, yes, they should. Review of the facility's policy Comprehensive Resident Centered Care Plan, dated 3/2025, revealed: . Resident's Goal-refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning . Person-centered care- means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Review of the facility's policy Safe Transfer of a Resident, dated 3/2025, revealed: .Mechanical lift transfers are usually used for resident who are very large or extremely dependent .Safe and secure mechanical lift transfers may require the help of one, two, or three caregivers depending on the resident's condition . Review of the facility's policy, Patient Rights, undated, revealed: . Receive adequate and appropriate care. To be free from mental . abuse . Reasonable accommodation of one's needs and preferences . Right to Dignity, Respect, and Freedom. To be treated with consideration, respect, and dignity . .

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	025036	A. Building B. Wing	05/22/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. . Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) were provided to maintain good personal hygiene for 3 dependent residents (#'s 4, 19, and 40), out of 21 sampled residents. Specifically, the facility failed to assist residents with oral hygiene and bathing as specified in the plan of care. This failed practice had the potential to place residents at risk of poor outcomes from lack of hygiene, infection, and a decreased sense of self-worth. Findings: Resident #4 Record review on 5/18-22/25 revealed Resident #4 was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), rheumatoid arthritis (autoimmune disorder that affected the joints), and depression. Review of Resident #4's Minimum Data Set (MDS - A federally required assessment) quarterly assessment, dated 1/7/25, revealed Resident #4 had an impairment of the upper limbs. Resident #4 was dependent on staff for his/her shower transfers. Review of Resident #4's Care Plan Report, dated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Fatigue . Goal: Will maintain current level of function in .Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: . BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Wednesday and Saturday . During an interview on 5/18/25 at 12:45 PM, Resident #4 stated the facility was so short-staffed that he/she only received 1 shower a week, instead of the 2 scheduled showers that was care planned for him/her. During an interview on 5/19/25 at 3:57 PM, Certified Nursing Assistant (CNA) #1 stated that due to being short-staffed, residents were unable to get the care that they deserve. He/she confirmed that Resident #4 was scheduled for showers on Wednesdays and Saturdays but added that if staff was unable to give showers on the scheduled days, .they would have to wait until the next shower day . During an interview on 5/21/25 at 10:36 AM, Resident #4's POA (Power of Attorney) stated he/she was concerned due to the resident's reports of inadequate showers. Review of Resident #4's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: -During the month of March 2025, the resident received a shower twice on 3/19 and 3/26; -During the month of April 2025, the resident received a shower twice on 4/9 and 4/30 and; -Between 5/1-21/25, he/she received a shower on 5/7, 5/14, and 5/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included multiple sclerosis (chronic autoimmune disease where the immune system attacks the protective covering of nerve cells), type 2 diabetes mellitus with diabetic polyneuropathy (Type 2 DM: non-insulin-dependent diabetes with nerve damage complications), neuromuscular dysfunction of the bladder (condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (mood disorder characterized by persistent feeling of sadness and loss of interest in activities). Review of Resident #19's MDS Quarterly Review, dated 1/3125, revealed Resident #19 had an impairment on one side of the upper and lower limbs. Resident #19 was dependent for his/her shower transfers. Review of Resident #19's Care Plan Report, dated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Activity Intolerance . Goal: Will maintain current level of function in . Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: .BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Tuesday and Friday . During an interview on 5/18/25 at 8:42 AM, Resident #19 stated he/she would only get showers once a month, and . maybe sometimes two if I guilt them into doing it . During an interview on 5/19/25 at 3:58 PM, CNA #1 confirmed Resident #19 is scheduled for showers on Tuesday and Friday. Record review of Resident #19's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: -During the month of March 2025, the resident received a shower five times on 3/7, 3/11, 3/18, 3/25, and 3/31; -During the month of April 2025, the resident received a shower four times on 4/11, 4/15, 4/22, and 4/28, and; -Between 5/1-21/25, the resident received a shower four times on 5/6, 5/13, 5/14 and 5/20. Resident #40 Record review on 5/18-22/25 revealed Resident #40 was admitted to the facility with diagnoses that included coronary artery disease, morbid obesity (disease characterized by Body Mass Index [BMI] of 40 or higher), heart failure, hypertension, end stage renal disease (a condition in which the kidney function is less than 10% of normal; kidneys can no longer remove wastes, concentrate urine, and regulate electrolytes) and diabetes mellitus. Review of Resident #40's MDS quarterly assessment, dated 3/11/25, revealed Resident #40 had an impairment of the lower limbs and required wheelchair transportation, always incontinent of bladder and bowel, and at risk for pressure ulcers. Resident #40 required assistance for his/her shower transfers. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's Care Plan Report, dated 4/15/25, revealed . BED MOBILITY (ROLL LEFT AND RIGHT, SIT TO LYING, LYING TO SITTING ON SIDE OF BED): Requires 1-2 people providing more than half the effort. PERSONAL HYGIENE/ORAL CARE (ORAL HYGIENE): SET UP ASSIST . I need my aides to help me brush . During an interview on 5/18/25 at 8:35 AM, CNA #2 stated he/she was the only CNA in the Deshka cottage. CNA #2 further stated from 3:30 PM to 7:00 PM on 5/18/25, he/she had to cover the Kenai cottage while covering the Deshka cottage because there was not enough staff. CNA #2 stated he/she was concerned about how all residents would be cared for timely. CNA #2 stated there were two residents in the Deshka cottage that required feeding assistance and would be required to wait longer for assistance. During an interview on 5/18/25 at 1:06 PM, Resident #40 stated he/she was unable to brush his/her teeth when requested. Resident #40 stated staff was not available to gather his/her supplies. Resident #40 further stated that he/she could not get to the toilet independently so he/she would often have episodes of incontinence. Resident #40 stated that he/she had to wait 1 hour and 45 minutes for staff to come and provide peri care after he/she pressed the call light. Resident #40 further stated he/she had not received a shower for 1 ½ months due to not enough staff. Resident #40 stated it required two CNAs to transfer him/her out of bed. During an interview on 5/19/25 at 8:20 AM, CNA #2 stated Resident #40 was showered about 2 months ago. CNA #2 further stated Resident #40 was transferred to the shower by the ceiling lift and required two staff members to complete a safe transfer. CNA #2 stated he/she did not always have a second staff member to assist. During an interview on 5/20/25 at 1:40 PM, the MDS Coordinator (MC) reviewed Resident #40's care plan. The MC stated Resident #40 required one or two staff to complete the transfer with the use of the ceiling lift based on their comfort level and ability. The MC further stated Resident #40's current weight on 5/13/25 was 278 pounds. Review of Resident #40's Documentation Survey Report. Task Only, dated March 2025, revealed from 3/1/25 - 3/31/25; - No showers were documented as successfully completed; - Oral Hygiene- was only documented on three days: 3/3/25, 3/17/25 and 3/19/25, and; - Personal Hygiene- was only documented on the following days: 3/3/25, 3/11/25, 3/16-19/25. Review of Resident #40's Documentation Survey Report . Task Only, dated April 2025, revealed from 4/1-30/25 tub/shower transfer occurred on two occasions. Review of Resident #40's Task: Bathing, dated 5/1-20/25, revealed . 5/17/25 Shower. No other showers were documented as successfully completed. During an interview on 5/20/25 at 3:10 PM, CNA #2 stated he/she provided Resident #40 a shower with the assistance of a hospitality aide. CNA #2 stated the hospitality aide was able to assist with the transfer of Resident #40 out of bed to the shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/25 at 2:15 PM, Resident #40 was smiled and stated he/she received a shower two days ago. Resident #40 stated when he/she did not receive a shower over the past 2 months, he/she felt uncomfortable. Resident #40 further stated he/she felt down because there was not enough help and I just cry and go to sleep. During an interview on 5/22/25 at 3:30 PM, Physical Therapist (PT) #1 stated when operating a ceiling lift, one to two staff members were required. When PT #1 was asked how many staff members were required to transfer Resident #40 out of bed, PT #1 stated one to two staff members. PT #1 stated if Resident #40 requested two staff members or the staff member operating the lift did not feel comfortable operating the lift alone, then the transfer required an assist of two staff members. Review of the facility's policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE dated 12/2024, revealed . AM CARE (EVERY MORNING): Hands and face washed, Toilet & Peri Care. Oral Care. H.S. [bedtime] CARE (EVERY HS AT BEDTIME): Hands and face washed, Toilet & Peri Care. Oral Care. BEFORE MEAL CARE: Toileting and Peri care. PERIODIC CARE: Shower/Bath as scheduled. Provide a complete bed bath if scheduled shower cannot be given. ONGOING CARE: . Call lights: work as team to meet the goal of answering regular within 5-10 minutes. Provide peri care after voids . Promote resident choice and personal preference . Review of the facility's policy Adequate Staffing, dated 3/2025, revealed: . 2. The facility maintains adequate staff on each shift to assure that the resident's needs are met . Review of the facility's policy Services to carry out ADL [Activity of Daily Living], dated 3/2025, revealed: . 2. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain: Good nutrition, Grooming, Personal hygiene, Oral hygiene, Bathing, Showering, Toileting . Review of the facility's policy Comprehensive Resident Centered Care Plan, dated 3/2025, revealed: . Resident's Goal-refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning . Person-centered care- means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Review of the facility's policy Safe Transfer of a Resident, dated 3/2025, revealed: .Mechanical lift transfers are usually used for resident who are very large or extremely dependent .Safe and secure mechanical lift transfers may require the help of one, two, or three caregivers depending on the resident's condition . Review of the facility's policy Patient Rights, undated, revealed: .Receive adequate and appropriate care .To be free from mental .abuse .Reasonable accommodation of one's needs and preferences . .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to develop, implement, and ensure appropriate oversight supervisor of the activity program to support residents in their choice of activities. Specifically, the facility failed to: 1) Ensure activities admission evaluations were completed per established activities program policy for 4 sampled residents (#'s 13; 22; 70; and 292), and 3 unsampled residents (#'s 192, 193, and 293), out of 11 residents reviewed who were admitted since 3/1/25; 2) Ensure the activity director developed, implemented and supervised the activity program which included scheduling of activities, both individual and groups, monitoring the response or reviewing/evaluating the response to the programs to determine if the activities meet the assessed needs of the resident; and 3) Develop and implement methods of ongoing evaluation of activities offered under the activities program. Specifically, the facility did not have a method to document specific resident activity participation in residents' medical records to evaluate effectiveness of the program. These failed practices placed all residents (based on a census of 91) at risk for: 1) not having activity preferences be known, which could affect their overall involvement in activities; and 2) not having their activities participation documented to show engagement, or lack of participation. Findings: Activity admission Evaluations During an interview on 5/22/25 at 9:04 AM, when asked how newly admitted residents were assessed for activity preferences, the Activities Supervisor stated there was a paper assessment completed in the residents' room and then that information would be put into the Resident's Minimum Data Set (MDS - a federally required assessment). When asked if the activity preferences were documented anywhere else in the medical record, the Activity Supervisor was not sure. When asked who completed the activity admission assessments, the Activity Supervisor stated she would do some, but the Activity Staff completed most of them for the facility's new admissions. During an interview on 5/22/25 at 9:14 AM, the Assistant Administrator stated new admission activity assessments were a document on a form called Activity - admission Evaluation which was to be completed for each resident admitted to the facility. The normal process would be to print off the evaluation and go to the resident's room and work with the resident to fill out the form. The Activity - admission Evaluation form in the medical record would then be completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked to review resident records to show where this information was documented, the Assistant Administrator stated after his review it appeared that activity information was mostly documented was in the MDS and not on the Activity - admission Evaluation form in the medical record. The Assistant Administrator further stated that these Evaluation forms needed to be completed so the Certified Nurse Assistants (CNAs) and Licensed Nurses (LNs) could view them and implement activity choices. During an interview on 5/22/25 at 9:34 AM, Activities Staff #2 stated he/she mostly charted the activities admission evaluations for newly admitted residents in MDS assessments. Review of resident medical records for 11 residents admitted to the facility, from 3/1/25 to 5/22/25, revealed: Sampled Residents - Resident #13 was admitted on [DATE] and had no Activity - admission Evaluation form completed. - Resident #22 had an Activity - admission Evaluation form, dated 3/24/25, in his/her medical record, however this evaluation was completely blank. - Resident #70 was admitted on [DATE] and had no Activity - admission Evaluation form completed. - Resident #292 was admitted on [DATE] and had no Activity - admission Evaluation form completed. Unsampled Residents - Resident #192 was admitted on [DATE] and had no Activity - admission Evaluation form completed. - Resident #193 was admitted on [DATE] and had no Activity - admission Evaluation form completed. - Resident #293 was admitted on [DATE] and had no Activity - admission Evaluation form completed. Activities Supervisor Responsibilities During an interview on 5/22/25 at 9:04 AM, the Activities Supervisor stated her role as the Activities Supervisor was to oversee the activity programs for two different Long Term Care (LTC) facilities that were housed on the same property. There were two Activity Staff who assisted her in the implementation of the activities program for this facility and one for the other. When asked who created the monthly activity calendar for the facility, the Activities Supervisor stated the Activities Staff created and implemented the calendar. When asked to describe how she oversaw the activity program for the facility, the Activities Supervisor stated she really didn't oversee the activity program for this facility, as she was usually implementing the activity program for the other LTC on the property. The Activities Supervisor stated the activity calendar had not changed since the new owner took over the facility on 3/1/25. Review of the facility-provided job description for Activities Supervisor, dated 12/27/21, revealed the Essential Duties and Responsibilities included: . Plan, develop, organize, implement, and direct the activities programs of this facility. Develops and implements activities calendars. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility-provided job description for Activities Staff, dated 12/27/21, revealed the Essential Duties and Responsibilities included: . Assist in planning, developing, organizing, implementing, supervising, and evaluating the activities program of this facility. Further review revealed creating the activities program calendar was not within their scope of duties. Activity Participation Documentation During an interview on 5/22/24 at 9:34 AM, Activities Staff #2 stated he/she mostly documented resident participation with activities offered in the medical record's Point of Care (POC) charting section. Review of the POC charting section of resident medical records revealed there was no way to document on each specific activity offered on a given day or to show which of these activities a resident participated in. It only provided a once-a-day notation for a creative activity; entertainment activity; independent activity; mental activity; one on one activity; religious activity; social activity; or trip activity. During an interview on 5/22/25 at 4:47 PM, the Assistant Director and Medical Records Supervisor stated after reviewing the electronic medical record there was no place for activity staff to document resident participation of each specific activity offered at this time. Review of the facility policy Activities Programming, dated 3/2025, revealed: . It is the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident . An Activity - admission Evaluation will be conducted at the time of admission to determine resident preferences and interests . Attempts will be made to accommodate resident preferences, when safe to do so, for planning activities programs and calendars. Program considerations may include group offerings, independent offerings, or religious/spiritual offerings . Some activities can be adapted to accommodate the resident's change in functioning dur to physical or cognitive limitations . Calendars will include a variety of activities designed to meet resident preferences and requests as much as possible . .

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	025036	A. Building B. Wing	05/22/2025

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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, observation, and interview, the facility failed to ensure residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 4 sampled Residents (#12, #28, #51, and #492), out 21 sampled residents, and 2 unsampled Residents (#74 and #77). Specifically, the facility failed to: 1) Implement and follow individualized turning and repositioning schedules for 3 resident (#'s 12, 51, and #492) with impaired mobility and pressure injury risk; 2) Accurately assess and document the presence of open wounds for 2 residents (#28 and #51); 3) Administer enteral nutrition and medications in accordance with physician orders and clinical standards for 2 resident (#51 and #77); and 4) Provide timely incontinence care for 1 resident (#74). These failures resulted in prolonged periods of immobility, inaccurate wound assessments, compromised nutrition safety, and delays in hygiene care-placing residents at risk for pressure injuries, aspiration, infection, discomfort, and psychosocial harm. Findings: Resident #12 Record review on 5/18-22/25 revealed Resident #12 was admitted to the facility with diagnoses including Epilepsy (recurrent seizure disorder), Hypertension (high blood pressure), Osteoarthritis (joint inflammation, arthritis), Dementia (progressive cognitive decline), and Pneumonitis due to inhalation of food and vomit (lung inflammation, aspiration). Resident has expressive aphasia (language disorder) and due to being hard of hearing Resident #12 is non-interviewable. Turn and Reposition Concern Review of Resident #12's most recent Minimum Data Set (MDS - a federally required assessment) quarterly assessment, dated 1/20/25, revealed resident #12 was bedridden and had limited range of motion . Review of Resident #12's bedside schedule, dated 1/18/23, outlined a turning schedule with repositioning as follows: 12:00 AM on left, 2:00 AM on back, 4:00 AM on right, 6:00 AM on left, 8:00 AM on back, 10:00 AM on right, 12:00 PM on left, 2:00 PM on back, 4:00 PM on right, 6:00 PM on left, 8:00 PM on back, and 10:00 PM on right. The schedule involved repositioning every 2 hours, alternating between left, back, and right positions, and could be found posted inside the closet doors of the resident's wardrobe. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's Baseline Care Plan, dated 2/12/25, revealed: . the resident is at high risk for pressure injury and falls, with specific precautions including frequent monitoring, notifying nurses of side-effects, and using pillows to reposition every two hours. The resident requires the assistance of 1-2 people to achieve 100% of the effort for repositioning every two hours to prevent pressure injuries, utilizing a turning schedule and keeping the head of the bed elevated less than 30 degrees for short periods. Additionally, the resident has a major neurocognitive disorder, requires assistance with communication and eating . and needs a wheelchair with a blue-trimmed sling for transfers, with hospice care in place for end-of-life support . A continuous observation on 5/20/25 from 9:50 AM to 4:00 PM, revealed that Resident #12 was on his/her back, slumped to the left in bed with the head elevated, remaining in this position throughout the surveyor's observation, despite different staff entering to provide care and change linens. Random observations 5/21/25, from 8:40 AM to 5:00 PM, showed that the resident remained on his/her back throughout the entire period timeframe. Random observations on 5/22/25, the resident continued to stay on his/her back during day shift, with no repositioning noted. During an interview on 5/18/25 at 1:33 PM, Resident's #12's Representative stated, [Resident #12] cannot reposition by themselves . I will come in there to visit every other day, and [his/her] toes will be squished all the way at the bottom of the bed with [Resident #12] in the same exact position. Staff only gets [Resident #12] out of bed and onto the chair when I ask, but I don't ask much these days because the facility is chronically understaffed .It's frustrating. During an interview on 5/20/25 at 1:30 PM, Certified Nurse Assistant (CNA) #8 stated he/she repositioned Resident #12 every two hours, followed the closet-posted schedule, placed him/her on his/her preferred left side with pillows on each side and under the legs. CNA #8 further stated, CNAs typically perform arm stretches to aid his/her eating difficulties post-seizure, but none were done today due to a busy holiday. Also added due to a new charting system issue, repositioning is no longer documented. During an interview on 5/21/25 at 10:30 AM, the MDS Nurse revealed how the MDS assessment reflected a resident's immobilization and seizures, explaining that positioning was documented in section GG and seizures in section I for diagnoses. When Resident #12 was discussed, the MDS Nurse reviewed his/her latest MDS assessment and revealed Resident #12's bed mobility limitations and seizure documentation. The MDS stated that his/her transfer status was incorrectly marked as not applicable when it should have indicated total dependence due to his/her reliance on dependent assistance for transfers. Review of Resident #12's MDS progress notes, dated 4/21/25, revealed after a conducted quarterly assessment interview, that Resident #12 could transfer into wheelchair but spends most of his/her time in bed. Resident #28 (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non- Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), heart failure (inability of the heart to maintain adequate blood circulation). Accuracy of Wound Charting Review of Resident #28's most recent MDS annual assessment, dated 2/20/25, revealed Resident #28 also had a diagnosis that included, .Malnutrition . or at risk for malnutrition . The MDS also indicated Resident #28 was at risk for developing pressure ulcers. An observation on 5/18/25 at 12:01 PM, revealed Resident #28 had what appeared to be an approximately 2-3 millimeters in size, open round skin wound, on the right third toe. Review of Resident #28's nursing assessment titled, LN [Licensed Nurse]- Nursing Summary- Weekly, dated 5/20/25, revealed the weekly skin assessments was noted Free of any open areas. Record review on 5/21/25 at 7:43 AM, of Resident #28's Order Summary Report revealed no active wound care orders. Review of Resident #28's latest Care Plan Report, dated 12/10/24, revealed: . I: have the potential to have a skin injury . MY GOAL IS TO: keep my skin healthy and intact . Interventions . check my skin with cares . Avoid tight shoes/footwear . During an interview on 5/21/25 at 12:37 PM, LN #10 stated, Typically nurses do a weekly skin assessment, CNAs are checking with cares. If CNAs see [a wound], they notify the nurses, then they notify team . [including] . the DON [Director of nursing], [nursing] supervisor, wound team, and MD [doctor]. When asked if he/she had noticed skin issues on Resident #28 the LN replied, . no open areas. During an interview on 5/21/25 at 5:08 PM, Wound Care Licensed Nurse (WCLN) #12 and WCLN #13, both stated they were not aware of any wounds on Resident #28's toe. WCLN #13 stated he/she had just helped [Resident #28] put their socks on Monday [5/19/25] and didn't see anything. An observation on 5/22/25 at 8:37 AM, revealed WCLN #12 and WCLN #14 performed an assessment of Resident #28's feet. WCLN # 12 stated there were wounds visible to Resident #28's left great toe, left second toe first and second joint, and to the side of the right third toe. WCLN further stated, We always have issues with [his/her] shoes. Record review of the wound care notes titled, LN-Skin Evaluation- PRN/ Weekly, dated 5/22/2025 at 8:30 AM, WCLN #12 described wounds to R 3rd toe, medial . abrasion . L great toe . pressure . L 2nd toe . pressure . The left great toe with dry brown discoloration over the PIP joint [proximal interphalangeal or first joint of the toes] with dr[dark]/flaky epithelium [thin protective tissue that covers exposed surfaces] over top with surrounding blanchable erythema [when the redness (erythema) or discoloration disappears with pressure, but then returns] ; left second toe with brown, stable eschar [hardened dry black, or brown dead tissue covering a wound] over the PIP joint with surrounding blanchable erythema. There is a small healing abrasion of the right third medial toe covered with dried hemecrust [dried blood scab]. