STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085058	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Polaris Healthcare and Rehabilitation Center	21 W Clarke Avenue Milford, DE 19963

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 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. Based on observation, interviews, record review and other facility documentation, the facility failed to provide sufficient nursing staff to meet the needs of residents for 7 of 20 residents reviewed for staffing. The facility did not ensure adequate availability of staff to respond to resident care needs in a timely manner. Findings Include:As of December 2024, the facility assessment documented the following: 5 residents were independent with ADL's; 35 to 40 residents required assistance from 1-2 staff members; 50 to 55 residents were dependent on staff for ADL support.Despite this, residents experienced prolonged call bell response times and unmet care needs. At the time, the census on the Riverwalk unit was 58.1. Interview with a resident who wished to remain anonymous:8/6/25 2:51 PM - F1 reported multiple instances of delays when resident A1 called for assistance with toileting. On 7/16/25 7:30 PM A1 rang bell and contacted F1 about no one answering or providing assistances. F1 contacted E18 who contacted a supervisor to find assistance for A1. R3 contacted F1 at 8:30 PM to let her know someone had come to assist her to the bathroom. On 8/1/25 6:45 PM - A1 rang the call bell at 6:45 PM. At 7:55 PM, A1 contacted F1 who contacted the E18 (Former DON) due to lack of response. A1 reported finally being assisted and returned to bed by 8:45 PM.8/11/25 in the morning an interview with E6 (Supervisor) it was confirmed that he did receive calls about A1 waiting for assistance and would need to find someone to assist with toileting.2. Interview with a resident who wished to remain anonymous:8/7/25 10:00 AM to 10:40 AM - An observations of A2's call bell ringing continuously for 40 minutes before staff responded. During this time, A2 reported to the surveyor of needing assistance with changing and noted such delays were common, stating that sometimes staff just shut the light off and do not return promptly.3. R6's review revealed:7/19/25 11:30 PM - A concern form documented that R6 was not placed in bed until 11:30 PM, indicating a significant delay in bedtime assistance.8/6/25 7:00 PM to 8:00 PM - During an observation while on the Riverwalk unit there were two staff bathing a person, two staff in a room providing care and one staff person picking up trays and answering call bells. During this time an interview was conducted with R6, and it was explained that assistance was required by staff to help R6 to bed. R6 further revealed that there are times that we do wait more than 30 minutes or longer for call bell to be answered or to be put to bed.4. R11's review revealed:8/11/25 8:53 AM - During an interview R11and F2, long wait times for assistance were reported when for call bell response. F2 stated F11 was often found lying in urine and feces, prompting F2 to clean and change A2 personally due to lack of staff response.5. R13's review revealed:8/7/25 2:23 PM - During an interview with R13 it was revealed that call bell responses often take longer than 20 minutes to get assistance.6. R19's review revealed:7/21/25 3:48 PM - A concern form noted that on Sunday morning, 7/20/25, R19 waited approximately 1.5 hours for call bell response. R19 disclosed needing to use the bathroom and had to wait for F3 to assist, indicating staff were unavailable when needed.7. R20's review revealed:8/11/25 9:48 AM - 10:13 AM - R20's call bell rang continuously for 25 minutes before a staff person responded.8/11/25 3:05 PM - Findings were reviewed during the exit meeting with E1, E2 (Regional), and E3 (Regional nurse).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review, it was determined that for one (R6) out of three sampled residents for dental services, the facility failed to ensure the resident received dental services. Findings include:A review of R6's clinical record revealed:9/27/23 - R6 was admitted to the facility.7/25/24 - A dental progress note documented that R6 wanted her teeth extracted and to receive dentures. The note documented that the treatment plan for R6 was to have new upper and lower dentures along with the extraction of the bottom teeth.12/17/24 - A dental progress note documented that R6 stated that she wanted her lower teeth extracted and full dentures made.3/31/25 - A dental exam note documented that R6 requested to have extractions.4/10/25 - A dental exam note documented that R6 was seen to be reviewed for teeth extractions.8/7/25 9:15 AM - During an interview, R6 stated that she has four teeth remaining on the bottom and has been asking to have them pulled for over a year. R6 stated that she wanted to have dentures. An observation was completed and it was noted that R6 has four remaining teeth on the bottom front. During this observation, R6 demonstrated how one of the four teeth can be moved all the way forward because it is loose.8/8/25 8:45 AM - During an interview, E4 (unit secretary) stated that the dental team can perform teeth extractions in the facility. E4 stated that they understand that R6 wants to have her teeth extracted and the dental team is coming to the facility on 8/29/25. E4 stated that she is unaware if R6 is scheduled to have them extracted.8/8/25 9:05 AM - During an interview, PC1 (dental company scheduler) stated that R6 is not scheduled to have extractions at that time. The appointment on 8/29/25 is for the new dentist to conduct their initial exam with R6.8/11/25 1:30 PM - During an interview, E1 (NHA) confirmed the delay in R6's teeth extraction and starting her denture process.8/11/25 3:05 PM - Findings were reviewed during the exit meeting with E1, E2 (Regional), and E3 (Regional nurse).