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	02/11/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** An unannounced Follow-up Survey was conducted on March 26, 2026, for the Annual and Complaint Survey ending February 11, 2026, by the State of Delaware Division of Health Care Quality, Office of Long-Term Care Residents Protection. The facility census on the first day of the survey was ninety-two (92). The sample size was twenty (20) residents. The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of March 17, 2026.An informal dispute resolution (IDR) was conducted for this citation. It was determined that the citation was past non-compliance and corrected by the facility 8/24/25. No additional correction on part of the facility was necessary as a result of the survey.Based on record review, interview, and policy review, the facility failed to ensure resident safety for one of two residents (Resident (R) 108) reviewed for elopement and one of six residents (R83) reviewed for accidents. As a result, R108, who had been assessed as an elopement and fall risk with cognitive impairment and an unsteady gait, exited the facility without staff knowledge. R108 remained outside the facility for approximately one hour before being located by staff in the back employee parking lot. This had the potential to result in serious injury or death.On 02/10/26 at 7:09 PM, the Administrator was notified that Immediate Jeopardy (IJ), which also constituted Substandard Quality of Care (SQC), was identified at F689 at a Scope and Severity (S/S) of J related to the facility's failure to ensure a resident's safety after R108 eloped. The IJ began on 08/24/25 when R8, who had been assessed as an elopement and fall risk with cognitive impairment and an unsteady gait, exited the facility without staff knowledge. On 02/11/26 the facility provided a Removal Plan that was accepted at 3:34 PM. The survey team validated the implementation of the removal plan through observations, staff interviews, and record reviews on 02/11/26 at 6:57 PM, and the scope and severity was lowered to D, isolated, potential for more than minimal harmFindings include:1. Review of R108's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included history of falling, muscle weakness, and abnormalities of gait and mobility. Review of R108's Elopement Evaluation, dated 08/21/25 and located in the EMR under the Assessments tab, revealed a score of three indicating the resident was at risk of elopement. Review of R108's Care Plan, dated 08/21/25 and located in the EMR under the Care Plan tab, revealed that it did not include his elopement risk or any interventions.Review of a Nurses Note, dated 08/24/25 at 11:50 AM and located in the EMR under the Progress Notes tab, revealed, Pt [patient] was wandering around unit this morning. After multiple redirections, he was placed in front of the fish tanks. Pt was content. CNA [Certified Nurse Aide] stated she saw him recently prior to incident and he was still sitting on the couch. Pt was found in back employee parking lot tending to the flowers. Patient unharmed and checked out ok. Wander guard to be placed asap [as soon as possible].Review of R108's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/28/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severe cognitive impairment. During an interview on 02/09/26 at 1:27 PM, Licensed Practical Nurse (LPN) 1 reported she was the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	nurse on duty on 08/24/25 that was assigned to the unit R108 was on. LPN1 said on the morning of 08/24/25, R108 kept coming out of his room and walking around the unit. She was concerned about him falling, since he was unsteady on his feet. She made numerous attempts to redirect him back to his room unsuccessfully, but he did sit down in the visiting area by the fish tanks. She told the CNA staff to pass by that area every time they went anywhere on the unit to check on him. She was charting at the nurse's station that was out of view of the resident. A little while later one of the CNA staff asked her, Where did [R108] go? She, along with the two CNA staff and LPN2, immediately started to look for him. They alerted staff on the other unit and security. One of the CNA staff observed R108 through the window from room [ROOM NUMBER] and saw him outside by the street sign. She went out and immediately assessed him and brought him back into the facility. She was unsure of how long R108 was outside but thought it may have been about 20 minutes. She stated staff did hear a faint alarm sound that morning, but then it stopped so they were unaware that the emergency door had been opened. During an interview on 02/09/26 at 2:27 PM, LPN2 stated that on 08/24/25 she was not assigned to R108 but was made aware by staff that he could not be located, and she assisted in looking for him. When she went outside, she observed him and LPN1 together, and a CNA came with a wheelchair. He was in the back of the building