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 2:42 PM, the DON stated skin assessments should have been done at admission, as part of the weekly nursing summary, and as needed. If a CNA found a wound, they should have reported it to the nurse. Weekly skin assessments should be performed head to toe and documented anything found in weekly summary. Resident #51 Record review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses including atrial fibrillation (an irregular heart rhythm), dementia, and hemiplegia (paralysis on one side of the body). Gastric Residual Volume An observation on 5/20/25 at 10:34 AM, revealed LN #6 attached enteral tubing to Resident #51's feeding tube and began to administer a scheduled nutritional meal. During an interview on 5/20/25 at 10:35 AM, LN #6 was asked if gastric residuals had been checked prior to initiating the enteral nutrition. LN #6 replied, No, I should have done that. Review of Resident #51's physician orders, dated 3/2/25, revealed: .Check residuals and hold feeding if residuals above 300 cc. Review of the facility policy Gastrostomy Tube Care and Management, dated 3/2025, revealed: .Aspiration of stomach contents: The physician may recommend that you draw back on the syringe to check for residual feeding contents in the stomach . Follow physician orders . Head of Bed Elevation An observation on 5/21/25 at 10:21 AM, revealed LN #6 and Certified Nurse Assistant (CNA) #3 entered Resident #51's room to clean and reposition the resident. LN #6 positioned the resident's bed in a flat-lying position while an enteral nutrition meal was actively infusing. When asked if the resident's bed should be flat during an enteral meal, LN #6 stated, I needed him/her flat so that we could turn [him/her]. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Position the patient with the head of the bed elevated to at least 30 degrees, or upright in a chair, to prevent aspiration . Medication Administration An observation on 5/21/25 at 12:44 PM, revealed LN #6 administered medication through Resident #51's feeding tube without performing a pre-flush with 50 cc of water and used only 30 cc of water for the post-flush. Review of a physician order, dated 3/2/25, revealed: Flush tube with 50 cc of water pre and post medication administration via tube. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Gastrostomy Tube Care and Management, dated 3/2025, revealed: .Flush the feeding tube and adapter, if applicable per physician's order before and after giving any medication by tube . Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings .Flush the enteral tube . as ordered . Turn and Reposition Concern A continuous observation on 5/19/25, from 9:00 AM to 12:00 PM, revealed Resident #51 was positioned on his/her back with a slight left-sided tilt. During this time, Resident #51 remained in the same position without any repositioning interventions for a total of three hours. Record review of Resident #51's Resident Daily Care Plan (RDCP), dated 2/21/25, revealed: . Reposition me every 2 hours . Record review of Resident #51's care plan, initiated on 1/24/25, included interventions to prevent pressure injuries: . help me reposition at least every 1-2 hours while I'm in bed . Record review of Resident #51's, Turns and Repositions log, for 5/19/25, revealed the resident was repositioned two times, at 2:01 PM and at 8:35 PM. During an interview on 5/20/25 at 2:31 PM, when asked about the repositioning log indicating only two repositioning interventions on 5/19/25 for Resident #51, LN #6 stated: From the charting that is correct. It's not realistic to expect the residents to be turned every two hours when you only have one nurse and one CNA working . It's an organization problem. Wound Concern An observation on 5/20/25 at 10:34 AM, revealed Resident #51's left hip had an oval-shaped, 1.5 inch x 1 inch, bright-red wound with a shiny appearance. The resident's incontinence brief was observed rubbing directly against the wound. No dressing or protective intervention was in place. Record review of Resident #51's Order Summary Report, dated 5/20/25, revealed: Left hip blister: cleanse with NS [normal saline], pat dry, cover with a dry dressing . During an interview on 5/20/25 at 10:40 AM, when discussing interventions for wound healing, LN #6 stated, I leave it [the wound] open to air. When discussing the ordered intervention to cover the wound with a dry dressing, LN #6 stated, There should be a dry dressing in place. Review of the facility provided Lippincott Nursing Procedures Ninth Edition book, revealed: . Tailoring wound care to wound color . Cover a red wound, keep it moist and clean, and protect it from trauma . Resident #74 (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/18-22/25 revealed resident #74 was admitted to the facility with diagnosis including Cerebrovascular Accident (CVA - also known as a stroke, is when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel) and Hemiplegia or Hemiparesis. Review of Resident #74's MDS annual assessment, dated 2/21/25, revealed the Resident was coded as being severely depressed that consisted of little interest or pleasure doing things; feeling down, depressed, and hopeless; feeling bad about oneself; feelings he/she would be better off dead or hurting oneself in some way. Further review of the assessment revealed the Resident had functional limitations to upper and lower extremities and utilized a wheelchair. Furthermore, the Resident was coded as being fully dependent on staff for toileting, bathing, and transferring to and from bed to wheelchair. The Resident was identified as always being incontinent of bowel and bladder. Timeliness of Incontinence Care A continuous observation on 5/20/25 at 9:26 AM to 1:01 PM, revealed Resident #74 had an episode of incontinence and stated he/she needed to be changed. Further observation revealed: - At 9:26 AM: the resident pushed the call light; - At 9:50 AM: [NAME] #1 came into the resident's room. Resident #74 informed [NAME] #1 he/she needed to be changed. [NAME] #1 informed Resident #74 they would let the Nurse or CNA know; - At 9:53 AM: [NAME] #1 verbally informed LN #10 of the Resident #74's request. LN #10 informed [NAME] #1 that CNA #4 would help the resident; - At 1:01 PM, CNA #4 went into Resident #74's room and performed incontinence care and a brief change. Resident #74 waited a total of 3 hours and 35 minutes for cares. During an interview, on 5/20/25 at 11:06 AM, while waiting for staff to come in for cares, Resident #74 stated staff would tell the resident he/she pushed the call light too much and that made the resident feel like he/she, did not belong. Resident #74 stated he/she felt care was better with more staff and it often takes this long [3 hours and 35 minutes] or longer to get cleaned up. Resident #74 further stated he/she was used to 2 hours rounding at other facilities. They are giving people [staff] 2-3 cottages, which is way too much. He/she felt staff was getting worn down. The resident added, Night shift has left me worse- in my piss and my feces. During an interview on 5/22/25 at 2:33 PM, the Director of Nursing (DON) stated he was not sure of exact timeframe incontinence care was supposed to be carried out once staff was notified, but added, As soon as caregiver is aware. The DON further stated if a CNA was not available, a nurse could perform cares, . as long as they are not in the middle of med pass but even then, they are expected to coordinate this. When asked if one hour and forty-five minutes was an acceptable timeframe to wait, he replied, no. When asked if four hours was an acceptable timeframe to wait, the DON also replied, no. Review of the facility's policy ADL, Services to carry out, reviewed on 3/25, revealed: . Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain . Personal Hygiene include . Toileting . among others . (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 Record review on 5/18-22/25 revealed Resident #77 was admitted to the facility with diagnoses of cerebral palsy (a group of disorders affecting movement and muscle tone), epilepsy (a neurological disorder marked by seizures), and developmental disorder of motor function (delays or impairments in coordinated movement). Enteral Tubing Contamination An observation on 5/21/25 at 10:50 AM, revealed LN #6 entered Resident #77's room to administer scheduled enteral nutrition meal. There was enteral tubing already attached to the feeding pump, which was undated and hung uncapped from an IV pole at the Resident's bedside. This tubing contained enteral nutrition solution throughout the tubing. LN #6 proceeded to attach the uncapped tubing to the resident's feeding tube, however the surveyor intervened before attachment and asked, Should the tube feeding be administered through that tubing since it was uncapped? LN #6 responded, It should have been capped, but since it wasn't I will use alcohol wipes to sanitize it, then begin the feed. He/she then attached tube feeding to the resident's feeding tube and began infusion of the enteral nutrition. During an interview on 5/21/25 at 1:50 PM, the facility's Infection Preventionist (IP) was asked whether the tubing would be safe to use if left uncapped. The IP stated, It would not be safe if it has been uncapped and not knowing what it has been exposed to, which would require a change of new tubing-dated, capped-then the standard is that it would be good for 24 hours. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Don't use formula if its integrity is compromised or if it's expired. Instead, obtain a new container of the formula . Resident #492 Turn and Reposition Concern Record review on 5/18-22/25 revealed Resident #492 was admitted to the facility with diagnoses that included depression (mood disorder), bipolar disorder (mental health condition characterized by alternating episodes of emotional highs and lows, significantly affecting mood, energy, and daily functioning), and atrial fibrillation. Review of Resident #492's MDS admission assessment, dated 5/8/25, revealed the Resident had upper and lower extremity impairments and was fully dependent on staff for transfers to and from the, as well as requiring substantial/maximal assistance with mobility rolling right and left. Further review revealed the Resident was at risk of pressure ulcers. Record review of Resident #492's care plan, initiated on 5/2/25, revealed: . Has the potential for pressure ulcer development r/t [related to] Generalized body weakness and impaired mobility . Out of bed unless contraindicated . Needs monitoring/reminding/assistance to turn/reposition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continuous observation on 5/18/25 from 8:20 AM to 12:00 PM, revealed Resident #492 remained positioned supine (lying face up) in bed, without any staff entering the room to reposition the resident for a total of 3 hours and 40 minutes. During an interview on 5/18/25 at 9:12 AM, Resident #492's family member stated: .At times it feels like some staff members don't care about [Resident #492] at all. When [Resident #492] needs to go to the bathroom, the staff don't come until 15 minutes or later, or whenever their next rounding comes. The family member further stated that Resident #492 was rarely up in the wheelchair and was not often seen being repositioned. Record review of the facility's Turns and Repositions log for Resident #492, dated 5/18/25, revealed the resident was only turned or repositioned at 1:06 PM and 3:30 PM. During an interview on 5/22/25 at 3:25 PM, when asked about the facility's policy for turning and repositioning residents with impaired mobility, the Assistant Director of Nursing (ADON) stated, We expect the staff to turn every two hours and as needed. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, published 2023, revealed: . Pressure Injury Prevention .Turn and reposition the patient regularly and frequently . .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. . Based on record review, observation, and interview, the facility failed to ensure residents received the necessary care and services to monitor for and prevent the development of pressure ulcers for 3 sampled residents (#28, #51, and #492), out of 21 sampled residents. Specifically, the facility failed to: 1) Accurately assess and monitor for wounds for Resident #28; and 2) Consistently turn and reposition 2 residents (#51 and #492). These failed practices had the potential to place the residents at risk for unnecessary pain, increased risk of infection, skin breakdown, and impair the residents' overall health and wellbeing. Findings: Accurately Assess and Monitor Skin Resident #28 Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non-Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), heart failure (inability of the heart to maintain adequate blood circulation). Review of Resident #28's Minimum Data Set (MDS - a federally required assessment), annual assessment, dated 2/20/25, revealed Resident #28 also had a diagnosis that included, .Malnutrition . or at risk for malnutrition . The MDS also indicated Resident #28 was at risk for developing pressure ulcers. An observation on 5/18/25 at 12:01 PM, revealed Resident #28 had what appeared to be an approximately 2-3 millimeters in size, open round skin wound, on the right third toe. Review of Resident #28's nursing assessment titled, LN [Licensed Nurse]- Nursing Summary- Weekly, dated 5/20/25, revealed the weekly skin assessments was noted: Free of any open areas. Record review on 5/21/25 7:43 AM, of Resident #28's Order Summary Report revealed no active wound care orders. Review of Resident #28's latest Care Plan Report, dated 12/10/24, revealed: . I: have the potential to have a skin injury . MY GOAL IS TO: keep my skin healthy and intact . Interventions . check my skin with cares . Avoid tight shoes/footwear . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 12:37 PM, Licensed Nurse (LN) #10 stated, Typically nurses do a weekly skin assessment, CNAs [certified nurse assistants] are checking with cares. If CNAs see [a wound], they notify the nurses, then they notify team . [including] . the DON, [nursing] supervisor, wound team, and MD. When asked if he/she had noticed skin issues on Resident #28 the LN replied, . no open areas. During an interview on 5/21/25 at 5:08 PM, Wound Care Licensed Nurse (WCLN) #12 and WCLN #13, both stated they were not aware of any wounds on Resident #28's toe. WCLN #13 stated he/she had just helped [Resident #28] put their socks on Monday [5/19/25] and didn't see anything. An observation on 5/22/25 at 8:37 AM, revealed WCLN #12 and WCLN #14 performed an assessment of Resident #28's feet. WCLN # 12 stated there were wounds visible to Resident #28's left great toe, left second toe first and second joint, and to the side of the right third toe. WCLN further stated, We always have issues with [his/her] shoes. Record review of the wound care notes titled, LN-Skin Evaluation- PRN/ Weekly, dated 5/22/2025 at 8:30 AM, WCLN #12 described wounds to R 3rd toe, medial . abrasion . L great toe . pressure . L 2nd toe . pressure . The left great toe with dry brown discoloration over the PIP joint [proximal interphalangeal joint, or first joint of the toes] with dr[dark]/flaky epithelium [thin protective tissue that covers exposed surfaces] over top with surrounding blanchable erythema [when the redness (erythema) or discoloration disappears with pressure, but then returns] ; left second toe with brown, stable eschar [hardened dry black, or brown dead tissue covering a wound] over the PIP joint with surrounding blanchable erythema. There is a small healing abrasion of the right third medial toe covered with dried hemecrust [dried blood scab]. During an interview on 5/22/25 at 2:42 PM, the Director of Nursing (DON) stated skin assessments should be done at admission, as part of the weekly nursing summary, and as needed. If a CNA found a wound, they should report it to the nurse. Weekly skin assessments should be performed head to toe and document anything found in weekly summary. Turning and Repositioning Resident #51 Record review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses that included atrial fibrillation (an irregular heart rhythm), dementia (a decline in cognitive functioning affecting daily living), and hemiplegia (paralysis on one side of the body). Review of Resident #51's Care Plan Report, initiated on 1/24/25, revealed: .MY GOAL IS TO: keep my skin healthy and intact . My nurses to reduce pressure and friction between myself and my bed . Further review revealed interventions to prevent pressure injuries: . help me reposition at least every 1-2 hours while I'm in bed . Review of the resident's Kardex (a shortened version of the care plan used to help initiate cares on the floor), dated 2/21/25, revealed: Reposition me every 2 hours. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation on 5/19/25, from 9:00 AM to 12:00 PM, revealed Resident #51 was positioned on his/her back with a slight left-sided tilt. During this time, Resident #51 remained in the same position without any repositioning interventions for a total of three hours. An observation on 5/20/25 at 10:34 AM, revealed Resident #51's left hip had an oval shaped, 1.5-inch x 1 inch, bright-red wound with a shiny appearance. The resident's incontinence brief was observed rubbing directly against the wound. No dressing or protective intervention was in place. Review of Resident #51's Order Summary Report, dated 5/20/25, revealed: Left hip blister: cleanse with NS [normal saline], pat dry, cover with a dry dressing . During an interview on 5/20/25 at 10:40 AM, when discussing interventions for wound healing, LN #6 stated, I leave it [the wound] open to air. When discussing the ordered intervention to cover the wound with a dry dressing, LN #6 stated, There should be a dry dressing in place. Record review of Resident #51's, Turns and Repositions, dated 5/19/25, revealed the resident was only repositioned two times during that day, once at 2:01 PM and once at 8:35 PM. During an interview on 5/20/25 at 2:31 PM, when asked about the repositioning log indicating only two repositioning interventions on 5/19/25 for Resident #51, LN #6 stated, From the charting that is correct. It's not realistic to expect the residents to be turned every two hours when you only have one nurse and one CNA working . It's an organization problem. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Tailoring wound care to wound color . Cover a red wound, keep it moist and clean, and protect it from trauma . Resident #492 Record review on 5/18-22/25 revealed Resident #492 was admitted to the facility with diagnoses that included depression (mood disorder causing persistent feelings of sadness, loss of interest in activities, and impaired daily functioning, impacting emotional and physical health), bipolar disorder (mental health condition characterized by alternating episodes of emotional highs and lows, significantly affecting mood, energy, and daily functioning), and atrial fibrillation. Review of Resident #492's MDS admission assessment, dated 5/8/25, revealed the Resident had upper and lower extremity impairments and was fully dependent on staff for transfers to and from the, as well as requiring substantial/maximal assistance with mobility rolling right and left. Further review revealed the Resident was at risk of pressure ulcers. Review of Resident #492's Care Plan Report, initiated 5/2/25, revealed: . Has the potential for pressure ulcer development r/t [related to] Generalized body weakness and impaired mobility . Out of bed unless contraindicated . Needs monitoring/reminding/assistance to turn/reposition . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation on 5/18/25, from 8:20 AM to 12:50 PM, revealed Resident #492 remained in bed on his/her back, without any staff entering the room to reposition the resident for a total of 4 hours and 30 minutes. Review of Resident #492's Daily Skilled Note, dated 5/12/25 at 6:15 PM, revealed: INTEGUMENTARY .has a small area on [his/her] coccyx acquired at the hospital previous admission . Review of Resident #492's Turns and Repositions log, dated 5/18/25, revealed the resident was only repositioned two times during that day, once at 1:06 PM and once at 3:30 PM. During an interview on 5/22/25 at 3:25 PM, when asked about the facility's policy for turning and repositioning of residents with impaired mobility, the Assistant Director of Nursing (ADON) stated, We expect the staff to turn [residents] every two hours and as needed. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Pressure Injury Prevention .Turn and reposition the patient regularly and frequently . Review of the facility policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE, last revised 12/2024, revealed: . ONGOING CARE . Inspect skin for rashes, trauma, and pressure ulcers over any bony prominences .Turning/reposition q [every] 2 hours for residents with dependent mobility . Review the facility policy Skin and Wound Monitoring and Management, revised on 3/2025, revealed: . Prevention . Stabilize, reduce, or remove any existing any underlying risks . Reposition the resident . .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. . Based on record review, observation, and interview, revealed the facility failed to ensure 1 unsampled resident (#60) was free from accident hazards. This failed practice had the potential to cause an accident that may have resulted in resident injury. Findings: Record review on 5/18-22/25 revealed Resident #60 was admitted to the facility with diagnoses that included non-traumatic subarachnoid (the space in the brain where cerebrospinal fluid circulates) hemorrhage, hemiplegia (paralysis of one side of the body), and hemiparesis (one sided muscle weakness). Review of Resident #60's Care Plan Report, initiated on 3/11/25, revealed: Requires assistance . for transferring from one position to another r/t [related to]: Cognitive deficit, Decreased strength Provide two persons for supervision/physical assist with mechanical aid or transfer belt. An observation on 5/18/25 at 11:05 AM, Resident #60 was lying in bed. Certified Nursing Aide (CNA) #7 provided Resident #60's personal cares. During the cares, CNA #7 inserted a ceiling lift sling behind the Resident and hooked the sling to the ceiling lift once it was in place. He/she pressed the lift button to transfer the Resident from the bed to the wheelchair. While the ceiling lift moved from bed to wheelchair, the ceiling lift stopped working. CNA #7 stated the cord was pulled out, pointing at the red button (emergency button) with a cord hanging from the ceiling lift. During the same observation, CNA #7 continued to point to the red button. The Resident tried to help and held the red cord, while he/she was suspended in in the air. Then, CNA #7 pushed the call light. While waiting for help, the CNA rushed towards the door and left the Resident suspended in the air. The CNA left the Resident alone without any other staff present next to him/her and out of sight of CNA #7. As CNA #7 opened the door, Licensed Nurse (LN) #12 went inside the room, and was followed by Hospitality Aide (HA) #1. LN #12 reached and pushed the red button back while HA #1 and CNA #7 were guarding the Resident. Then, CNA #7 continued to lower the Resident unto the wheelchair. During an interview on 5/20/25 at 10:00 AM, Nurse Supervisor (NS) #1 was asked what it meant if the resident's care plan stated, two persons for supervision/ physical assist with mechanical aid or transfer belt. The NS stated it should be two persons assist. During a follow-up interview on 5/22/25 at 8:55 AM, the Dirctor of Nursing DON stated the CNA should have used a radio transmitter to ask for help. The DON stated there should have been somebody else in the room and to not leave the Resident suspended in the air alone. DON stated CNAs will be educated. Review of the facility's policy Transfer of a Resident, Safe, dated 3/2025, revealed: .safe and efficient transfers are combination of resident's ability and perceptual capacity, proper equipment and proper techniques and good planning.transfers may involve.mechanical lift. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Maxi Sky 2 (the ceiling lift used by the certified nurse aide to transfer a resident from bed to wheelchair), INSTRUCTIONS FOR USE, revised date 6/2024, revealed: .Actions Before Every Use Note: The need for a second attendant to support the patient must be assessed in each individual case. WARNING: Before an attempt is made to attempt to move a patient, a clinical assessment of the patient's suitability for transfer must be carried out by a qualified professional considering that, among other things, the transfer may include substantial pressure on the patient's body. .

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. . Based on interview and record review, the facility failed to provide appropriate, timely treatment for a possible urinary tract infection (UTI) for 1 resident (#70), out of 21 sampled residents. This failed practice left the resident with UTI symptoms for over a month despite repeated requests for answers and possible treatment from the resident which resulted in continued pain and discomfort. Findings: Record review of 5/18-22/25 revealed Resident #70 was admitted to the facility with diagnoses that included large B-cell lymphoma, unspecified cite (an aggressive, fast-growing form of non-Hodgkin lymphoma that originates in B cells), mysthenia gravis with (Acute) excerbation (a weakness and rapid fatigue of muscles under voluntary control), and other polyuria (excessive urination). During an interview on 5/18/25 at 10:45 AM, Resident #70 stated he/she requested a urine analysis (UA- a lab test to see if there were any abnormalities in a urine sample) to be completed back in April for symptoms of a UTI he/she was having, mainly bladder pain and painful urination. Resident #70 stated there was a huge delay in getting a UA successfully completed, Once the nurse forgot to order the UA, the second time the UA was never sent to the lab, the third time the UA was contaminated, and the fourth sample is still at the lab. Resident #70 stated, currently, he/she continued to have UTI symptoms of flank pain (pain over the kidney area, near lower back) and painful urination, and has had no doctor come and talk to him/her about them. Resident #70 further stated that he/she usually used a purewick catheter (a flexible external catheter that used low pressure suction to wick urine away from the patient), however it was currently broken because a Certified Nursing Assistant (CNA) accidently threw a part away during cares and the facility had ordered the part but was waiting for its delivery to continuing using the catheter. Review of Resident #70's medical record, dated 4/16/25 to 5/22/25, revealed: 1) An order for a UA was written on 4/16/25 and documented it was completed, however a review of Resident #70's lab reports revealed this UA was never received or analyzed by the lab vendor. A review of Resident #70's progress notes revealed: - 4/20/25 at 6:48 PM: Resident #70 inquired about the results of last UA. - 4/27/25 at 4:51 PM: Ibuprofen (pain medication) was given resident complained of back pain. - 4/28/25 at 4:33 PM: Ibuprofen was given pain scale 5 (on a scale of 0 to 10), requested for back pain. - 4/29/25 at 8:31 AM: Ibuprofen was given complained of low back pain. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0690 Level of Harm - Actual harm Residents Affected - Few	- 4/29/25 at 12:03: Documentation of Phenazopyridine HCL [a pain reliever for the lower urinary tract, but not for UTIs] Oral Tablet 95mg . Give 2 tablet by mouth every 8 hours as needed for Urinary tract/Badder discomfort until [5/1/25 11:59 PM] three times a day. - 4/29/25 at 6:28 PM: Resident complaint of back pain, offered Morphine but refused. Requested Ibuprofen PRN [as needed], given and was effective. Pain scale was down to 3 [at] 1:44 PM . Resident wants to know last urine test result, will send message to ANP [advanced nurse practitioner]. - 5/1/25 at 12:00 AM: Provider progress note from ANP #3, Chief Complaint: urine/flank pain . [He/she] states [he/she] is generally not feeling well with urethral pain/burning/lack of urinary frequency . Labs/Radiology/Tests: Labs: Labs and imaging reviewed on Epic [electronic medical record] . Assessment and Plan: Urethral Pain. U/A C&S [urine analysis with culture and sensitivity - analyze the urine, culture it to determine sensitivity to antibiotics if indicated] . ICD [International Classification of Disease] Codes . N39.0 urinary tract infection, site not specified . 2) An order for a UA was written on 5/1/25 and documented it was completed, however a review of Resident #70's lab reports revealed this UA was never received or analyzed by the lab vendor. Further review of Resident #70's progress notes revealed: - 5/5/25 at 10:32 AM: Resident stated that [he/she] is having bladder pain . wanted to know [his/her] last urine test result . Message to [ANP #3] about the result, waiting . - 5/5/25 at 6:12 PM: Change of Condition: Symptoms or signs noted of condition change . pain in urination . Reported to primary care clinician [ANP #3] Date and time of clinician notification: [5/5/25] 1:00 PM. - 5/5/25 at 7:33 PM: Order from [ANP #3] for U/A, C&S if indicated transcribed . - 5/6/25 at 10:06 AM: Resident stated complained of bladder pain . Resident is waiting for the lab result of [his/her] urine, informed [him/her] it was sent by [night] nurse this morning . - 5/6/25 at 6:57 PM: At [3:04 PM] Resident check [his/her] lab result [through] MyChart wants result. Writer message [ANP #3] said she will order antibiotics. Waiting for actual [antibiotic] order . 3) An order for a UA was written on 5/6/25 and documented it was completed. A review of Resident #70's UA lab report from 5/6/25 revealed the following abnormalities: - Clarity: Turbid (cloudy or hazy urine, can be caused by bacteria, cells, or mucus) - Leukocyte Esterase: Moderate (increased number of leukocytes in urine, could indicate UTI) - [NAME] Blood Cells: 26-50 (normal range is 0-5, could indicate serious medical conditions like inflammation or infection) - [NAME] Blood Cell Clumps: Rare (could indicate an infection or inflammation) (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Further review revealed: Culture results: 10,000-50,000 CFU/ml mixed flora (multiple morphologies present) suggestive of superficial contamination/colonization. Suggest appropriate recollection with timely delivery to the laboratory, if clinically indicated. Further review of Resident #70's medical record revealed no re-order or re-collection of another UA took place after this report was received by the facility. Further review of Resident #70's progress notes revealed: - 5/6/25 at 7:47 PM: Diagnosis or Condition(s) being monitored: Pain in Urination . Pain originates from during urination located at bladder described as sharp nonpharmaceutical interventions include repositioning as tolerated . Genitourinary and renal: Urine is slightly darker yellow urine Active [symptoms] difficult/painful urination . offered pain medication was refused . encouraged to drink fluids. - 5/9/25 at 4:09 PM: Resident is requesting for another U/A C&S to be done due to [his/her] back pain 3-5/10 [3 to 5 out of 10]. Pain medication was offered. Resident refused. Resident's recent U/A C&S was reviewed by [ANP #3]. Per NP, [Resident #70's] UA C&S came back normal but if [he/she] would like to have another test then that's okay. Ordered noted and carried out. Resident aware . - 5/9/25 at 4:54 PM: Received a phone call from [Resident #70's] POA [Power of Attorney], at [1:55 PM] today. She was concerned about ongoing complaints to her from [Resident #70] about a UTI that was not being treated. This writer [Licensed Nurse (LN) #14] called [ANP #3] and learned that the UA C&S microscopic that resulted on 5/6/25 was [negative] for nitrates and growth, with moderate leukocytes. Electrolytes WNL [within normal limits]. The Macrobid [an antibiotic] that had been ordered prophylactically was withdrawn. After speaking with [Resident #70], I believe the results had not been explained to [him/her]. The current problem is the resident still has complaints of intermittent kidney pain. I called the Provider again who said to get a new UA with C&S and microscopic if indicated if the resident was good with that plan. [Resident #70] agreed & the order was entered. The [Registered Nurse] in Matanuska will obtain the sample via sterile straight cath. Just before the time of this note, this writer called the POA back to update her on the above events. Will continue to monitor. 4) An order for a UA was written on 5/9/25 and documented it was completed, however a review of Resident #70's lab reported revealed this UA was never received or analyzed by the lab vendor. - 5/14/25 at 8:34 AM: Received new order from [ANP #3] to resume the order for Phenazopyridine HCL oral tablet 95mg PRN for bladder discomfort . - 5/14/25 at 4:40 PM: Writer [LN #15] spoke with [Resident #70] and updated [him/her] of an order for a Urology consult obtained from yesterday . also I asked [him/her] if [he/she] has any urinary difficulties and would like to have a UA done, 'I still have random discomfort after peeing, yes, I would like to have it done.' UA C&S with micro if indicated was entered in PCC [Point Click Care - electronic medical record] for tomorrow's collection at [6:00 AM]. POA is aware that UA will be done tomorrow. - 5/14/25 at 5:12 PM: Spoke with [Resident #70] and let [him/her] know that [night] nurse will collect urine from [him/her] tomorrow early morning and [he/she] agreed . (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0690 Level of Harm - Actual harm Residents Affected - Few	- 5/15/25 at 7:02 AM: UA C&S with micro [microscope analysis] if indicated. One time only for 1 day collected at [6:50 AM]. 5) An order for a UA was written on 5/15/25 and documented it was completed. A review of Resident #70's UA lab report from 5/15/25 revealed the following abnormalities: - Specific Gravity: high at 1.031 - Protein: 20mg/dL (normal range is 0-14mg/dL. Could be indicative of kidney disease or dehydration) - Leukocyte Esterase: Small - [NAME] Blood Cells: 11-15 Further review of Resident #70's progress notes revealed: - 5/18/25 at 2:13 AM: Phenazopyridine was administered. With an effective reassessment at 2:41 AM. - 5/18/25 at 12:24 PM: Phenazopyridine was administered, resident requested for bladder pain and discomfort. Stated [his/her] pain scale was 7. Had an effective reassessment at 6:42 PM (over 6 hours after having administered it). - 5/18/25 at 7:50 PM: . Resident complain of [bladder] pain and symptoms. Pain scale of 7. Check on Resident went down to 2 as stated . - 5/21/25 at 9:34 AM: Phenazopyridine was administered, per requested for urinary pain. During an interview on 5/21/25 at 10:21 AM, after reviewing Resident #70's UA lab reports from 5/6/25 and 5/15/25, the Medical Director stated there were some abnormalities to both lab reports. When asked to review Resident #70's medical record to see if any provider had assessed Resident #70 after these samples were received, the Medical Director stated no one had seen him/her for these concerns. The Medical Director stated he was taking over resident care this week and would assess Resident #70. Further review of Resident #70's progress notes revealed antibiotics were started after the Medical Director's assessment. - 5/21/25 at 1:47 PM: . Nitrofurantoin Macrocrystal Capsule 100mg give 1 capsule by mouth two times a day for cystitis [An inflammation of the urinary bladder, often caused by a bacterial infection. It's a common type of UTI] for 7 days . - 5/22/25 at 1:24 PM: . Received order to change [Nitrofurantoin Macrocrystal] to Macrobid BID [for] 7 days . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/22/25 at 5:30 PM, after having reviewed Resident #70's medical record, the Director of Nursing and Infection Preventionist both stated they could not find documentation that a Provider followed up with Resident #70's symptoms of UTI and they could not explain why three of the five UAs obtained did not make it to the lab for analysis. Review of the facility's policy Patient Rights, undated, revealed: . Receive adequate and appropriate care . Be informed of all changes in medical condition . participate in their own assessment, care-planning, treatment, and discharge . To be treated with consideration, respect, and dignity . Reasonable accommodation of one's needs and preferences . .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, observation, and interview, the facility failed to ensure safe and appropriate administration of enteral nutrition (the introduction of nutrients directly into the stomach by a soft plastic feeding tube surgically implanted directly through the abdomen) and medication was free of possible complications for 1 sampled resident (#51) and 1 unsampled resident (#77), out of 2 residents reviewed with feeding tubes. Specifically, the facility failed to: 1) Check Resident #51's gastric residual volume prior to initiating enteral nutrition; 2) Ensure Resident #51's head-of-bed remained elevated to an angle of 30 degrees or higher during active feeding; 3) Follow a physician order for flushing Resident #51's feeding tube before and after medication administration; and 4) Use non-contaminated enteral tubing for Resident #77's enteral nutrition. These failed practices placed the residents at risk for aspiration, tube occlusion, infection, and other gastrointestinal complications. Findings: Resident #51 Record review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses including atrial fibrillation (an irregular heart rhythm), dementia (a decline in cognitive functioning affecting daily living), and hemiplegia (paralysis on one side of the body). Gastric Residual Volume Review of Resident #51's physician orders, dated [DATE], revealed: .Check residuals and hold feeding if residuals above 300 cc. An observation on [DATE] at 10:34 AM, revealed LN #6 attached enteral tubing to Resident #51's feeding tube and began to administer a scheduled nutritional meal. During an interview on [DATE] at 10:35 AM, LN #6 was asked if gastric residuals had been checked prior to initiating the enteral nutrition. LN #6 replied, No, I should have done that. Review of the facility policy Gastrostomy Tube Care and Management, dated 3/2025, revealed: .Aspiration of stomach contents: The physician may recommend that you draw back on the syringe to check for residual feeding contents in the stomach . Follow physician orders . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Head of Bed Elevation An observation on [DATE] at 10:21 AM, revealed LN #6 and Certified Nurse Assistant (CNA) #3 entered Resident #51's room to clean and reposition the resident. LN #6 positioned the resident's bed in a flat-lying position while an enteral nutrition meal was actively infusing. When asked if the resident's bed should be flat during an enteral meal, LN #6 stated, I needed him/her flat so that we could turn [him/her]. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Position the patient with the head of the bed elevated to at least 30 degrees, or upright in a chair, to prevent aspiration . Medication Administration Review of a physician order, dated [DATE], revealed: Flush tube with 50 cc of water pre and post medication administration via tube. An observation on [DATE] at 12:44 PM, revealed LN #6 administered medication through Resident #51's feeding tube without performing a pre-flush with 50 cc of water and used only 30 cc of water for the post-flush. Review of the facility policy Gastrostomy Tube Care and Management, dated 3/2025, revealed: .Flush the feeding tube and adapter, if applicable per physician's order before and after giving any medication by tube . Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings .Flush the enteral tube . as ordered . Resident #77 Record review on 5/18-22/25 revealed Resident #77 was admitted to the facility with diagnoses of cerebral palsy (a group of disorders affecting movement and muscle tone), epilepsy (a neurological disorder marked by seizures), and developmental disorder of motor function (delays or impairments in coordinated movement). Enteral Tubing Contamination An observation on [DATE] at 10:50 AM, revealed LN #6 entered Resident #77's room to administer scheduled enteral nutrition meal. There was enteral tubing already attached to the feeding pump, which was undated and hung uncapped from an IV pole at the Resident's bedside. This tubing contained enteral nutrition solution throughout the tubing. LN #6 proceeded to attach the uncapped tubing to the resident's feeding tube, however the surveyor intervened before attachment and asked, Should the tube feeding be administered through that tubing since it was uncapped? LN #6 responded, It should have been capped, but since it wasn't I will use alcohol wipes to sanitize it, then begin the feed. He/she then attached tube feeding to the resident's feeding tube, after using an alcohol wipe on the enteral tubing port, and began infusion of the enteral nutrition. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:50 PM, the facility's Infection Preventionist (IP) was asked whether the tubing would be safe to use if left uncapped. The IP stated, It would not be safe if it has been uncapped and not knowing what it has been exposed to, which would require a change of new tubing-dated, capped-then the standard is that it would be good for 24 hours. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Don't use formula if its integrity is compromised or if it's expired. Instead, obtain a new container of the formula . .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, observation, and interview, the facility failed to provide necessary respiratory care and services for 2 sampled residents (#2 and #28), out of 21 sampled residents, and 1 resident (#89), out of 3 closed records reviewed. Specifically, the facility failed to: 1) Properly monitor and assess Resident #2's, and #89's supplemental oxygen use; and 2) Ensure written physician orders were in place for oxygen use for Resident #28 and #89. These failed practices placed the residents at risk for not receiving necessary oxygen therapy and not having oxygen therapy appropriately monitored for effectiveness. Findings: Resident #2 Record review on 5/18-22/25 revealed Resident #2 was admitted to the facility with diagnoses that included vascular dementia unspecified severity, without behavioral disturbance (problems with blood flow to the brain, resulting in brain tissue damage), anxiety, and dependence on supplemental oxygen. An observation on 5/19/25 at 9:08 AM, revealed Resident #2 received 2 liters per minute (LPM) of oxygen through a nasal cannula (NC - a thin flexible tube used to deliver supplemental oxygen through the nose). Review of Resident #2's provider's orders, dated 5/14/25, revealed: Oxygen 1-3L [liters] via humidified nasal cannula to maintain SpO2 [percentage of blood saturated with oxygen] >[greater than] 92% . [Directions] every day and night shift for hypoxia [low levels of oxygen in body tissues] . [Start Date] 4/19/2025 07:00 [7:00 AM] Review of Resident #2's medical record from 5/1-20/25, revealed there was a total of 15 oxygen saturation recordings [NAME] were not documented during the day shift (out of a total of 20 required) and a total of 10 oxygen saturation recordings that were not documented during the night shift (out of a total of 20 required). Review of Resident #2's care plan, revised on 2/25/25, revealed: . I . have hypoxia . I SHOW THIS BY: . wearing O2 [oxygen] at 2 LPM as needed . I need my nurses to . ensure that my oxygen tubing is in place as ordered, assess me for hypoxia or shortness of breath. Give me PRN [as needed] nebulization [a device that turns liquid medication into mist that is then inhaled to treat respiratory conditions] as ordered. Check oxygen saturation as ordered . During an interview on 5/22/25 at 2:55 PM, the Director of Nursing (DON) stated it was expected for nursing staff to follow the resident's care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 5/22/25 at 3:08 PM, the DON confirmed missing oxygen saturations during 5/1-20/25. The DON further stated Resident #2's oxygen saturation should have been documented every shift as ordered, and oxygen saturation recordings were needed to assess for hypoxia. Resident #28 Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non-Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), heart failure (inability of the heart to maintain adequate blood circulation), and hypertension (repeatedly elevated blood pressure). An observation on 05/18/25 at 12:07 PM, revealed Resident #28 was receiving 2 LPM of humidified oxygen through a nasal cannula while in bed. An observation on 5/19/25 at 9:01 AM, revealed a sign on Resident #28's doorframe that read oxygen in use. An observation on 5/20/25 at 9:43 AM, revealed Resident #28 in bed with a nasal cannula in place and humidified oxygen running at 2 LPM. The resident stated he/she used the oxygen at night while sleeping. Review of Resident #28's care plan, revised on 4/1/25, revealed: . Administer my supplemental oxygen as ordered . Review of Resident's 28's medical record revealed no provider's orders for the use of oxygen therapy. During an interview on 5/21/25 at 10:31 AM, when asked if Resident #28 received supplemental oxygen, the Medical Director responded, I don't believe so . , and further confirmed Resident #28 did not have an order for oxygen therapy after reviewing the resident's medical record. During an interview on 5/22/25 at 2:32 PM, when asked if residents who used supplemental oxygen should have an order, the DON stated, yes. The DON further stated there was no order for Resident #28's supplemental oxygen and that oxygen saturations should be monitored for residents on supplemental oxygen. Resident #89 Record review on 5/18-22/25 revealed Resident #89 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD - a long-term lung condition that causes breathing difficulties due to airflow obstruction). Further review revealed Resident #89 had passed away on 4/25/25. Review of Resident #89's nursing assessment, LN [Licensed Nurse]-Condition Monitoring-V 2, dated 3/6/25 at 2:56 PM, revealed: oxygen level 97 percent on 2 [liters]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #89's nursing assessment, Activity- Change in Condition Evaluation, dated 3/22/25 at 2:56 PM, revealed: c/o productive cough, feeling hot, bp [blood pressure] 118/73, pulse 88, temp[temperature] 98.3 orally, pulse ox [oximetry] 97 percent on 2 liters nasal cannula. Review of Resident #89's weekly nursing assessment, LN- Nursing Summary-Weekly, dated 4/11/25 at 5:24 PM, revealed, Oxygen used Continuous .2 LPM at night only .Average Saturation reading for this month .95. Review of Resident #89's medical record revealed no provider's orders for the use of oxygen therapy. Review of Resident #89's physician orders, dated 2/28/25 with a start date of 3/1/25, revealed: NURSING ORDER: Ensure weekly BP [blood pressure] & [and] P [pulse] is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . There were no orders in place to monitor the oxygen therapy the resident had received as noted on 3/6/25, 3/22/25 and 4/11/25. Review of Resident #89's physician orders, dated 4/19/25 with a start date of 4/26/25, revealed: NURSING ORDER: Ensure weekly Vital Signs is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . The resident had passed away before this monitoring order had started. During an interview on 5/21/25 at 10:01 AM, when asked how often oxygen saturations should have been recorded for Resident #89 when he/she was using continuous oxygen, the Medical Director stated, every four hours, titrate oxygen above 88%. During an interview on 5/22/25 at 3:08 PM, the DON stated Resident #89 used supplemental oxygen and only one oxygen saturation from the dates of 3/1/25 to 4/25/25 was recorded. The DON further stated orders for oxygen therapy should have been put in place. Review of the facility-provided policy, Oxygen Therapy, revised on 3/2025, revealed: . Plan of Care: The resident's plan of care should be addressed. 1. That oxygen is to be administered. 2. Who is responsible for administering the oxygen. 3. The type of oxygen device to use (i.e., mask, nasal) 4. Any special procedures or treatment to be administered. i.e.: Oxygen saturation monitoring while on Oxygen therapy when applicable . Charting and Documentation: 1. The date and time the procedure was ordered. 2. The rate of flow, route and rationale. 3. The name of the person administering the oxygen. 4. The frequency and duration of the treatment. 5. The resident's tolerance to the treatment. 6. Any complaints made by the resident. 7. If the resident refused the treatment, the reason(s) why. 8. All pertinent observations . Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition, dated 2023, revealed: . Oxygen Administration . Implementation . Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed . Monitor the patient's oxygen saturation level using pulse oximetry to assess the response to oxygen therapy . .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. . Based on record review, observation, and interview the facility failed to ensure orders for residents' care were provided for 2 sampled residents (#28 and #31), out of 21 sampled residents, and 1 resident (#89), out of 3 closed records reviewed. This failed practice had the potential to place the residents at risk for not receiving the necessary care and services to maintain their highest practicable physical well-being. Findings: Oxygen Orders Resident #28 Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non-Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), heart failure (inability of the heart to maintain adequate blood circulation), and hypertension (repeatedly elevated blood pressure). An observation on 05/18/25 at 12:07 PM, revealed Resident #28 was receiving 2 liters per minute (LPM) of humidified oxygen through a nasal cannula while in bed. An observation on 5/19/25 at 9:01 AM, revealed a sign on Resident #28's doorframe that read oxygen in use. An observation on 5/20/25 at 9:43 AM, revealed Resident #28 in bed with a nasal cannula in place and humidified oxygen running at 2 LPM. The resident stated he/she used the oxygen at night while sleeping. Review of Resident #28's care plan, revised on 4/1/25, revealed: . Administer my supplemental oxygen as ordered . Review of Resident's 28's medical record revealed no provider's orders for the use of oxygen therapy. During an interview on 5/21/25 at 10:31 AM, when asked if Resident #28 received supplemental oxygen, the Medical Director responded, I don't believe so . , and further confirmed Resident #28 did not have an order for oxygen therapy after reviewing the resident's medical record. During an interview on 5/22/25 at 2:32 PM, when asked if residents who used supplemental oxygen should have an order, the Director of Nursing (DON) stated, yes. The DON further stated there was no order for Resident #28's supplemental oxygen and that oxygen saturations should be monitored for residents on supplemental oxygen. Resident #89 (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 5/18-22/25 revealed Resident #89 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD - long-term lung condition that causes breathing difficulties due to airflow obstruction). Further review revealed Resident #89 had passed away on 4/25/25. Review of Resident #89's nursing assessment, LN [Licensed Nurse]-Condition Monitoring-V 2, dated 3/6/25 at 2:56 PM, revealed: oxygen level 97 percent on 2 [liters]. Review of Resident #89's nursing assessment, Activity- Change in Condition Evaluation, dated 3/22/25 at 2:56 PM, revealed: c/o productive cough, feeling hot, bp [blood pressure] 118/73, pulse 88, temp[temperature] 98.3 orally, pulse ox [oximetry] 97 percent on 2 liters nasal cannula. Review of Resident #89's weekly nursing assessment, LN- Nursing Summary-Weekly, dated 4/11/25 at 5:24 PM, revealed: Oxygen used Continuous .2 LPM at night only .Average Saturation reading for this month .95. Review of Resident #89's medical record revealed no provider's orders for the use of oxygen therapy. Review of Resident #89's physician orders, dated 2/28/25 with a start date of 3/1/25, revealed: NURSING ORDER: Ensure weekly BP [blood pressure] & [and] P [pulse] is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . There were no orders in place to monitor the oxygen therapy the resident had received as noted on 3/6/25, 3/22/25 and 4/11/25. Review of Resident #89's physician orders, dated 4/19/25 with a start date of 4/26/25, revealed: NURSING ORDER: Ensure weekly Vital Signs is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . The resident had passed away before this monitoring order had started. During an interview on 5/22/25 at 3:08 PM, the DON stated Resident #89 used supplemental oxygen and only one oxygen saturation from the dates of 3/1/25 to 4/25/25 was recorded. The DON further stated orders for oxygen therapy should have been orders put in place. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition, dated 2023, revealed: . Oxygen Administration . Implementation . Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed . Monitor the patient's oxygen saturation level using pulse oximetry to assess the response to oxygen therapy . Dental Services Orders Resident #31 Record review on 5/18-22/25 revealed Resident #31 was admitted to the facility with diagnoses that included legal blindness and disorder of teeth and supporting structures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/18/25 at 1:24 PM, Resident #31 stated he/she was having dental pain intermittently. The resident put in a request to see a dentist about two months ago but had not heard anything more about it. Review of Resident #31 provider's progress note, dated 4/28/25, revealed: . [Resident#31] would like to go to the dentist, has broken tooth . Poor dentition . [Resident #31] will return to dentist when [he/she] feels [he/she] is ready to tolerate further extractions. -please schedule appointment for f/u extractions . Review of Resident #31's medical record revealed there were no physician orders for dental services from the 4/28/25 provider's progress note through the survey dates. During an interview on 5/21/25 at 12:52 PM, the Health Unit Clerk (HUC) stated she would look for dental orders in the medical record, then she would schedule the dental appointments. The HUC was unaware that Resident #31 wanted a dental appointment. She reviewed the resident's chart for dental orders and was unable to find an order. During an interview on 5/21/25 at 1:18 PM, LN #10 stated he/she was aware Resident #31 had occasional pain with his/her teeth and mouth. Resident #31 had several dental appointments before March, but the resident had cancelled them due to not feeling well. LN #10 further stated the resident did not have any upcoming dental appointments. During an interview on 5/22/25 at 1:45 PM, the DON stated the physician should have entered in the orders to have a dental appointment set up for Resident #31. Review of the facility-provided policy SNF/AL Dental Services, effective 10/2019, revealed: . SNF/AL will provide or obtain the following dental services to meet the needs of each resident . will assist resident in making appointments . will either directly or contractually provide dental services that all residents may elect to receive . Review of the facility's policy Patient Rights, undated, revealed: . Receive adequate and appropriate care . participate in their own assessment, care-planning, treatment, and discharge . To be treated with consideration, respect, and dignity . Reasonable accommodation of one's needs and preferences . .

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. . Based on record review, interview, and observation, the facility failed to have sufficient nursing staff to provide care and services for 7 sampled residents (#'s 4; 12; 19; 40; 48; 51; and 492), out of 21 sampled residents, and 1 unsampled resident (#74). Specifically, the facility failed to ensure: 1) Scheduled showers were provided for 3 resident (#'s 4, 19 and 40); 2) Requests to get out of bed to go outside and participate in activities was honored for 1 resident (#48); 3) Timely incontinence care was provided for 1 resident (#74); 4) Scheduled turning and repositioning interventions for 3 residents (#'s 12, 51 and 492) with impaired mobility and at high risk for pressure injuries, were followed. These failed practices placed the residents at risk for not receiving care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings: Scheduled Showers Resident #4 Record review on 5/18-22/25 revealed Resident #4 was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), rheumatoid arthritis (autoimmune disorder that affected the joints), and depression. Review of Resident #4's Minimum Data Set (MDS - a federally required assessment) quarterly assessment, dated 1/7/25, revealed Resident #4 had an impairment of the upper limbs. Resident #4 was dependent on staff for his/her shower transfers. Review of Resident #4's Care Plan Report, initiated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Fatigue . Goal: Will maintain current level of function in .Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: . BATHING (SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Wednesday and Saturday . During an interview on 5/18/25 at 12:45 PM, Resident #4 stated the facility was so short-staffed that he/she only received 1 shower a week, instead of the two scheduled showers that was care planned for him/her. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/25 at 3:57 PM, Certified Nursing Assistant (CNA) #1 stated that due to being short-staffed, residents were unable to get the care that they deserve. He/she confirmed that Resident #4 was scheduled for showers on Wednesdays and Saturdays but added that if staff was unable to give showers on the scheduled days, .they would have to wait until the next shower day . During an interview on 5/21/25 at 10:36 AM, Resident #4's POA (Power of Attorney) stated he/she was concerned due to the resident's reports of inadequate showers. Review of Resident #4's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: - During the month of March 2025, the resident received a shower twice on 3/19 and 3/26; - During the month of April 2025, the resident received a shower twice on 4/9 and 4/30 and; - Between 5/1-21/25, he/she received a shower on 5/7, 5/14, and 5/21. Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included multiple sclerosis (chronic autoimmune disease where the immune system attacks the protective covering of nerve cells), type 2 diabetes mellitus with diabetic polyneuropathy (Type 2 DM: non-insulin-dependent diabetes, with nerve damage complications), neuromuscular dysfunction of the bladder (condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (MDD: mood disorder characterized by persistent feeling of sadness and loss of interest in activities). Review of Resident #19's MDS quarterly assessment, dated 1/31/25, revealed Resident #19 had an impairment on one side of the upper and lower limbs. Resident #19 was dependent for his/her shower transfers. Review of Resident #19's Care Plan Report, initiated 3/15/25, revealed: .Focus: ADL Self Care Performance Deficit r/t [related to] Limited Mobility, Activity Intolerance . Goal: Will maintain current level of function in . Grooming, Toilet Use and Personal Hygiene . Interventions/Tasks: .BATHING(SHOWER/BATHE SELF): help of 1 person providing all the effort. Shower days: Tuesday and Friday . During an interview on 5/18/25 at 8:42 AM, Resident #19 stated he/she would only get showers once a month, and . maybe sometimes two if I guilt them into doing it . During an interview on 5/19/25 at 3:58 PM, CNA #1 confirmed Resident #19 is scheduled for showers on Tuesday and Friday. Record review of Resident #19's Documentation Survey Report v2 [version] . Intervention/Task .Bathing ., revealed: - During the month of March 2025, the resident received a shower five times on 3/7, 3/11, 3/18, 3/25, and 3/31; (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- During the month of April 2025, the resident received a shower four times on 4/11, 4/15, 4/22, and 4/28, and; - Between 5/1-21/25, the resident received a shower four times on 5/6, 5/13, 5/14 and 5/20. Resident #40 Record review on 5/18-22/25 revealed Resident #40 was admitted to the facility with diagnoses that included coronary artery disease (CAD, a narrowing of the small blood vessels that supply blood and oxygen to the heart), morbid obesity (disease characterized by a BMI [Body Mass Inde] of 40 or higher), heart failure, hypertension, end stage renal disease (a condition in which kidney function is less than 10% of normal; the kidneys can no longer remove wastes, concentrate urine, and regulate electrolytes), and diabetes mellitus. Review of Resident #40's MDS quarterly assessment, dated 3/11/25, revealed Resident #40 had an impairment of the lower limbs and required wheelchair transportation, always incontinent of bladder and bowel, and at risk for pressure ulcers. Resident #40 required assistance for his/her shower transfers. Review of Resident #40's Care Plan Report, dated 4/15/25, revealed . BED MOBILITY (ROLL LEFT AND RIGHT, SIT TO LYING, LYING TO SITTING ON SIDE OF BED): Requires 1-2 people providing more than half the effort. PERSONAL HYGIENE/ORAL CARE (ORAL HYGIENE): SET UP ASSIST . I need my aides to help me brush . During an interview on 5/18/25 at 1:06 PM, Resident #40 stated he/she was unable to brush his/her teeth when requested. Resident #40 stated staff was not available to gather his/her supplies. Resident #40 further stated that he/she could not get to the toilet independently so he/she would often have episodes of incontinence. Resident #40 stated that he/she had to wait 1 hour and 45 minutes for staff to come and provide perineal care after he/she pressed the call light. Resident #40 further stated he/she had not received a shower for 1 ½ months due to not enough staff. Resident #40 stated it required two CNAs to transfer him/her out of bed. During an interview on 5/19/25 at 8:20 AM, CNA #2 stated Resident #40 was showered about 2 months ago. CNA #2 further stated Resident #40 was transferred to the shower by the ceiling lift and required two staff members to complete a safe transfer. CNA #2 stated he/she did not always have a second staff member to assist. During an interview on 5/20/25 at 1:40 PM, the MDS Coordinator (MC) reviewed Resident #40's care plan. The MC stated Resident #40 required one or two staff to complete the transfer with the use of the ceiling lift based on their comfort level and ability. The MC further stated Resident #40's current weight on 5/13/25 was 278 pounds. Review of Resident #40's Documentation Survey Report. Task Only, dated March 2025, revealed from 3/1/25 -3/31/25: - No showers were documented as successfully completed; - Oral Hygiene- was only documented on three days: 3/3/25, 3/17/25 and 3/19/25, and; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Personal Hygiene- was only documented on the following days: 3/3/25, 3/11/25, 3/16-19/25. Review of Resident #40's Documentation Survey Report . Task Only, dated April 2025, revealed from 4/1-30/25 tub/shower transfer occurred on two occasions. Review of Resident #40's Task: Bathing, dated 5/1-20/25, revealed . 5/17/25 Shower. No other showers were documented as successfully completed. During an interview on 5/20/25 at 3:10 PM, CNA #2 stated he/she provided Resident #40 a shower with the assistance of a hospitality aide. CNA #2 stated the hospitality aide was able to assist with the transfer of Resident #40 out of bed to the shower. During an interview on 5/22/25 at 2:15 PM, Resident #40 smiled and stated he/she received a shower two days ago. Resident #40 stated when he/she did not receive a shower over the past 2 months, he/she felt uncomfortable. Resident #40 further stated he/she felt down because there was not enough help and I just cry and go to sleep. During an interview on 5/22/25 at 3:30 PM, Physical Therapist (PT) #1 stated when operating a ceiling lift, one to two staff members were required. When PT #1 was asked how many staff members were required to transfer Resident #40 out of bed, PT #1 stated one to two staff members. PT #1 stated if Resident #40 requested two staff members or the staff member operating the lift did not feel comfortable operating the lift alone, then the transfer required an assist of two staff members. Transfer out of Bed Resident #48 Record review on 5/18-22/25 revealed Resident #48 was admitted to the facility with diagnoses that included, Type 2 DM, ESRD, hemiplegia (a condition in which half of the body is paralyzed) and hemiparesis (partial paralysis of one side of the body) following unspecified cerebrovascular disease (damage to the blood vessels in the brain) affecting right dominant side, MDD and post-traumatic stress disorder (PTSD, which is a mental health condition caused by a traumatic event that affects the ability to function daily). Review of Resident #48's MDS annual assessment, dated 9/20/24, revealed it was very important for Resident #48 to go outside to get fresh air when the weather was good, to attend activities, do things with groups of people and to be able to do his/her favorite activities. Resident #48 had an impairment on one side with limited range of motion and was dependent for his/her transfers. Further review revealed the Resident always felt lonely or socially isolated. In addition, the assessment determined that the Resident was fully dependent on staff for transfer to and from a bed or a chair or wheelchair. The Resident was coded as having depression and PTSD. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/18/25 at 12:53 PM, Resident #48 stated that he/she cannot get transferred in and out of bed when requested. Resident #48 further stated he/she had to make the decision to get out of bed or just stay in bed because there were not enough CNAs available. Resident #48 stated he/she had missed frequent activity events because he/she was not able to get out of bed or staff did not wake him/her up. Resident #48 stated he/she was frustrated. Resident #48 further stated, Staffing is an issue every day and has gotten worse. You get a good one [CNA], and the facility burns them out and they leave. Random observations from 5/18-22/25 of Resident #48's bedroom door revealed a sign that advised staff to wake up Resident if sleeping. During an interview on 5/22/25 at 9:05 AM, the Activity Supervisor stated the only documentation for activity participation was completed in the MDS upon admission, quarterly and the annual assessments. During an interview on 5/22/25 at 2:39 PM, the Director of Nursing (DON) stated if a resident requested to be transferred out of bed, the resident should be transferred out of bed. The DON further stated a resident should receive requested care as soon as possible. During an interview on 5/18/25 at 8:35 AM, CNA #2 stated he/she was the only CNA in the Deshka cottage. CNA #2 further stated from 3:30 PM to 7:00 PM on 5/18/25, he/she had to cover the Kenai cottage while covering the Deshka cottage, because there was not enough staff. CNA #2 stated he/she was concerned about how all residents would be cared for timely. CNA #2 stated there were two residents in the Deshka cottage that required feeding assistance and would be required to wait longer for assistance. Incontinence Care Resident #74 Record review on 5/18-22/25 revealed resident #74 was admitted to the facility with diagnoses that included Cerebrovascular Accident (CVA - also known as a stroke, is when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel) and hemiplegia or hemiparesis, anxiety disorder, depression and post-traumatic stress disorder (mental health condition caused by a traumatic event that affects the ability to function daily). Review of Resident #74's MDS annual assessment, dated 2/21/25, revealed the Resident was coded as being severely depressed that consisted of little interest or pleasure doing things; feeling down, depressed, and hopeless; feeling bad about oneself; feelings he/she would be better off dead or hurting oneself in some way. Further review of the assessment revealed the Resident had functional limitations to upper and lower extremities and utilized a wheelchair. Furthermore, the Resident was coded as being fully dependent on staff for toileting, bathing, and transferring to and from bed to wheelchair. The Resident was identified as always being incontinent of bowel and bladder. A continuous observation on 5/20/25 at 9:26 AM to 1:01 PM, revealed Resident #74 had an episode of incontinence and stated he/she needed to be changed. Further observation revealed: - At 9:26 AM: the resident pushed the call light; (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 9:50 AM: [NAME] #1 came into the resident's room. Resident #74 informed [NAME] #1 he/she needed to be changed. [NAME] #1 informed Resident #74 they would let the Nurse or CNA know; - At 9:53 AM: [NAME] #1 verbally informed LN #10 of the Resident #74's request. LN #10 informed [NAME] #1 that CNA #4 would help the resident; - At 1:01 PM, CNA #4 went into Resident #74's room and performed incontinence care and a brief change. Resident #74 waited a total of 3 hours and 35 minutes for cares. During an interview on 5/20/25 at 11:06 AM, while waiting for staff to come in for cares, Resident #74 stated staff would tell the Resident he/she pushed the call light too much and that made the Resident feel like he/she did not belong. Resident #74 stated he/she felt care was better with more staff and it often takes this long [3 hours and 35 minutes] or longer to get cleaned up. Resident #74 further stated he/she was used to 2-hour rounding at other facilities. They are giving people [staff] 2-3 cottages, which is way too much. He/she felt staff was getting worn down. The Resident added, Night shift has left me worse- in my piss and my feces. During an interview on 5/22/25 at 2:33 PM, the DON stated he was not sure of exact timeframe incontinence care was supposed to be carried out once staff was notified, but added, As soon as caregiver is aware. The DON further stated if a CNA was not available, a nurse could perform cares, . as long as they are not in the middle of med pass but even then, they are expected to coordinate this. When asked if one hour and forty-five minutes was an acceptable timeframe to wait, he replied, no. When asked if four hours was an acceptable timeframe to wait, the DON also replied, no. Review of the facility's policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE dated 12/2024, revealed . AM CARE (EVERY MORNING): Hands and face washed, Toilet & Peri Care. Oral Care. H.S. [bedtime] CARE (EVERY HS AT BEDTIME): Hands and face washed, Toilet & Peri Care. Oral Care. BEFORE MEAL CARE: Toileting and Peri care. PERIODIC CARE: Shower/Bath as scheduled. Provide a complete bed bath if scheduled shower cannot be given. ONGOING CARE: . Call lights: work as team to meet the goal of answering regular within 5-10 minutes. Provide peri care after voids . Promote resident choice and personal preference . Review of the facility's policy, Services to carry out ADL [Activity of Daily Living], dated 3/2025, revealed: . Residents who are unable to carry out activities of daily living (ADL) will receive necessary services, on a daily and on as needed basis, to maintain: Good nutrition, Grooming, Personal hygiene, Oral hygiene, Bathing, Showering, Toileting . Scheduled Turning and Repositioning Resident #12 Record review on 5/18-22/25 revealed Resident #12 was admitted to the facility with diagnoses including Epilepsy (recurrent seizure disorder), Hypertension (high blood pressure), Osteoarthritis (joint inflammation, arthritis), Hearing Loss, Hypomagnesemia (low magnesium levels), Dementia (progressive cognitive decline), and Pneumonitis due to inhalation of food and vomit (lung inflammation, aspiration). Resident has expressive aphasia (language disorder) and due to being hard of hearing Resident #12 is non-interviewable. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's MDS quarterly assessment, dated 1/20/25, revealed resident #12 is confined to bed and had limited range of motion. Review of Resident #12's most recent MDS quarterly assessment, dated 4/22/25, revealed Resident #12 was at risk for pressure ulcers and had significant cognitive impartment. Further review revealed the Resident was fully dependent on staff for rolling left and right, moving form sitting to lying flat and vice versa. Review of Resident #12's Baseline Care Plan, dated 2/12/25, revealed: . the resident is at high risk for pressure injury and falls, with specific precautions including frequent monitoring, notifying nurses of side-effects, and using pillows to reposition every two hours. The resident requires the assistance of 1-2 people to achieve 100% of the effort for repositioning every two hours to prevent pressure injuries . Review of Resident #12's bedside schedule, dated 1/18/23, outlined a turning schedule with repositioning as follows: 12:00 AM on left, 2:00 AM on back, 4:00 AM on right, 6:00 AM on left, 8:00 AM on back, 10:00 AM on right, 12:00 PM on left, 2:00 PM on back, 4:00 PM on right, 6:00 PM on left, 8:00 PM on back, and 10:00 PM on right. The schedule involved repositioning every 2 hours, alternating between left, back, and right positions, and could be found posted inside the closet doors of the resident's wardrobe. A continuous observation on 5/20/25, from 9:50 AM to 4:00 PM, revealed that Resident #12 was on his/her back, slumped to the left in bed with the head elevated, remaining in this position throughout the surveyor's observation, despite different staff entering to provide care and change linens. During an interview on 5/18/25 at 1:33 PM, Resident's #12 Representative stated that, [Resident #12] cannot reposition by themselves . I will come in there to visit every other day, and [his/her] toes will be squished all the way at the bottom of the bed with [Resident #12] in the same exact position. Staff only gets [Resident #12] out of bed and onto the chair when I ask, but I don't ask much these days because the facility is chronically understaffed .It's frustrating. Resident #51 Record review on 5/18-22/25 revealed Resident #51 was admitted to the facility with diagnoses including atrial fibrillation (an irregular heart rhythm), dementia, and hemiplegia. Review of Resident #51's MDS quarterly assessment, dated 1/10/25, revealed the Resident was fully dependent on staff for all self-care activities and transfer to and from bed. Further review revealed the Resident was at risk of pressure ulcers but did not have any pressure injuries at the time of assessment. Review of Resident #51's MDS quarterly assessment, dated 4/8/25, revealed the Resident was fully dependent on staff for all self-care activities and transfer to and from bed. Further review revealed the Resident was at risk of pressure ulcers but did not have any pressure injuries at the time of assessment. Review of Resident #51's Resident Daily Care Plan (RDCP), dated 2/21/25, revealed: Reposition me every 2 hours. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's Care Plan Report, initiated 1/24/25, revealed: .help me reposition at least every 1-2 hours while I'm in bed. A continuous observation on 5/19/25 from 9:00 AM to 12:00 PM, revealed Resident #51 was positioned on his/her back with a slight left-sided tilt. During this time, Resident #51 remained in the same position without any repositioning interventions for a total of three hours. An observation on 5/20/25 at 10:34 AM, revealed Resident #51's left hip had an oval shaped, 1.5-inch x 1 inch, bright-red wound with a shiny appearance. Review of Resident #51's Turns and Repositions, dated 5/19/25, revealed the resident was repositioned two times, at 2:01 PM and at 8:35 PM. During an interview on 5/20/25 at 2:31 PM, when asked about the repositioning log indicating only two repositioning interventions on 5/19/25 for Resident #51, LN #6 stated, From the charting that is correct. It's not realistic to expect the residents to be turned every two hours when you only have one nurse and one CNA working . It's an organization problem. Resident #492 Resident #492 was admitted to the facility with diagnoses of depression (mood disorder causing persistent feelings of sadness, loss of interest in activities, and impaired daily functioning, impacting emotional and physical health), bipolar disorder (mental health condition characterized by alternating episodes of emotional highs and lows, significantly affecting mood, energy, and daily functioning), and atrial fibrillation. Review of Resident #492's MDS admission assessment, dated 5/8/25, revealed the Resident had upper and lower extremity impairments and was fully dependent on staff for transfers to and from the, as well as requiring substantial/maximal assistance with mobility rolling right and left. Further review revealed the Resident was at risk of pressure ulcers. Review of Resident #492's Care Plan Report, initiated 5/2/25, revealed: Has the potential for pressure ulcer development r/t [related to] Generalized body weakness and impaired mobility . Out of bed unless contraindicated . Needs monitoring/reminding/assistance to turn/reposition. A continuous observation on 5/18/25 from 8:20 AM to 12:00 PM, revealed Resident #492 remained positioned supine (lying face up) in bed, without any staff entering the room to reposition the resident for a total of 3 hours and 40 minutes. Review of Resident #492's Turns and Repositions log, dated 5/18/25, revealed the resident was turned or repositioned two times, at 1:06 PM and 3:30 PM. Review of Resident #492's Daily Skilled Note, dated 5/12/25 at 6:15 PM, revealed: INTEGUMENTARY .has a small area on [his/her] coccyx acquired at the hospital previous admission . During an interview on 5/22/25 at 3:25 PM, when asked about the facility's policy for turning and repositioning of residents with impaired mobility, the Assistant Director of Nursing (ADON) stated, We expect the staff to turn every two hours and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Lippincott Nursing Procedures, Pressure Injury Prevention, published in 2023, revealed: . Turn and reposition the patient regularly and frequently . Review of the facility policy PEC/PTCC [Polaris Extended Care/Polaris Transitional Care Center] Anchorage Long Term Care STANDARDS OF CARE, last revised 12/2024, revealed: . ONGOING CARE . Turning/reposition q [every] 2 hours for residents with dependent mobility . Review of the facility's policy Adequate Staffing, dated 3/2025, revealed: . 2. The facility maintains adequate staff on each shift to assure that the resident's needs are met . Review of the facility's policy, Patient Rights, undated, revealed: . Receive adequate and appropriate care. To be free from mental . abuse . Reasonable accommodation of one's needs and preferences . Right to Dignity, Respect, and Freedom. To be treated with consideration, respect, and dignity. To be free from mental . abuse. Reasonable accommodation of one's needs and preferences. .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review, interview, and observation, the facility failed to ensure that licensed nursing staff had appropriate competencies, and skill sets necessary to care for resident's needs for 3 residents (#'s 49, 51, and 77), out of 21 sampled residents. Specifically, nursing staff failed to ensure: 1) Medication parameters were met before administration of medications for Resident #49; 2) Approved vital sign equipment was used for resident care in the Nenana cottage; 3) Resident #51's gastric residual volume was checked prior to initiating enteral nutrition; 4) Resident #51's head-of-bed remained elevated to an angle of 30 degrees or higher during active feeding; 5) A physician's order for flushing Resident #51's feeding tube before and after medication administration was followed; 6) Sterility was maintained during tracheostomy care for Resident #51; and 7) Non-contaminated enteral tubing was used for Resident #77's enteral nutrition. These failed practices represented significant deviations from professional standards of nursing practice, as outlined in facility policies and nationally recognized references, and placed the residents at risk for aspiration, infection, and/or medication error. Additionally, this failed practice caused an adverse outcome of low blood pressure for Resident #49. Findings: Resident #49 Record review on 5/18-22/25 revealed Resident #49 was admitted to the facility with diagnoses that included hypertrophic cardiomyopathy (thickening of the heart muscle), vascular dementia (a decline in cognitive functioning due to reduced blood flow to the brain), and hemiplegia following cerebral infarction affecting the left non-dominant side (paralysis on one side of the body due to a stroke). Review of Resident #49's Minimum Data Set (MDS - a federally required assessment) revealed Resident's speech was clear and usually makes herself understood. Further review revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12 (scores of 8 - 13 indicate moderate impairment). An observation on [DATE] at 8:24 AM, revealed Licensed Nurse (LN) #6 prepared the following medications, whole in applesauce, for Resident #49: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Acetaminophen (Tylenol - pain reliever) Oral Tablet 500 mg - 2 tablets - Carvedilol (medication used to treat high blood pressure and heart failure by lowering heart rate and reducing the heart's workload) Oral Tablet 3.125 mg - 1 tablet - Eliquis (medication used to thin the blood) Oral Tablet 5 mg - 1 tablet - Oyster Calcium Oral Tablet 500 mg - 1 tablet - Vitamin D3 Oral Tablet 25 mcg - 1 tablet Review of Resident #49's Physician Orders revealed: Carvedilol Oral Tablet 3.125 MG (Carvedilol) . Directions . Give 1 tablet by mouth two times a day for Hypertension[.] Hold if SBP [systolic blood pressure] is less than 110, Hold if Pulse is less than 60. This medication order was started on [DATE]. Review of Resident #49's Clinical Weights and Vitals documentation for [DATE] at 8:31 AM, revealed Resident #49's blood pressure (BP) was 109/63 and pulse was 82. Further observation on [DATE] at 8:24 AM, revealed LN #6 mixed all the whole tablets in a small clear cup of applesauce. When asked if LN #6 planned to administer the Carvedilol, LN #6 responded yes, stating Resident #49's heart rate was 82. When shown the ordered parameter to hold the medication if the Resident's systolic blood pressure (SBP) was less than 110, LN #6 agreed to hold the medication, then scooped out a medium sized, white round tablet from the applesauce, claimed it was the Carvedilol tablet, and discarded it in the Resident's trash bin. He/she then administered the remaining medications to Resident #49. The surveyor then retrieved the discarded tablet from the Resident's trash bin, and noted it was 2-3 times larger than the Carvedilol tablet and did not resemble the visual characteristics of Carvedilol. An observation on [DATE] at 12:45 PM, LN #6 obtained Resident #49's BP using a small, pink, automated BP device, used on the wrist. LN #6 stated the device was his/her own personal equipment, which he/she brought from home. Resident #49's BP was 93/50. An observation of the Resident revealed he/she was rousable only to painful stimuli. During an interview on [DATE] at 3:25 PM, when asked if it was appropriate for LN #6 to discard a medication that he/she could not determine was the correct medication, the Assistant Director of Nursing (ADON) replied, No, and if it was me, I would have thrown them all out and started again. An observation on [DATE] at 1:10 PM, revealed Resident #49's BP was taken using the facility's provided vital signs machine, and measured 89/48. With the DON present, a manual BP reading was performed which resulted in a BP reading of 105/44. The DON instructed LN #6 to notify the Resident's physician of the continued low BP readings. During an interview on [DATE] at 1:15 PM, when asked if nurses were allowed to bring their personal blood pressure machines to be used on the residents, the Director of Nursing (DON) stated, No, they should be using the facility provided equipment. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional Medication Errors Review of Resident #49's Electronic Medication Administration Record (EMAR), dated [DATE] - [DATE], revealed two medication administrations errors based on the ordered parameters for Carvedilol: [DATE] - BP 89/54, Pulse 56 - Documented as given by LN #7. [DATE] - BP 107/63, Pulse 71 - Documented as given by LN #6. Review of Resident #49's EMAR, dated [DATE] - [DATE], revealed two medication administrations errors based on the ordered parameters for Carvedilol: [DATE] - BP 96/69, Pulse 71 - Documented as given by LN #6. [DATE] - BP 101/79, Pulse 70 - Documented as given by LN #8. Resident #51 Gastric Residual Volume Resident #51 was admitted to the facility with diagnoses including atrial fibrillation (an irregular heart rhythm), dementia (a decline in cognitive functioning affecting daily living), and hemiplegia (paralysis on one side of the body). An observation on [DATE] at 10:34 AM, revealed LN #6 attached enteral tubing to Resident #51's feeding tube and began to administer a scheduled nutritional meal. During an interview on [DATE] at 10:35 AM, LN #6 was asked if gastric residuals had been checked prior to initiating the enteral nutrition. LN #6 replied, No, I should have done that. Review of the facility policy Gastronomy Tube Care and Management, dated 03/2025, revealed: .Aspiration of stomach contents: The physician may recommend that you draw back on the syringe to check for residual feeding contents in the stomach . Follow physician orders. Review of Resident #51's physician orders, dated [DATE], revealed: .Check residuals and hold feeding if residuals above 300 cc. Head of Bed Elevation An observation on [DATE] at 10:21 AM, revealed LN #6 and Certified Nurse Assistant (CNA) #3 entered Resident #51's room to clean and reposition the resident. LN #6 positioned the Resident's bed in a flat-lying position while an enteral nutrition meal was actively infusing. When asked if the Resident's bed should be flat during an enteral meal, LN #6 stated, I needed him/her flat so that we could turn [him/her]. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Position the patient with the head of the bed elevated to at least 30 degrees, or upright in a chair, to prevent aspiration . Medication Administration Observation on [DATE] at 12:44 PM, revealed LN #6 administered medication through Resident #51's enteral tube without performing a pre-flush with 50 cc of water and used only 30 cc of water for the post-flush. Review of the facility policy Gastronomy Tube Care and Management, dated 03/2025, revealed: .Flush the feeding tube and adapter, if applicable per physician's order before and after giving any medication by tube. Review of a physician order dated [DATE] revealed: Flush tube with 50 cc of water pre and post medication administration via tube. Review of the facility provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings .Flush the enteral tube . as ordered . Resident #51 Tracheostomy Concerns: An observation on [DATE] at 1:10 PM, revealed LN #6 performed tracheostomy care for Resident #51. He/she placed sterile supplies directly onto a non-sanitized bedside table. Then, he/she began cleaning the Resident's tracheostomy site which caused his/her sterile gloves to become visibly contaminated with secretions and debris. LN #6 then proceeded to use the contaminated gloves to grasp sterile suction tubing which was to enter Resident #51's airway for suctioning. Review of the facility provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: .Tracheostomy Care . To prevent infection, all tracheostomy care should be performed using sterile technique . Resident #77 Record review on 5/18-22/25 revealed Resident #77 was admitted to the facility with diagnoses that included cerebral palsy (a group of disorders affecting movement and muscle tone), epilepsy (a neurological disorder marked by seizures), and developmental disorder of motor function (delays or impairments in coordinated movement). Enteral Tubing Contamination (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on [DATE] at 10:50 AM, revealed LN #6 entered Resident #77's room to administer scheduled enteral nutrition meal. There was enteral tubing already attached to the feeding pump, which was undated and hung uncapped from an IV pole at the Resident's bedside. This tubing contained enteral nutrition solution throughout the tubing. LN #6 proceeded to attach the uncapped tubing to the Resident's feeding tube, however the surveyor intervened before attachment and asked, Should the tube feeding be administered through that tubing since it was uncapped? LN #6 responded, It should have been capped, but since it wasn't I will use alcohol wipes to sanitize it, then begin the feed. He/she then attached enteral feeding to the Resident's feeding tube, after using an alcohol wipe on the enteral tubing port and began infusion of the enteral nutrition. During an interview on [DATE] at 1:50 PM, the facility's Infection Preventionist (IP) was asked whether the tubing would be safe to use if left uncapped. The IP stated, It would not be safe if it has been uncapped and not knowing what it has been exposed to, which would require a change of new tubing-dated, capped-then the standard is that it would be good for 24 hours. Nursing Competency Training During an interview on [DATE] at 7:49 AM, when asked about the performance LN #6's competency, the Director of Nursing (DON) stated he has had one nurse bring forward concerns that LN #6 did not know how to use the kangaroo pump (enteral feeding pump used in the facility). When asked what he did with that information, the DON stated he talked with LN #6 about the pump. When asked if that training or assessment was documented, the DON stated, no, it was just a verbal discussion. When asked if he had any concerns with LN #6's competency as a nurse to deliver safe patient care, the DON stated he had no concerns with LN #6's safe practices. During an interview on [DATE] at 1:03 PM, the Director of Community Liaison stated that LN #6 was up to date and current with all training and competency requirements. Review of LN #6's training and competency records revealed he/she completed trainings in: 1) On-line training: - Change in Condition for Licensed Nurse, completed [DATE]; - Infection Control (Clinical Focus Including EBP [enhanced barrier precautions], completed [DATE]; - Infection Prevention and Control Basics, completed [DATE]; - Medication Basics (TO), completed [DATE]; - Side Effects of Common Medications, completed [DATE]; 2) During an interview on [DATE] at 2:00 PM, the Director of Nursing (DON) stated that LN #6 attended an in-service training on the kangaroo feeding pump used by the facility on [DATE]. 3) 2024 Regulatory Education & Skills Fair, completed [DATE], that included: (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Effective Communication (Language of Love); - Trauma Informed Care; - Substance Use Disorder: - Resident Rights; - Staff Development and Tuition Reimbursement Overview; - Emergency Preparedness; - O2 (oxygen); - Fire Safety; - Behavioral Health; - Cultural Competency; - QAPI (Quality Assurance and Performance Improvement); - Abuse, Neglect, and Mandatory Reporting; - Infection Control and Hand Hygiene Check off; - IDDSI (International Dysphagia Diet Standardisation Initiative - therapeutic diets); - Paint Management; and - Skin/Wound Care. 4) Skills Competency Check Off, completed [DATE], that included: - [NAME] (a leading international medical publisher that provides standards of practice for healthcare) Procedure and Check off; - Blood glucose monitoring (ACCU-CK [accucheck] and Continuous); - Bladder Ultrasonography and indwelling catheter (Foley) care and Management; and - Blood collection. 5) Job Specific Orientation Checklist - PCN [Primary Care Nurse], completed [DATE]; 6) 2024 Skills Fair, completed [DATE], that included Annual competency review and check off per facility protocol and [NAME]: (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hand hygiene and Enhanced barrier precautions; - PlakVac Suction Toothbrush; - Purewick External Female Catheter; - Safe Patient Handling; - IDDSI; - Blood Glucose Checks (Accu-check & Continuous Glucose Monitors); - CAUTI/UTI/Bladder Scanner; - Respiratory care (yaunker suctioning . Trach Care/Suctioning); - Enteral nutrition & feeding Pump; and - IV Access/Meds (Alaris Pump & venipuncture). Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Don't use formula if its integrity is compromised or if it's expired. Instead, obtain a new container of the formula . .

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	025036	A. Building B. Wing	05/22/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. . Based on record review and interview, the facility failed to ensure drug regimen review irregularities documented by the pharmacist had a documented review and response from the attending physician and/or medical director for 1 resident (#31), out of 5 residents reviewed for medication regimen reviews. This failed practice placed the resident at risk for adverse outcomes related to the resident's medication therapy, which had the potential to prevent the resident from achieving their highest practicable level of physical, mental and psychosocial well-being. Findings: Resident #31 Record review on 5/18-22/25 revealed Resident #31 was admitted to the facility with diagnoses that included anxiety disorder, delusional disorder (a mental health condition characterized by persistent delusions), and bipolar disorder (mental health condition characterized by alternating episodes of emotional highs and lows, significantly affecting mood, energy, and daily functioning). Review of Resident #31's medication order, start date of 3/1/25, revealed: . QUEtipine Fumarate [Seroquel - an antipsychotic medication] Oral Tablet 25 MG [milligrams] . Give 1 tablet by mouth two times a day for bipolar mood disorder . Review of an Interdisciplinary Team (IDT) note, dated 4/21/25, revealed: . IDT meeting regarding resident's seroquel order. MD [Medical Director] to evaluate resident . Review of a Pharmacy Review Note, dated 4/23/25, revealed: . During the April 2025 monthly PsychoPharmacology meeting, the Antipsychotic Medications and Diagnosis were discussed for this resident [Resident #31] and looking at the history of this individual will change the diagnosis to Bipolar for the Seroquel 25mg BID [twice a day] from Anxiety/Delusions . This note was signed by the pharmacist. By the end of the survey, the facility was unable to produce any provider notes regarding the response to Resident #31's 4/23/25 psychopharmacology meeting's recommendation to change the diagnosis on the Seroquel order to the bipolar diagnosis. During an interview on 5/21/25 at 10:20 AM, the MD stated he did not document his review and action taken of Resident #31's medication diagnosis change to the bipolar diagnosis. He stated, I just changed the order. Review of the facility assessment 2025 Polaris Extended Care Facility Assessment, revealed: . Resident support/care needs: Our facility cares for many different residents with various types of care needs. The list below identifies the most common or frequently provided services in these general categories . Mental Health and Behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety . other psychiatric diagnoses . (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure medication error rates are not 5 percent or greater. . Based on record review, observation, and interview, the facility failed to ensure their medication error rate was below 5% for 2 sampled residents (#4 and #36) and 2 unsampled residents (#49 and #55), out of 5 residents observed for medication administration. The facility's overall medication error rate was 23.08%. This failed practice placed the residents at risk for adverse medication outcomes. Findings: Resident #4 Record review on 5/18-22/25 revealed Resident #4 was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), rheumatoid arthritis (autoimmune disorder that affects the joints), and depression. An observation on 5/19/25 from 10:20 AM to 11:24 AM, revealed Licensed Nurse (LN) #2 prepared and administered medications for Resident #4. LN #2 administered the medications through the resident's G-tube (gastrotomy tube: a tube inserted through the belly that gives direct access to the stomach). Review of the physician orders for the medications LN #2 administered revealed two medications were to be administered by mouth: - DULoxetine [an antidepressant that can also treat pain] .Give 1 capsule by mouth . Administer PO [by mouth] with apple sauce . Order Date: 03/28/2025; and -Ferrous Sulfate [iron supplement] .Give 1 tablet by mouth .Order Date: 05/01/2025. During an interview on 5/19/25 at 10:30 AM, LN #2 stated the medications were written as a route of oral but explained, the resident only preferred to take [his/her] medications by the tube because [he/she] can't swallow very well. The only time I have seen [him/her] take medications by mouth are TUMS [brand name of antacids]. During an interview on 5/19/25 at 4:02 PM, Resident #4 stated he/she took all his/her prescribed medications via G-tube. He/she further stated, It's hard for me to be able to swallow. During a follow-up interview on 5/19/25 at 4:13 PM, LN #2 stated the eMAR (electronic medication administration record) was utilized during medication administration and LNs were to use the 5 rights. The 5 rights of medication administration included right drug, right patient, right dose, right route, and right time. He/she further added if there was a discrepancy or an issue with an order, the supervisor should be notified, who would then notify the provider and/or the pharmacy. When asked if LNs on the floor could contact the provider to verify orders prior to administration, he/she stated, yes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/25 at 2:30 PM, the Director of Nursing (DON) was asked if LNs were able to administer Residents' medications via a different route than what was ordered, he stated LNs were to follow the orders as its prescribed, and if the order needed to be changed, LNs are expected to call the doctor to make that decision before LNs administer. Resident #36 Record review on 5/18-22/25 revealed Resident #36 was admitted to the facility with diagnoses that included unspecified dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (paralysis on one side of the body due to a stroke), and type 2 diabetes (insulin dependent diabetes). Review of Resident #36's insulin orders revealed Lantus Solostar Subcutaneous [placing the needle between the skin and muscle, injecting medication into the fatty layer between the muscle and skin] Solution Pen-injector 100 unit/mL [milliliters] - Inject 14 unit[s] subcutaneously one time a day Diabetes Mellitus. This order was started on 3/19/25. An observation on 5/19/25 at 9:23 AM, revealed LN #16 prepared to administer Resident #36's Lantus insulin. He/she applied an insulin needle (a BD AutoShield Duo 30-gauge needle, 5mm long) to the insulin pen, primed the needle by injecting some insulin from the pen into the needle (to eliminate any air within the needle) and then turned the dial to14 units on the pen. LN #16 then entered Resident #36's room, checked Resident #36's blood sugar reading on his/her dexcom sensor (a sensor device worn to continuously monitor blood sugar which displayed the readings on a small electronic device close by), which was 268, and then approached Resident #36. LN #16 introduced himself/herself, told the Resident what he/she was doing, then swabbed Resident #36's left deltoid muscle (shoulder muscle) with an alcohol pad. LN #16 injected the Lantus insulin at a 90-degree angle into the area of the deltoid muscle, counted to 10 while the needle was still in place (to ensure all insulin was administered), then removed the needle. Further observation of Resident #36's shoulder area at the deltoid muscle, revealed no adipose, or fatty, tissue layer that would allow for safe injection of medication between the skin and deltoid muscle. During an interview on 5/19/25 at 10:21 AM, when asked to define a subcutaneous injection, LN #16 stated the injection would be between the skin tissue and muscle. When asked about the observation of Resident #36's Lantus insulin injection, and it being administered in the observed method of the deltoid muscle area, LN #16 stated he/she would not agree with that observation of injection over the deltoid area and that being a pediatric nurse for years, knew how to administer a subcutaneous injection. During an interview on 5/19/25 at 2:33 PM, when asked where a subcutaneous injection should be administered, the Nursing Supervisor #1 showed the back of his/her arm and stated, in nursing school we are instructed to use the back of the arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Subcutaneous Injection: Subcutaneous injection delivers a drug into the adipose (fatty) tissue beneath the skin . When compared with intramuscular injection, subcutaneous injection provides slower, more sustained drug delivery . The most common sites are the outer aspect of the upper arm [above the elbow and below the shoulder], anterior [outer] thigh, loose tissue of the lower abdomen, upper hips, buttocks, and upper back . Review of the DB AutoShield Duo insulin pen needle guideline BD Autoshield Duo Safety Pen Needle with Dual Automatic Protective Shields, dated 2023, at https://go.bd.com/rs/565-YXD-236/images/EMBC%20ASD%20How-to-Use%20Leaflet_23-023_HI.pdf, revealed: How to inject insulin with AutoShield Duo 5mm Safety Pen Needle . Step 7: Choose the injection site and disinfect the skin. Rotate injections between and within sites [body diagram on step seven showed injection sites on back of arms, outer aspects of hips, outer aspects of thighs, and abdomen] . Step 8 Inject into the skin at a 90-degree angle . Resident #49 Record review on 5/18-22/25 revealed Resident #49 was admitted to the facility with diagnoses that included hypertrophic cardiomyopathy (thickening of the heart muscle), vascular dementia (a decline in cognitive functioning due to reduced blood flow to the brain), and hemiplegia following cerebral infarction affecting the left non-dominant side (paralysis on one side of the body due to a stroke). An observation on 5/20/25 at 8:24 AM, revealed LN #6 prepared the following medications, whole in applesauce, for Resident #49: - Acetaminophen (Tylenol - pain reliever) Oral Tablet 500 mg - 2 tablets - Carvedilol (medication used to treat high blood pressure and heart failure by lowering heart rate and reducing the heart's workload) Oral Tablet 3.125 mg - 1 tablet - Eliquis (medication used to thin the blood) Oral Tablet 5 mg - 1 tablet - Oyster Calcium Oral Tablet 500 mg - 1 tablet - Vitamin D3 Oral Tablet 25 mcg - 1 tablet Review of Resident #49's Physician Orders revealed: Carvedilol Oral Tablet 3.125 MG (Carvedilol) . Directions . Give 1 tablet by mouth two times a day for Hypertension[.] Hold if SBP [systolic blood pressure] is less than 110, Hold if Pulse is less than 60. This medication order was started on 2/25/25. Review of Resident #49's Clinical Weights and Vitals documentation for 5/20/25 at 8:31 AM, revealed Resident #49's blood pressure (BP) was 109/63 and pulse was 82. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further observation on 5/20/25 at 8:24 AM, revealed LN #6 mixed all the whole tablets in a small clear cup of applesauce. When asked if LN #6 planned to administer the Carvedilol, LN #6 responded yes, stating Resident #49's heart rate was 82. When shown the ordered parameter to hold the medication if the Resident's systolic blood pressure (SBP) was less than 110, LN #6 agreed to hold the medication, then scooped out a medium sized, white round tablet from the applesauce, claimed it was the Carvedilol tablet, and discarded it in the Resident's trash bin. He/she then administered the remaining medications to Resident #49. The surveyor then retrieved the discarded tablet from the Resident's trash bin, and noted it was 2-3 times larger than the Carvedilol tablet and did not resemble the visual characteristics of Carvedilol. At 12:45 PM, a blood pressure reading showed Resident #49's blood pressure (BP) was 93/50, and the Resident was observed to be arousable only to painful stimuli. An observation on 5/20/25 at 1:10 PM, revealed Resident #49's BP was taken using the facility's provided vital signs machine, and measured 89/48. With the DON present, a manual BP reading was performed which resulted in a BP reading of 105/44. The DON instructed LN #6 to notify the Resident's physician of the continued low BP readings. During an interview on 5/22/25 at 3:25 PM, when asked if it was appropriate for LN #6 to discard a medication that he/she could not determine was the correct medication, the Assistant Director of Nursing (ADON) replied, No, and if it was me, I would have thrown them all out and started again. Resident #55 Resident #55 was admitted to the facility with diagnoses of gastritis with bleeding (inflammation of the stomach lining accompanied by bleeding), gastrostomy status (presence of a feeding tube), and long-term use of aspirin (a medication used to reduce inflammation and prevent blood clots). Review of Resident #55's Physician Orders revealed: - Aspirin Oral Tablet Chewable 81MG (Aspirin) Give 1 tablet by mouth one time a day for CAD [coronary artery disease]. This medication was started on 2/27/25; and - Calcium Carbonate Tablet Chewable 500 MG Give 1 tablet by mouth one time a day for gastric distress. This medication was started on 2/27/25. An observation on 5/20/25 at 8:19 AM, revealed LN #6 administered the chewable medications to Resident #55, without instructing him/her to chew the medications. Resident #55 swallowed the medications whole. An interview on 5/21/25 at 5:37 PM, the DON was asked how nurses should instruct residents to take chewable medications. The DON stated, They would instruct the resident to chew them. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, published in 2023, revealed: . To promote a culture of safety and to prevent medication errors, nurses must . adhere to the five rights of medication administration: . the right medication . administer the medication by the right route . Review of the facility's policy Medication Administration General Guidelines, dated 3/2025, revealed: .Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record . Medications are administered in accordance with .orders of the prescribed .If necessary, the nurse contacts the prescriber for clarification . .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. . Based on record review, observation and interview, the facility failed to ensure 2 sampled residents (#36 and #47), out of 21 sampled residents, and 2 unsampled residents (#49 and #56), were free from significant medication errors. These failed practices caused an adverse reaction of low blood pressure for resident #49 and placed these residents at risk of possible serious complications and hospitalization. Findings: Resident #36 Record review on 5/18-22/25 revealed Resident #36 was admitted to the facility with diagnoses that included unspecified dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (paralysis on one side of the body due to a stroke), and type 2 diabetes (insulin dependent diabetes). Review of Resident #36's insulin orders revealed: Lantus [long-acting insulin] Solostar Subcutaneous [placing the needle between the skin and muscle, injecting medication into the fatty layer between the muscle and skin] Solution Pen-injector 100 unit/mL [milliliters] - Inject 14 unit[s] subcutaneously one time a day Diabetes Mellitus. This order was started on 3/19/25. An observation on 5/19/25 at 9:23 AM, revealed Licensed Nurse (LN) #16 prepared to administer Resident #36's Lantus insulin. He/she applied an insulin needle (a BD AutoShield Duo 30-gauge needle, 5mm long) to the insulin pen, primed the needle by injecting some insulin from the pen into the needle (to eliminate any air within the needle) and then turned the dial to14 units on the pen. LN #16 then entered Resident #36's room, checked Resident #36's blood sugar reading on his/her dexcom sensor (a sensor device worn to continuously monitor blood sugar which displayed the readings on a small electronic device close by), which was 268, and then approached Resident #36. LN #16 introduced himself/herself, told the Resident what he/she was doing, then swabbed Resident #36's left deltoid muscle (shoulder muscle) with an alcohol pad. LN #16 injected the Lantus insulin at a 90-degree angle into the area of the deltoid muscle, counted to 10 while the needle was still in place (to ensure all insulin was administered), then removed the needle. Further observation of Resident #36's shoulder area at the deltoid muscle, revealed no adipose, or fatty, tissue layer that would allow for safe injection of medication between the skin and deltoid muscle. During an interview on 5/19/25 at 10:21 AM, when asked to define a subcutaneous injection, LN #16 stated the injection would be between the skin tissue and muscle. When asked about the observation of Resident #36's Lantus insulin injection, and it being administered in the observed method of the deltoid muscle area, LN #16 stated he/she would not agree with that observation of injection over the deltoid area and that being a pediatric nurse for years, knew how to administer a subcutaneous injection. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 2:33 PM, when asked where a subcutaneous injection should be administered, the Nursing Supervisor #1 showed the back of his/her arm and stated, in nursing school we are instructed to use the back of the arm. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Subcutaneous Injection: Subcutaneous injection delivers a drug into the adipose (fatty) tissue beneath the skin . When compared with intramuscular injection, subcutaneous injection provides slower, more sustained drug delivery . The most common sites are the outer aspect of the upper arm [above the elbow and below the shoulder], anterior [outer] thigh, loose tissue of the lower abdomen, upper hips, buttocks, and upper back . Review of the DB AutoShield Duo insulin pen needle guideline BD Autoshield Duo Safety Pen Needle with Dual Automatic Protective Shields, dated 2023, at https://go.bd.com/rs/565-YXD-236/images/EMBC%20ASD%20How-to-Use%20Leaflet_23-023_HI.pdf, revealed: . How to inject insulin with AutoShield Duo 5mm Safety Pen Needle . Step 7: Choose the injection site and disinfect the skin. Rotate injections between and within sites [body diagram on step seven showed injection sites on back of arms, outer aspects of hips, outer aspects of thighs, and abdomen] . Step 8 Inject into the skin at a 90-degree angle . Resident #47 Record review on 5/18-22/25 revealed Resident #47 was admitted to the facility with diagnoses that included type 1 diabetes mellitus (insulin-dependent diabetes), chronic kidney disease stage IIIb (moderate to severe kidney function loss) and vascular insufficiency (impaired blood flow). During an interview on 5/19/25 at 8:33 AM, Resident #47 stated he/she had issues with not receiving his/her medication on 3/25/25. Resident #47 further stated his/her medication, Sodium Bicarbonate, was ordered three times per day and sometimes would go days without receiving the medication due to staff not being able to locate it in the medication administration cart. During an observation and concurrent interview on 5/20/25 at 10:30 AM, LN #1 opened the medication administration cart in the Deshka cottage and removed a large white bottle with a pharmacy label for Resident #47's Sodium Bicarbonate medication. The pharmacy label documented that the medication was: . filled 2/25/25 and expires 8/24/25 . LN #1 further stated he/she was unsure why medication was not available on 3/25/25. Review of Resident #47's Medication Administration Record (MAR) for March 2025, revealed: . Sodium Bicarbonate oral tablet 650 mg . Give 1 tablet by mouth three times a day for Metabolic Acidosis Associated with CKD-Order Date-11/17/2022. Further review revealed the following doses of Sodium Bicarbonate were not given: 3/19/25 at 1:00 PM; 3/23/25 at 9:00PM; 3/24/25 at 9:00 PM; 3/25/25 at 9:00 PM; 3/26/25 at 9:00 AM; 1:00 PM; and 9:00 PM. Further review revealed all missed doses were documented as 2=Hold/See Nurse Notes or 7=Other/See Nurse Notes. Review of Resident #47's Provider Progress Note, dated 3/19/25 at 11:48 AM, revealed: . CKD stage IIIB . NaBicarb [Sodium Bicarbonate] 650mg TID . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #47's eMAR [electronic MAR] Medication Administration Note, dated 3/19/25 at 12:37 PM, revealed: . Morning dose was given at 1240 skipping noon dose. Review of Resident #47's eMAR Medication Administration Note, dated 3/23/25 at 9:27 PM, revealed: Sodium Bicarb missing. Review of Resident #47's eMAR Medication Administration Note, dated 3/25/25 at 8:51 AM, revealed: not available. Review of Resident #47's eMAR Medication Administration Note, dated 3/26/25 at 9:02 AM, revealed: not available. Review of Resident #47's eMAR Medication Administration Note, dated 3/26/25 at 9:39 PM, revealed: not in stock. Review of the National Kidney Foundation, dated 2025, retrieved from: https://www.kidney.org/kidney-failure-risk-factor-serum-bicarbonate, revealed . sodium bicarbonate. can help keep kidney disease from getting worse . Resident #49 Record review on 5/18-22/25 revealed Resident #49 was admitted to the facility with diagnoses that included hypertrophic cardiomyopathy (thickening of the heart muscle), vascular dementia (a decline in cognitive functioning due to reduced blood flow to the brain), and hemiplegia following cerebral infarction affecting the left non-dominant side. An observation on 5/20/25 at 8:24 AM, revealed LN #6 prepared the following medications, whole in applesauce, for Resident #49: - Acetaminophen (Tylenol - pain reliever) Oral Tablet 500 mg - 2 tablets - Carvedilol (medication used to treat high blood pressure and heart failure by lowering heart rate and reducing the heart's workload) Oral Tablet 3.125 mg - 1 tablet - Eliquis (medication used to thin the blood) Oral Tablet 5 mg - 1 tablet - Oyster Calcium Oral Tablet 500 mg - 1 tablet - Vitamin D3 Oral Tablet 25 mcg - 1 tablet Review of Resident #49's Physician Orders revealed: Carvedilol Oral Tablet 3.125 MG (Carvedilol) . Directions . Give 1 tablet by mouth two times a day for Hypertension[.] Hold if SBP [systolic blood pressure] is less than 110, Hold if Pulse is less than 60. This medication order was started on 2/25/25. Review of Resident #49's Clinical Weights and Vitals documentation for 5/20/25 at 8:31 AM, revealed Resident #49's blood pressure (BP) was 109/63 and pulse was 82. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation on 5/20/25 at 8:24 AM, revealed LN #6 mixed all the whole tablets in a small clear cup of applesauce. When asked if LN #6 planned to administer the Carvedilol, LN #6 responded yes, stating Resident #49's heart rate was 82. When shown the ordered parameter to hold the medication if the resident's systolic blood pressure (SBP) was less than 110, LN #6 agreed to hold the medication, then scooped out a medium sized, white round tablet from the applesauce, claimed it was the Carvedilol tablet, and discarded it in the Resident's trash bin. He/she then administered the remaining medications to Resident #49. The surveyor then retrieved the discarded tablet from the resident's trash bin, and noted it was 2-3 times larger than the Carvedilol tablet and did not resemble the visual characteristics of Carvedilol. At 12:45 PM, a blood pressure reading showed Resident #49's blood pressure (BP) was 93/50, and the resident was observed to be rousable only to painful stimuli. An observation on 5/20/25 at 1:10 PM, revealed Resident #49's BP was taken using the facility's provided vital signs machine, and measured 89/48. With the DON present, a manual BP reading was performed which resulted in a BP reading of 105/44. The DON instructed LN #6 to notify the Resident's physician of the continued low BP readings. During an interview on 5/22/25 at 3:25 PM, when asked if it was appropriate for LN #6 to discard a medication that he/she could not determine was the correct medication, the Assistant Director of Nursing (ADON) replied, No, and if it was me, I would have thrown them all out and started again. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, published 2023, revealed: . To promote a culture of safety and to prevent medication errors, nurses must . adhere to the five rights of medication administration: .the right medication . Additional Medication Errors Record review of Resident #49's eMAR, dated 3/1/25-3/31/25, revealed two medication administrations occurred in error based on the ordered parameters for Carvedilol: 3/13/25 - BP 89/54, Pulse 56 - Documented as given by LN #7. 3/26/25 - BP 107/63, Pulse 71 - Documented as given by LN #6. Record review of Resident #49's EMAR, dated 4/1/2025-4/30/2025, revealed two medication administrations occurred in error based on the ordered parameters for Carvedilol: 4/6/25 - BP 96/69, Pulse 71 - Documented as given by LN #6. 4/20/25 - BP 101/79, Pulse 70 - Documented as given by LN #8. Resident #56 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 5/18-22/25 revealed Resident #56 was admitted to the facility with diagnoses that included absence epileptic syndrome, not intractable, without status epilepticus, other sequelae of cerebral infarction (stroke), hemiplegia following cerebral infarction, and long term (current) use of anticoagulants (blood-thinning medication). During an interview on 5/20/25 at 10:27 AM, Resident #56 stated he/she had epilepsy and missed several doses of Celotin (anti-seizure medication) medication. Resident #56 stated the facility ordered his/her medications and had run out multiple times. Resident #56 further stated, I cannot miss any doses as it is my lifeline. Resident #56 stated he/she reported the concern about the missed doses of Celotin but was not sure which member of staff was reported to. During an interview on 5/20/25 at 10:45 AM, LN #1 stated Resident #56's monthly medications were automatically filled by an out of state pharmacy contracted by the facility. LN #1 stated the medications were received and checked in by the nursing supervisors. LN #1 further stated if a medication was missing for administration, he/she would contact the nursing supervisor, and then the pharmacy would be notified. LN #1 stated that if the medication was needed right away, the facility would request the pharmacy to send a prescription to the local satellite pharmacy, so the patient could receive it that day. LN #1 further stated if a medication was ordered and not administered, then the resident, the resident's POA (Power of Attorney) and the provider must be notified. Review of Resident #56's Care Plan Report, dated 2/25/25, revealed: . Because I: History of . seizure disorder . Interventions/Tasks. I need my nurses to . give me my medications as ordered . notify MD [Medical Doctor] as needed . Review of Resident #56's Medication Administration Record (MAR), dated March 2025, revealed Resident #56 missed: Celotin 300mg capsule BID for Seizure Disorder on 3/20-25/25. All missed doses documented as 2=Hold/See Nurse Notes or 7=Other/See Nurse Notes. Review of Resident #56's eMAR Medication Administration Note, dated 3/20/25 at 5:50 AM, revealed: Medication not available. Review of Resident #56's eMAR Medication Administration Note, dated 3/20/25 at 1:28 PM, revealed: Med was ordered 3/19/2025 in the NOC [night] shift. Has not been delivered yet. Review of Resident #56's eMAR Medication Administration Note, dated 3/21/25 at 5:08 AM, revealed: unavailable, ordered from pharmacy. Review of Resident #56's eMAR Medication Administration Note, dated 3/21/25 at 1:58 PM, revealed: unavailable. Review of Resident #56's Progress Note, dated 3/22/25 at 5:18 AM, revealed: RX [Celotin] unavailable, pharmacy contacted 3/20/25. Review of Resident #56's Progress Note, dated 3/22/25 at 6:10 AM, revealed: Resident POA called and upset that [his/her] [sibling] was not getting [his/her] seizure medication and why it has not been delivered . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #56's Progress Note, dated 3/22/25 at 10:00 AM, revealed: Dilantin 100mg TID initiated until Celotin is available. Review of Resident #56's Provider Progress Note, dated 3/24/25 at 5:03 PM, revealed: . Chief Complaint: Nursing reports missing Celotin, pt [patient] started on Dilantin .Seizure. Celotin 300mg BID . Review of Resident #56's Progress Note, dated 3/26/25, revealed Celotin was restarted. Review of Resident #56's MAR, dated May 2025, revealed missed administrations of the following ordered doses for Celotin 300 mg: 5/1/25 at 6:00 AM, 5/5/25 at 6:00 AM, 5/7/25 at 2:00 PM, 5/8/25 at 6:00 AM, 5/10/25 at 6:00 AM, 5/11/25 at 6:00 AM, 5/14/25 at 2:00 PM and 5/17/25 at 6:00 AM. All missed doses were documented 2=Hold/See Nurse Notes. Review of Resident #56's Provider Progress Note, dated 5/1/25 at 9:53 AM, revealed . being seen today for f/u care . Seizure-Nonintractable absence epilepsy without status epilepsy-Methsuximide (Celotin) 300mg BID. Further review revealed there was no documentation noted regarding the unavailable Celotin medication. Review of Resident #56's eMAR Medication Administration Note, dated 5/5/25 at 5:05 AM, revealed Celotin 300mg capsule not available, reordered, given Ethosuximide. This was the only documentation noted for any of the missed administrations of Celotin on 5/25. Review of Resident #56's Order Summary Report, dated 5/20/25, revealed . Celotin Oral Capsule 300MG Give 1 capsule by mouth two times a day for Seizure Disorder. Order Date 10/1/22 Start Date 3/1/25 . Ethosuximide Oral Capsule 250 MG Give 1 capsule by mouth as needed for Absence Seizures related to ABSENCE EPILEPTIC SYNDROME, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS (G40.A09) Give if resident runs out of Celotin. order date 5/2/25 start date 5/3/25. During an interview on 5/22/25 at 1:50 PM, the Director of Nursing (DON) stated if a nurse was unable to locate an ordered medication, the nurse should check the emergency kit (ekit) for a dose. The nurse should contact the pharmacy for to the medication to be dispensed from the ekit. If the medication was not in the ekit, the pharmacy would send a prescription to the local satellite pharmacy to be dispensed right away. The DON further stated if a medication was omitted, the nurse should contact the physician, document in the medical record why the medication was not given, the steps taken to obtain the medication, the discussion held with the physician and if there was any harm to the resident. Review of the Epilepsy Foundation, dated 2024, retrieved from https://www.epilepsy.com/what-is-epilepsy/seizure-triggers/missed-medicines, revealed: . Missing doses of seizure medication is the most common cause of breakthrough seizures. Missed medicines can trigger seizures in people with both well-controlled and poorly controlled epilepsy. Missing doses of medicine can also lead to falls, injuries and other problems from seizures and changes in medicine levels . stopping seizure medication . suddenly, a person can have withdrawal symptoms. You could also have long seizures, cluster of seizures or status epilepticus, even if you've never had these problems before. If you're taking more than one seizure medicine, stopping one of the medicines could change the level or amount of another seizure medicine in your body. These sudden changes in drug levels can trigger seizures . (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Medication Administration, dated 3/25, revealed . If a dose of regularly scheduled medication is withheld . the nurse shall document either in the Electronic Medication Administration Record . and enter an explanatory note. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition, book, published 2023, revealed: . To promote a culture of safety and to prevent medication errors, nurses must . adhere to the five rights of medication administration: .administer the medication by the right route . Safe Medication, Administration Practices . If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions. .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, revealed the facility failed to ensure medication and medical supplies were labeled appropriately, and removed from service if expired, in 2 medication carts, out of 8 medication carts inspected, and 1 treatment cart, out of 1 treatment cart inspected. These failed practices had the potential to place the residents at risks of: 1) having inaccurate blood sugar analysis due to expired supplies or the use of an uncalibrated blood sugar monitor; and/or 2) receiving expired medications and supplies which could cause adverse reactions and/or complications. Findings: Aniak Medication Cart An observation on 5/20/25 at 11:35 AM, of the Aniak cottage, revealed a medication cart which had an opened box labeled Medline EvenCare Glucose Control Solutions (solutions used at quality control checks for glucose monitors to ensure they were accurately measuring blood sugar) that contained: - One opened 2.5 ml (milliliters) bottle of EvenCare High Control Solution, with no open date; - One opened 2.5 ml bottle of EvenCare Low Control Solution, with no open date, and; - One separate opened container of EvenCare Blood Glucose Test Strips .50 Test Strips (test strips to place in glucose monitors. A drop of blood would be set on or in the test strip for analysis) with no open date on the container. Further review of the test strip's container label revealed, Use within 6 months after first opening or before the expiration date. Review of the Medline EvenCare Glucose Control Solutions package insert, undated, revealed: Discard any unused control solution 90 days after opening or after expiration date. During an interview on 5/21/25 at 1:42 PM, the Infection Preventionist (IP) stated glucose meter control solutions and test strips should be labeled with an open date and were good for 30 days afterwards. Talkeetna Cottage Medication Cart An observation on 5/22/25 at 6:00 PM, of the Talkeetna cottage, revealed the medication cart contained the following expired medications: - One container of PEG 3350 Polyethylene Glycol (generic form of Miralax powder used to treat constipation) 3350 Powder for Solution Osmotic Laxative, expired on 2/26/25; - One container of PEG 3350 Polyethylene Glycol 3350 Powder for Solution Osmotic Laxative, expired on 5/3/25; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Three bottles of Chlorhexidine Gluconate 0.12% Peridex for gingivitis (an oral rinse to help with gum disease), expired on 4/11/25; - One tube of Metronidazole Gel USP (an antibiotic topical agent), 1% for topical use for inflammation, expired on 4/11/25, and; - One box of ACCU-CHEK Inform II 50 test strips for testing glucose, expired on 4/30/25. During an interview on 5/22/25 at 6:00 PM, Licensed Nurse (LN) #13 stated nurses checked the medication and supply expiration dates every day. Kenai Treatment Cart An observation on 5/20/25 at 10:59 AM, of the Kenai cottage, revealed the treatment cart contained the following expired and unlabeled opened date medical supplies: -four packets of [NAME] & Nephew Allevyn (brand name) Life 10.3 cm (centimeters) x 10.3 cm dressing, expired on 9/1/24; -one bottle of Medline (brand name) Hydrogen Peroxide 3% 8 fluid ounces, expired on dated 12/1/24; -one opened bottle of [NAME] (brand name) Sterile Water for Irrigation, USP (United States Pharmacopeia), approximately 25% of the bottle was used with no opened date. During an interview on 5/20/25 at 11:22 AM, LN #3 stated the expired supplies should have been discarded. He/she further added, We [the facility] have not used the Allevyn in a while, so I'm surprised that it is still there. LN #3 stated, I think night shift are supposed to be auditing but if we [LNs] see something is expired, we [LNs] just throw it away. LN #3 further stated, . Opened sterile water should be dated and is expected to be good for 24 hours. Review of the facility's Registered Nurse, and Licensed Vocational/ Practical Nurse, position description, dated 12/17/21, revealed: .Ensures that adequate stock levels of . medical supplies and equipment are maintained . .

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. . Based on record review and interview, the facility failed to provide or obtain dental services to meet the needs of 1 resident (#31), out of 21 sampled residents. This failed practice placed the resident at risk for not receiving the necessary care and services to maintain his/her highest practicable physical well-being. Findings: Record review on 5/18-22/25 revealed Resident #31 was admitted to the facility with diagnoses that included legal blindness, and disorder of teeth and supporting structures. During an interview on 5/18/25 at 1:24 PM, Resident #31 stated he/she was having dental pain intermittently. The resident put in a request to see a dentist about two months ago but had not heard anything more about it. Review of Resident #31 provider's progress note, dated 4/28/25, revealed, . [Resident#31] would like to go to the dentist, has broken tooth . Poor dentition . [Resident #31] will return to dentist when [he/she] feels [he/she] is ready to tolerate further extractions. -please schedule appointment for f/u extractions . Review of Resident #31's medical record revealed there were no physician orders for dental services from the 4/28/25 provider's progress note through the survey dates. During an interview on 5/21/25 at 12:52 PM, the Health Unit Clerk (HUC) stated she would look for dental orders in the medical record, then she would schedule the dental appointments. The HUC was unaware that Resident #31 wanted a dental appointment. She reviewed the resident's chart for dental orders and was unable to find an order. During an interview on 5/21/25 at 1:18 PM, Licensed Nurse (LN) #10 stated he/she was aware Resident #31 had occasional pain with his/her teeth and mouth. Resident #31 had several dental appointments before March, but the resident had cancelled them due to not feeling well. LN #10 further stated the resident did not have any upcoming dental appointments. During an interview on 5/22/25 at 1:45 PM, the Director of Nursing (DON) stated the physician should have entered in the orders to have a dental appointment set up for Resident #31. Review of the facility-provided policy SNF/AL Dental Services, effective 10/2019, revealed: . SNF/AL will provide or obtain the following dental services to meet the needs of each resident . will assist resident in making appointments . will either directly or contractually provide dental services that all residents may elect to receive . .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. . Based on interview and record review, the facility failed to ensure all staff involved in food preparation, distribution, and service maintained current food handling licenses, called food handler cards, for 24 Night Shift (NOC) staff (#'s 2; 3; 5; 6; 7; 8; 9; 10; 13; 19; 20; 24; 25; 28; 29; 30; 31; 32; 34; 35; 36; 37; 41; and 43), out of 44 NOC staff, and 3 Cooks (#'s 32; 33; and 35), out of 11 Cooks. This failed practice put all 75 residents, who receive food from the kitchen, at risk of health and safety issues due to receiving food prepared and served by unqualified individuals. Findings: Food Handler Cards During an interview on 5/21/25 at 5:15 PM, the Kitchen Manager (KM) stated all staff including housekeepers, cooks, Licensed Nurses (LNs), and Certified Nursing Assistants (CNAs) who handled food must have current food handler cards: all staff are trained during orientation about snack availability, and all are supposed to hold current food handler cards, allowing them to prepare snacks. Review of the facility-provided document Food handler cards for After-hours staff, undated, revealed a total of 44 Night Shift (NOC) staff members listed. Further review revealed 10 NOC staff with expired food handler cards: 1) NOC Staff #3 - expired 1/13/25; 2) NOC Staff #5 - expired 3/10/25; 3) NOC Staff #7 - expired 2/9/25; 4) NOC Staff #8 - expired 11/8/24; 5) NOC Staff #9 - expired 12/31/24; 6) NOC Staff #13 - expired 11/23/07; 7) NOC Staff #19 - expired 10/28/24; 8) NOC Staff #20 - expired 1/26/25; 9) NOC Staff #41 - expired 2/2025; and 10) NOC Staff #43 - expired 1/14/25. Further review revealed the facility was unable to provide proof that 14 NOC Staff (NOC Staff #'s 2; 6; 10; 24; 25; 28; 29; 30; 31; 32; 34; 35; 36; and 37) had food handler cards. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Cook's Food Handler cards documentation, for 11 Cooks, revealed Cooks #32 and #33 had no proof of a food handler cards and [NAME] #35's food handler care expired on 11/19/24. During an interview on 5/22/25 at 4:50 PM, the KM stated, during the Providence period [old owner], staff development sent out notices for card renewals and managed the process, but now I'm unsure who's responsible for keeping these cards current. The KM further stated they were unaware of these expired cards. When asked what to do when a staff member with an expired food handler card is on the schedule, the KM replied, they won't be able to work until they get the card. Review of the evening and night shift schedule for the CNA's on 5/18/25 revealed: 3 current, 2 expired and 3 with unknown status of their food handler cards. Review of the evening and night shift schedule for the nurses on 5/18/25, revealed 2 current, 2 expired and 4 with unknown status of their food handler cards. During an interview on 5/21/25 at 5:15 PM, the KM initially stated no written policies exist for late-night or after-hours snacks, relying instead on verbal communication amongst staff. The KM retrieved a policy from the previous owner's stock titled Dietary: Snacks, and hand wrote the date 5/28/25 at the top of the policy and stated the 03/2025 date at the bottom of the policy was an error and wrote error. Copied by mistake [KM's name]. Review of this policy, Dietary: Snacks revealed: It is the policy of this facility to provide the residents with snacks between meals and HS [night] as indicated. Procedure . Snacks will be delivered from the kitchen with breakfast, lunch and dinner trays if indicated. Snacks will be offered to residents following throughout the day and at HS by dietary, activities and/or nursing staff. Staff will deliver the snacks according to their diet and restrictions . The KM hand wrote Staff have food handler cards on the policy as well. .

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	025036	A. Building B. Wing	05/22/2025

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. . Based on interview, record review, and observation, the facility failed to: 1) Ensure residents received meals at times and in a manner consistent with their needs, preferences, and requests; and 2) Consistently offer access to suitable snacks or alternative meals outside of scheduled mealtimes to prevent prolonged periods without nourishment. These failed practices placed all 75 residents, who received food from the kitchen, at risk of less-than-optimal nutritional intake and decreased quality of life. Findings: During an interview on 5/21/25 at 2:01 PM, members of the Resident Council (Residents #'s 18; 20; 28; 34; 35; 47; 48; 68; and 87) shared their concerns about how close mealtimes were scheduled and the 15-hour gap between dinner (between 4:15 and 5:00 PM) and breakfast (8:00 AM). Residents stated snacks must be requested before cooks left at 6:00 PM, or they would go without food until breakfast. Some residents resorted to ordering food from outside the facility due to lack of consistent access to after-hours snacks. The cooks worked from 7:30 AM to 6:00 PM, leaving Licensed Nurses (LNs) or Certified Nurse Assiatants (CNAs) to handle snack preparation after hours. During an interview on 5/21/25 at 5:15 PM, the Kitchen Manager (KM) acknowledged resident complaints about meal timing and cook availability. The KM stated they were open to adjusting the meal schedules based on resident preferences. The KM added resident satisfaction was informally assessed through verbal check-ins by housekeepers, the KM, or the dietitian during quarterly reviews, but currently there was no formal or written process to consistently document preferences or satisfaction. The KM confirmed snacks were available between meals and after hours via a pre-order with the cooks, or snacks could be prepared by LNs, CNAs, or housekeepers who were aware of residents' dietary needs, but noted some residents preferred ordering DoorDash. She further stated residents could access snacks from cottage refrigerators, though many residents were unaware of this option. Random observations on 5/18-22/25, revealed residents did not have access to snacks without staff assistance. The kitchen area, where the refrigerators were located, and dry storage areas with snack items, were off-limits to residents. There were no indications posted on how to obtain food after hours. Residents were also observed with food stored in their rooms. During an interview on 5/21/25 at 5:15 PM, the KM stated all staff received training on snack availability, including CNAs and LNs. The KM further stated dietary was constantly addressing communication gaps by having housekeepers verify snack needs daily with residents. While a tracking system for snacks existed, it was not consistently used, and they were working on improvements. The KM also added, no formal grievances about food were reported in the past year. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/21/25 at 5:15 PM, the KM initially stated no written policies exist for late-night or after-hours snacks, relying instead on verbal communication amongst staff. The KM retrieved a policy from the previous owner's stock titled Dietary: Snacks, and hand wrote the date 5/28/25 at the top of the policy and stated the 03/2025 date at the bottom of the policy was an error and wrote error. Copied by mistake [KM's name]. Review of this policy, Dietary: Snacks revealed: It is the policy of this facility to provide the residents with snacks between meals and HS [night] as indicated. Procedure . Snacks will be delivered from the kitchen with breakfast, lunch and dinner trays if indicated. Snacks will be offered to residents following throughout the day and at HS by dietary, activities and/or nursing staff. Staff will deliver the snacks according to their diet and restrictions . The KM hand wrote Staff have food handler cards on the policy as well. .

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	025036	A. Building B. Wing	05/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 in the kitchen at Susitna and Talkeetna Cottages were prepared, distributed, and served in accordance with professional standards of food safety for 3 residents (#s 29, 37, and 84), out of 19 residents who were receiving food from these kitchens. This failed practice placed the residents at risk of eating contaminated food and at risk of contracting foodborne illness. Findings: Susitna Cottage: During a continuous observation on 5/18/25, from 11:34 AM through 11:51 AM in the Susitna kitchen, revealed at 11:43 AM, [NAME] #2 scooped cooked chicken and corn mixture unto the plate, served the plate to Resident #37 and began to feed the resident. While [NAME] #2 was feeding Resident #37, the pans of cooked chicken and cooked corn mix was set on top of a stove uncovered. This surveyor asked Licesned Nurse (LN) #12 who entered the kitchen about the uncovered pans. LN #12 notified [NAME] #2, who rushed to the kitchen and covered the pans at 11:51 AM. During an interview on 5/21/25 at 9:23 AM, when this surveyor informed the Dietary Service Manager (DSM) of the uncovered food, the DSM stated, it should have been covered, even if left for few minutes. Review of the Food and Drug Administration (FDA) Food Code 2022, at this link: https://www.fda.gov/food/fda-food-code/food-code-2022, accessed on 5/22/25, revealed: .Food contamination prevention. prevent the introduction of foreign objects into the food, and minimize the possibility of transmitting disease through food. Talkeetna Cottage: Hand hygiene and Gloves Use An observation on 5/18/25 at 8:22 AM, [NAME] #4 was wearing gloves while preparing a minced and moist breakfast for Resident #29 and #84. [NAME] #4 took three pieces of bread, pulled the edges of the bread off and put the white part of the bread into the food processor. After processing the bread, the [NAME] transferred the minced bread onto two separate plates. Further observation revealed [NAME] #4, who was still wearing the same gloves, took a used pan from the sink, touched the sink, and touched the used cutting board in the sink. [NAME] #4 moved to the counter then, poured used oil from a used pan into a paper cup and covered the cup with plastic wrap. Without changing his/her gloves and without performing hand hygiene, [NAME] #4 transferred the two plates of minced bread from the table to a tray on top of the counter. With the same gloved hands, [NAME] #4 sliced fresh tomato, took two pieces of fried eggs from the warmer and put the eggs and slices of tomato into the food processor. Then, [NAME] #4 removed his/her gloves and washed the dishes. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 9:01 AM, the DSM stated the cooks should wear gloves when preparing food and wash their hands in between tasks and after removing gloves. Review of the facility's policy Protocol Dietary, revised date 11/2012, revealed: '. PROPER FOOD HANDLING.wash hands before handling any food or beginning any food preparation procedure. Review of the Food and Drug Administration (FDA) Food Code 2022, at his link: https://www.fda.gov/food/fda-food-code/food-code-2022, accessed on 5/22/25, revealed: . 3-304.15 Gloves, Use Limitation . Hands must be washed before donning [putting on] gloves. Gloves must be discarded when soil or other contaminants enter the inside of the glove. Food Temperature An observation on 5/18/25 at 8:22 AM, revealed [NAME] #4 scooped minced egg with tomato onto a plate of minced bread, and then left the plate on top of the counter uncovered. The food temperature was not measured. Further observation revealed [NAME] #4 proceeded to puree one fried egg with tomato. [NAME] #4 stated the puree was watery because of the tomato. [NAME] #4 poured the pureed food into a sippy cup and left it on top of the kitchen table. The food temperature was not measured. Further observation revealed at 8:52 AM (30 minutes later) the minced and moist bread with egg and tomato was still uncovered on the tray placed on the counter. [NAME] #4 then served the meal without checking the temperature and left the plate uncovered. During an interview on 5/18/25 at 9:08 AM, [NAME] #4 stated he/she did not put the pureed food and the minced and moist food in the warmer because it would dry-out. During an interview on 5/20/25 at 3:11 PM, [NAME] #3 stated the cooks measured the food temperature at least 15 minutes before the food was serviced. [NAME] #3 stated the temperature of everything was taken, even cold food like pureed sandwiches. [NAME] #3 further stated that the minced and moist food was placed in the warmer while waiting for the resident. [NAME] #3 also stated pureed foods were steamed until it reached the right temperature. If the food was supposed to be cold, it should have been kept in the refrigerator and if the food was supposed to be hot the food should have been placed in the warmer. During an interview on 5/21/25 at 9:01 AM, the DSM stated the food danger zone was 41 -135 degrees Fahrenheit (F), and bacteria could grow in this zone. She further stated the cooks were expected to measure the temperature of the minced and moist breakfast and to be at least at 135 degrees F before the meal service and expected to place the food on a tray with a dome lid to keep it warm while the tray was on the counter. Review of the facility's policy Protocol Dietary, revised date 11/2012, revealed: PROPER FOOD HANDLING. danger zone of food is 41 degrees - 135 degrees. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Food and Drug Administration (FDA) Food Code 2022, at this link: https://www.fda.gov/food/fda-food-code/food-code-2022, accessed on 5/22/25, revealed: . 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above . or (2) At 5°C (41°F) or less. .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. . Based on record review and interview, the facility failed to ensure their facility assessment was up to date and accurate. This failed practice had the potential to place all residents (based on a census of 91) at risk for not having the necessary care and resources required for day-to-day operations including nights, weekends, and emergencies. Findings: Record review on 5/18-22/25 of the facility's 2025 Polaris Extended Care Facility Assessment, revealed: 1) Language Spoken, Page 7: . Resident Characteristics: Language Spoken: English - 88 [residents]; Spanish - 1 [resident]; Tagalog - 1 [resident]; Samoan - 1 [resident] . Further review of the facility assessment revealed no inclusion of a translation service to assist in communicating with the three non-English speaking residents. 2) Staffing, Page 13: . CMS requires a minimum staffing hours for nursing care as 3.5 nursing hours per patient (NHPPD), and 2.4 of those will be provided by certified nursing assistants (CNAs). The facility has a waiver in place to authorize the use of licensed nurse hours to cover those of the CNAs should they fall below 2.4 in each day. This waiver is renewed annually as applicable . During the course of this survey, the facility was asked to provide a copy of this waiver approval. 3) Vendor List, Pages 20-21: Review of the facility assessment's vendor list revealed: 1) Advanced Diagnostic, which serviced the facility's medical gas, listed a contact name who no longer worked at that vendor; and 2) the facility's vendor for contracted physicians, Pacific Medical Group, was not listed. During an interview on 5/22/25 at 3:00 PM, the Administrator stated that the facility's translation service would be added to the facility assessment. The Administrator further stated the vendor contact for Advanced Diagnostic would be updated and vendor information for the Pacific Medical Group would be added. During an interview on 5/22/25 at 3:20 PM, the Administrator stated the information listed about a staffing waiver was not accurate information for the facility and this would be removed from the facility assessment's verbiage. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the facility-provided Polaris Extended Care Facility Assessment, dated 2025, revealed: . The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually . The facility assessment is organized into three main components/sections: 1. Resident profile including . physical and cognitive disabilities, decisions regarding caring for residents with conditions not listed . 2. Services and care offered including but not limited to, care needed by the resident population using evidence-based, data-driven methods . 3. Facility resources needed including, but not limited to, providing competent care for residents, including facility staff, staffing plan, staff training/education and competencies . working with medical practitioners, physical environment, equipment, technology, communication, building needs and other resources . .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. . Based on record review, observation, and interview, the facility failed to ensure medical records were complete and/or accurate for 5 sampled residents (#'s 28; 31; 42; and 343), out of 21 sampled residents, and 1 unsampled resident (#89). This failed practice created incomplete medical records which placed the resident at risk for inconsistencies in treatment and care provided. Findings: Resident #28 Oxygen Order Record review on 5/18-22/25 revealed Resident #28 was admitted to the facility with diagnoses that included non-Alzheimer's dementia (a decline in intellectual functioning, including problems with memory, reasoning and thinking), Parkinson's disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), heart failure (inability of the heart to maintain adequate blood circulation), and hypertension (repeatedly elevated blood pressure). An observation on 5/18/25 at 12:07 PM, revealed Resident #28 was lying in bed receiving 2 LPM (liters per minute) of humidified oxygen through a nasal cannula (a thin flexible tube with two prongs that fits into the nostrils, allowing oxygen to flow directly into the nose). An observation on 5/19/25 at 9:01 AM, revealed a sign on Resident #28's doorframe that read oxygen in use. An observation on 5/20/25 at 9:43 AM, revealed Resident #28 in bed with a nasal cannula in place and humidified oxygen running at 2 LPM. The resident stated he/she used the oxygen at night while sleeping. Review of Resident #28's care plan, revised on 4/1/25, revealed: . Administer my supplemental oxygen as ordered . Review of Resident's 28's medical record revealed no provider's order for the use of oxygen therapy. During an interview on 5/21/25 at 10:31 AM, when asked if Resident #28 received supplemental oxygen, the Medical Director responded, I don't believe so . , and after reviewing the resident's medical record, further confirmed Resident #28 did not have an order for oxygen therapy. During an interview on 5/22/25 at 2:32 PM, when asked if residents who used supplemental oxygen should have an order, the Director of Nursing (DON) stated, yes. The DON further stated there was no order for Resident #28's supplemental oxygen and that oxygen saturations should be monitored for residents on supplemental oxygen. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 and #31 Consent Forms for Medication Review of Resident #28's Psychotherapeutic Medications Facility Verification of Resident Informed Consent forms, dated 3/1/25, revealed these forms were for the consent to use Trazadone (An antidepressant medication used to treat insomnia); Mirtazapine (An antidepressant); and Quetipine (Seroquel - an antpsychotic medication). Review of Resident #31's Psychotherapeutic Medications Facility Verification of Resident Informed Consent form, dated 3/1/25, revealed this form was for the consent to use Seroquel. Record review of Psychotherapeutic Medications Facility Verification of Resident Informed Consent forms for Resident #28 and #31 revealed both residents had signed these forms on 3/1/25 and the Quality Assurance Coordinator (QAC) and the provider had signed these forms on 3/1/25. During an interview 5/22/25 at 4:47 PM, both Resident #28 and #31 stated the QAC had the residents sign the consent forms on 5/21/25. Both residents verified they did not sign those forms on 3/1/25. During an interview on 5/22/25 at 3:15 PM, when asked what date the provider had signed the Psychotherapeutic Medications Facility Verification of Resident Informed Consent form, the Quality Assurance Coordinator (QAC) stated the provider signed the forms on . possibly Friday [5/16/25], or maybe Monday [5/19/25] . The QAC stated when she started on 3/1/25 the facility had no informed consent forms filled out, so she started a PIP (Performance Improvement Project) to ensure all residents that needed them were completed. During an interview on 5/22/25 at 3:42 PM, the Medical Director (MD) stated the facility would give him a stack of informed consent forms to sign periodically. He stated he had returned to work from an extended period away on Monday 5/19/25. When asked if he had ever signed a blank form, he stated, It may have happened and then referred to the QAC to confirm. The MD was unsure which day he signed Resident # 28, and #31 ' s forms. Resident #42 Record review on 5/18-22/25 revealed Resident #42 was admitted to the facility with diagnoses that included borderline personality disorder (a mental health condition that affects the way people feel about themselves and others), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, affects how one feels, think and behaves), and anxiety. Record review of Resident #42's PSYCHOTHERAPEUTIC MEDICATIONS FACILITY VERIFICATION OF RESIDENT INFORMED CONSENT, dated 3/1/25, revealed the following handwritten description: Olanzapine [an antipsychotic medication] 10mg [milligrams] .for Bipolar r/t [related] to PTSD [Post Traumatic Stress Disorder] . Review of Resident #42's diagnoses list, accessed on 5/21/25, revealed the resident was diagnosed with . BIPOLAR DISORDER, CURRENT EPISODE MANIC WITHOUR PSYCHOTIC FEATURES, MILD . on 5/6/25, 66 days after the date of the signed consent. The facility was unable to provide authentication of the diagnosis by the end of the survey. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/25 at 9:20 AM, when the Assistant Director of Nursing (ADON) and Director of Quality (DOQ) was asked if Resident #42's informed consent for the drug Olanzapine had the diagnosis for Bipolar added after the informed consent was signed, the DOQ stated yes, just this form with the new diagnosis, bipolar. Normally we would not, we would have completed a new form, but this time I did. During an interview on 5/21/25 at 10:45 AM, when the Medical Director was asked if it was appropriate for staff to update a signed informed consent with a new diagnosis after the physician and resident signed it, the Medical Director stated, no. Resident #89 Record review on 5/18-22/25 revealed Resident #89 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (long-term lung condition that causes breathing difficulties due to airflow obstruction). Further review revealed Resident #89 had passed away on 4/25/25. Review of Resident #89's nursing assessment, LN [Licensed Nurse]-Condition Monitoring-V 2, dated 3/6/25 at 2:56 PM, revealed: oxygen level 97 percent on 2 [liters]. Review of Resident #89's nursing assessment, Activity- Change in Condition Evaluation, dated 3/22/25 at 2:56 PM, revealed: c/o productive cough, feeling hot, bp [blood pressure] 118/73, pulse 88, temp[temperature] 98.3 orally, pulse ox [oximetry] 97 percent on 2 liters nasal cannula. Review of Resident #89's weekly nursing assessment, LN- Nursing Summary-Weekly, dated 4/11/25 at 5:24 PM, revealed, Oxygen used Continuous .2 LPM at night only .Average Saturation reading for this month .95. Review of Resident #89's medical record revealed no provider's order for the use of oxygen therapy. Review of Resident #89's physician order, dated 2/28/25 with a start date of 3/1/25, revealed: NURSING ORDER: Ensure weekly BP [blood pressure] & [and] P [pulse] is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . There was no order in place to monitor the oxygen therapy the resident had received as noted on 3/6/25, 3/22/25 and 4/11/25. Review of Resident #89's physician order, dated 4/19/25 with a start date of 4/26/25, revealed: NURSING ORDER: Ensure weekly Vital Signs is recorded per facility protocol FREQUENCY: 1 x wk. Saturday every night shift every Sat . The resident had passed away before this monitoring order had started. During an interview on 5/21/25 at 10:01 AM, when asked how often oxygen saturation should have been recorded for Resident #89 when he/she was using continuous oxygen, the Medical Director stated, every four hours, titrate oxygen above 88%. During an interview on 5/22/25 at 3:08 PM, the DON stated Resident #89 used supplemental oxygen and only one oxygen saturation from the dates of 3/1/25 to 4/25/25 was recorded. The DON further stated orders for oxygen therapy should have been put in place. Resident #343 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 5/18-22/25 revealed Resident #343 was admitted to the facility with diagnoses that included spinal stenosis of the lumbar region with neurogenic claudication (narrowing of the lower spine causing pain), vascular dementia (problems with blood flow to the brain resulting in damage to the brain tissue), obstructive sleep apnea (breathing issues during sleep), overactive bladder (frequent need to urinate) and major depressive disorder (severe sadness). During an interview on 5/21/25 at 5:15 PM, when asked how residents were assessed for nutritional needs, the Kitchen Manager (KM) stated most of the assessments were done verbally. When asked if there was a form or questionnaire used, the KM stated, no, the cook and housekeepers check in with their preferences and we [KM and Dietitian] go around and ask. On 5/22/25 at 4:50 PM, the KM returned with a paper copy of Resident #343's Nutrition -admission Evaluation, dated 5/1/25. Review of Resident #343 's dietary assessment Nutrition - admission Evaluation, dated 5/1/25, revealed the resident was on a regular diet with a chopped texture (where the food is cut up into small pieces). The assessment was handwritten and contained various other written notes. These added handwritten notes were not initialed, dated or timed. Review of Resident #343's electronic medical record revealed this 5/1/25 Nutrition - admission Evaluation was not included in the record. During an interview on 5/22/25 at 4:50 PM, the KM confirmed he/she wrote these notes at various times in the past but could not precisely say when, and stated this evaluation was not part of Resident #343's medical record. During an interview on 5/22/25 at 4:42 PM, the Director of Quality and the Administrator stated the QAPI committee performed chart audits on the resident's medical record. Review of the facility-provided policy Medical Record, Content of, revised on 3/2025, revealed: . All physicians, nursing staff and other health care professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record . The medical record shall contain . Authentication of Diagnoses . Physician Orders . Treatment records . vital signs . .

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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, observation, and interview, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure: 1) A urinary catheter (a medical device that helps drain urine from the bladder) bag was hung in a manner to remain clean and sanitary for 1 resident (#19), out of 10 residents with indwelling catheters (a tube inserted through the urinary tract into the bladder, connected to a drainage bag); 2) Sterile technique was maintained during tracheostomy care and suctioning for 1 resident (Resident #51), out of 1 resident reviewed for tracheostomy care; 3) Appropriate implementation of droplet precautions for 1 resident (Resident #71), out of 1 resident reviewed for infection control precautions; 4) Safe infection control practices were followed during enteral tube feeding administration for 1 residents (Resident #77), out of 2 residents reviewed for tube feedings; and 5) Food was prepared and served under sanitary conditions for 17 residents (#'s 9; 13; 20; 29; 32; 35; 38; 49; 50; 55; 65; 69; 78; 83; 84; 192; and 492), of 75 residents who received food from the kitchen. These failed practices placed the residents at risk for infection which could have affected their overall health and wellbeing. Findings: Resident #19 Record review on 5/18-22/25 revealed Resident #19 was admitted to the facility with diagnoses that included neuromuscular dysfunction of the bladder (condition where the bladder lacks control due to nerve or muscle problems), and major depressive disorder (mood disorder characterized by persistent feeling of sadness and loss of interest in activities). Review of the Resident #19's Care Plan Report, initiated 4/29/25, revealed: .Focus: [Resident 19] has a foley catheter [a medical device that helps drain urine from the bladder leading to a drainage bag] r/t [related to]: NEUROMUSCULAR DYSFUNCTION OF BLADDER . Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door . Check for catheter privacy bags to bed/wc [wheelchair] Q shift [once a shift]. Replace as needed . An observation on 5/19/25 at 9:34 AM, revealed Resident #19's urinary catheter drainage bag was covered with a transparent trashcan liner and was hung on a handle towards the upper left side of his/her bed. (continued on next page)

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	025036	A. Building B. Wing	05/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/20/25 at 10:34 AM, revealed Resident #19's urinary catheter drainage bag was covered with a transparent trashcan liner and hung on a trash bin by the lower left side of his/her bed, which was visible upon entrance to Resident's room. During an interview on 5/20/25 at 10:38 AM, Resident #19 stated he/she just took a shower and after completing the assistance with ADLs (Activities of daily living), Certified Nursing Assistant (CNA) #1 hung the drainage bag on the trash bin. He/she stated, this happens all the time, and would be corrected, when found by staff later in the day, or if he/she asked. During an interview on 5/20/25 at 10:42 AM, Licensed Nurse (LN) #3 stated urinary catheters were assessed each shift which includes the positioning of the bag and ensure it was free of kinks. LN #3 further stated the drainage bags were to remain off the floor by hanging it on the side of the bed or placed in a wash bin. He/she stated drainage bags should not be hung on the trash bin. During an interview on 5/20/25 at 10:50 AM, CNA #1 stated drainage bags should have been hung on the side of the bed. He/she added, there was a handle on the bed to attach it to. CNA #1 stated that the drainage bags should not be hung on a trash bin. During an interview on 5/21/25 at 1:55 PM, the Infection Preventionist (IP) stated catheters were part of the audits that were completed in the facility. This would include catheter care, making sure the line of the drainage bag was not kinked and/or the drainage bag was off the floor. When observation of Resident #19's drainage bag being hung on the trash bin was relayed to the IP, IP stated it would be an infection control concern. Review of the Lipincott Essentials for Nursing Assistants, A Humanistic Approach to Caregiving, page 563, published in 2025, revealed: .Bacteria can enter the closed drainage system .The presence of bacteria in the system can cause a urinary tract infection . Review of the facility's policy Indwelling Urinary Catheter Care, last revised 3/2025, revealed: .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection . Resident #51 Resident #51 was admitted to the facility with diagnoses including atrial fibrillation (an irregular heart rhythm), dementia (a decline in cognitive functioning affecting daily living), and hemiplegia (paralysis on one side of the body). Observation on 5/21/25 at 1:10 PM, revealed LN #6 performed tracheostomy care for Resident #51. He/she placed sterile supplies directly onto a non-sanitized bedside table. Then, LN #6 cleaned the Resident's tracheostomy site which caused his/her sterile gloves to become visibly contaminated with secretions and debris. LN #6 then used the contaminated gloves to grasp sterile suction tubing which was used to enter Resident #51's airway for suctioning. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Tracheostomy Care . To prevent infection, all tracheostomy care should be performed using sterile technique . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 71 Record review on 5/18-22/25 revealed Resident #71 was admitted to the facility with diagnoses that included hemiplegia, cerebrovascular disease (conditions that affect blood flow to the brain and can lead to serious events such a stroke), dementia (decline in cognitive function), and aphasia (difficulty speaking, understanding, reading, or writing, that occurs as a result of brain damage). An observation on 5/19/25 at 8:39 AM, revealed a Droplet Precautions sign outside Resident #71's door: EVERYONE MUST: . Put on surgical mask and face shield before entering the room . Put on gloves before entering the room . Put on gown before entering the room . A concurrent observation and interview on 5/19/25 at 8:40 AM, revealed LN #4 put on a surgical mask and gown from the PPE (Personal Protective Equipment) drawer outside of Resident #71's room. LN #4 then put on gloves but did not wear a face shield prior to entering Resident #71's room. LN #4 stated typically staff should have been wearing a face shield prior to entering a resident's room that was on droplet precautions. A concurrent observation and interview on 5/20/25 at 12:53 PM, revealed LN #5 put on a gown and surgical mask from the PPE drawer outside of Resident #71's room. LN #5 then put on gloves but did not wear a face shield prior to entering Resident #71's room. LN #5 stated face shields were typically stocked in the clean utility room, but that staff had been going into Resident #71's room with no face shields on 5/20/25. During an interview on 5/22/25 at 2:39 PM, the IP stated face shields were to be worn prior to entering a resident's room that was on droplet precautions. When relayed surveyor's observations of staff not wearing face shields prior to entering Resident #71's room, IP stated staff should have worn face shields prior to entering a Resident #71 room. Record review of Resident #71's physician orders, with at start date of 5/14/25 and end date of 5/24/24, revealed: Isolation (Contact/Droplet Precautions) for parainfluenza: PPE Including; N95 mask, gown, eye protection, gloves. Review of the facility's policy IPCP [Infection Prevention and Control Program] Standard and Transmission-Based Precautions, dated 3/2025, revealed: . Droplet Precautions (TBP) . Personal protective equipment (PPE) . Wear a gown, mask, face shield and gloves for all interactions that may involve contact with the patient or the patient's environment . Resident #77 Record review on 5/18-22/25 revealed Resident #77 was admitted to the facility with diagnoses of cerebral palsy (a group of disorders affecting movement and muscle tone), epilepsy (a neurological disorder marked by seizures), and developmental disorder of motor function (delays or impairments in coordinated movement). Enteral Tubing Contamination (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/21/25 at 10:50 AM, revealed LN #6 entered Resident #77's room to administer scheduled enteral nutrition meal. There was enteral tubing already attached to the feeding pump, which was undated and hung uncapped from an IV pole at the Resident's bedside. This tubing contained enteral nutrition solution throughout the tubing. LN #6 proceeded to attach the uncapped tubing to the resident's feeding tube, however the surveyor intervened before attachment and asked, Should the tube feeding be administered through that tubing since it was uncapped? LN #6 responded, It should have been capped, but since it wasn't I will use alcohol wipes to sanitize it, then begin the feed. He/she then attached tube feeding to the resident's feeding tube, after using an alcohol wipe on the enteral tubing port and began infusion of the enteral nutrition. During an interview on 5/21/25 at 1:50 PM, the facility's Infection Preventionist (IP) was asked whether the tubing would be safe to use if left uncapped. The IP stated, It would not be safe if it has been uncapped and not knowing what it has been exposed to, which would require a change of new tubing-dated, capped-then the standard is that it would be good for 24 hours. Review of the facility-provided standard used in resident care Lippincott Nursing Procedures Ninth Edition book, dated 2023, revealed: . Enteral Gastric, Duodenal, and Jejunal Tube Feedings . Don't use formula if its integrity is compromised or if it's expired. Instead, obtain a new container of the formula . Kitchen Hygiene Nenana Cottage An observation on 5/18/25 at 8:25 AM, revealed [NAME] #5 prepared and plated multiple trays of food without adhering to sanitary standards. [NAME] #5 was observed with either not wearing gloves or only wore one gloved hand. Additionally, [NAME] #5 was not wearing a face mask or beard net, despite having visible facial hair approximately 1-2 inches in length. [NAME] #5 was also observed wiping his/her hands on his/her shirt while handling food on multiple occasions. During an interview on 5/20/25 at 5:22 PM, when asked whether [NAME] #5 should have been wearing a hair covering for his/her facial hair, the Dietary Service Manager (DSM) responded, Yes. When asked whether it was acceptable for kitchen staff to wipe their hands on their clothing while handling food, she stated, No. Review of the facility provided protocol Providence Extended Care Protocol Dietary, last revised 11/2012, revealed: .Use proper hair covering and clean clothing . Avoid touching ready to eat foods with bare hands . Do not use bare hands to handle ready-to-eat foods at any time . Change gloves after changing food preparation tasks . Talkeetna Cottage An observation on 5/18/25 at 8:22 AM, revealed [NAME] #4 was wearing gloves while preparing minced and moist breakfast for Residents #29 and #84. [NAME] #4 took three pieces of bread, pulled the edges of the bread off and put the white part of the bread into the food processor. After processing the bread, the [NAME] transferred the minced bread into two separate plates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025036	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Extended Care	920 Compassion Circle Anchorage, AK 99504

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation revealed [NAME] #4, who was still wearing the same gloves, took a used pan from the sink, touched the sink, and touched the used cutting board in the sink. [NAME] #4 moved to the counter then poured used oil from a used pan into a paper cup and covered the cup with plastic wrap. Without changing his/her gloves and without performing hand hygiene, [NAME] #4 transferred two plates of minced bread from the table to a tray on top of the counter. With the same gloved hands, [NAME] #4 sliced fresh tomato, took two pieces of fried eggs from the warmer and put the eggs and slices of tomato into the food processor. Then, [NAME] #4 removed his/her gloves and washed the dishes. During an interview on 5/21/25 at 9:01 AM, the DSM stated the cooks should wear gloves when preparing food and wash their hands in between tasks and after removing gloves. Review of the facility's policy Protocol Dietary, revised date 11/2012, revealed: . PROPER FOOD HANDLING.wash hands before handling any food or beginning any food preparation procedure. Review of the Food and Drug Administration (FDA) Food Code 2022, at https://www.fda.gov/food/fda-food-code/food-code-2022, accessed on 5/22/25, revealed: . 3-304.15 Gloves, Use Limitation . Hands must be washed before donning [putting on] gloves. Gloves must be discarded when soil or other contaminants enter the inside of the glove. .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. . Based on interview, observation, and record review, the facility failed to ensure staff were appropriately trained, or with competencies up to date, for direct resident care in 2 cottages, Susitna and Nenana. This failed practice had the potential to create diminished resident care for 23 residents (Susitna Cottage: #'s 2; 3; 24; 26; 33; 45; 46; 52; 60; 68; 71; and 193; Nenana Cottage: #'s 5; 20; 35; 38; 49; 50; 51; 55; 77; 83; and 492) which could affect their overall quality of care and quality of life. Findings: Nenana Cottage During an interview on 5/20/25 at 8:30 AM, Rehabilitation Aide (RA) #1 stated, I'm working in Nenana Cottage today because I was asked to help because surveyors are here. Normally I work in the Rehab department, I haven't worked as a CNA [Certified Nursing Assistant] in the cottages for over three years. During an interview on 5/21/25 at 1:03 PM, when asked to review RA #1's training and competencies for CNA duties, the Director of Community Liaison stated RA #1's last training for safe patient handling occurred during the 7/27/23 annual skills fair and last training for peri care was 5/30/23. The Director of Community Liaison further stated there was no current CNA training or competencies for RA #1. Susitna Cottage An observation on 5/20/25 at 12:53 PM, revealed the Minimum Data Set (MDS - a federally required assessment) Nurse was providing incontinence care to Resident #71. During an interview on 5/20/25 at 1:39 PM, the MDS Nurse stated, I've never worked as a CNA before so [the Director of Staff Development] is here to support me because there is no CNA available. The MDS Nurse further stated, I have been an MDS nurse for 15 years, so I haven't provided patient care in a long time. During an interview on 5/21/25 at 1:03 PM, when asked to show the MDS Nurse's training and competencies for peri care, the Director of Community Liaison could not provide this after reviewing the MDS Nurse's training records. During an interview on 5/21/25 at 1:03 PM, when asked if Licensed Nurses (LNs) were provided training and competencies for peri care, the Director of Staff Development stated since being in the position, no nurse had been trained in peri care. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility-provided 2025 Polaris Extended Care Facility Assessment, revealed: Staff training/education and competencies: Polaris Extended Care ensures that all staff receive training and demonstrate competencies necessary to provide the appropriate level and type of care required for our resident population. Training is tailored to the acuity and specialized need of our residents . Competency evaluations are conducted during orientation and annually thereafter, and include direct observation, skills validation, and knowledge-based testing . Training records and competency validations are maintained by the staff development coordinator and reviewed by department heads and the Quality Assurance & Performance Improvement (QAPI) committee . .