in an employee parking lot on the sidewalk and messing with the flowers in the flower bed. He had a tote bag with him. She said the time of 11:48 AM that she wrote down on her statement for the facility's investigation was the time she found him. During an observation and interview on 02/10/26 at 10:30 AM, the Maintenance Director (MD) stated he was told R108 got out of the emergency/egress door located on the 2nd floor unit. He said the door alarm would sound when the emergency bar was pushed, and it would release the door lock after fifteen seconds, but the alarm would stop sounding once the door was pushed open. He stated he installed fire alarms on the door after the incident that required a key to stop the alarm and were louder. He stated they checked the door locks daily, but they never checked the alarm function prior to this incident or since. The MD demonstrated holding down on the bar on the emergency/egress door and the door unlocked. He also opened the door that showed the two flights of steps going down that led to the door that R108 exited through. During review of the facility's video surveillance on 02/10/26 at 11:30 AM, R108 was observed on the video standing in front of the fish tank and there were no staff visible in the camera view. At 10:48 AM on 08/24/25, R108 walked away from his walker, carrying a tote bag, and went straight to the emergency door and pressed down on the emergency bar. After about 15 seconds, the door opened, and R108 walked through the door. Staff were still not observed in the camera view. During an interview on 02/10/26 at 2:05 PM, the Administrator stated surveyors were not allowed to see the facility's Quality Assurance and Performance Improvement (QAPI) meeting minutes, agenda, or any current Performance Improvement Projects (PIPs) the facility was working on. She reported what PIPs were in place and what was being followed in QAPI, and elopement was not being monitored. During an interview on 02/11/26 at 3:42 PM, The Administrator said the nurse who completed R108's admission elopement assessment should have put an immediate intervention in place, and the Interdisciplinary Team (IDT) would have met the following day to see what else, if anything, needed to be put in place. There also should have been a review of his admission records. The unit manager or shift supervisor should have checked to ensure that based on the findings of the elopement assessment that everything was put in place. That process did not happen in this situation. She said when R108 was wandering around the unit and could not be redirected, staff should have tried other things to keep him safe. The staff did not make good use of their resources. They could have gotten other disciplines involved to see what could have been done to supervise him, but they failed in this situation. She said the time of 11:05 AM on 08/24/25 listed in the facility's investigation reflected the moment on the video when staff were seen walking around and appeared to realize the resident was unaccounted for. The time of 11:16 AM that was indicated as the time R108 was found in the facility's investigation was when staff found him. She said she probably wrote that down somewhere, but she did not have anything that documented (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that time, and she did not preserve the video of the time R108 was returned to the facility. She said she did not think about it because she was more concerned with how he got out. She also stated she was unaware that the alarm system and the wander guard system were not being tested, but she would have expected that to have been completed.Review of the facility's policy titled Wandering and Elopements, revised April 2024, revealed, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk on admission for wandering/elopement, or other safety issues, a wandering/elopementassessment is completed as well as an obtained wandering/elopement history if able. A wanderguard is placed on resident. A care plan is initiated that will include the wanderguard and strategies and interventions to maintain the resident's safety.2. Review of R83's Face Sheet, located in resident's EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included difficulty in walking and muscle weakness.Review of R83's Care Plan, dated 11/17/22 and located in the residents' EMR under the Care Plan tab, revealed The resident has potential for falls related to decreased weakness. Interventions in place were Hoyer lift [non-weight bearing mechanical lift] for transfers. Further review revealed two staff were to be present to provide care at all times. Review of R83's quarterly MDS with an ARD of 06/06/25, located in the EMR under the MDS tab, revealed a BIMS score of 14 out of 15, which indicated no cognitive impairment. Review of a Nurses Note, dated 08/12/26 at 4:05 PM and located under Progress Notes tab, revealed, Patient was received in bed awake. Patient complained of foot pain. Patient was given Tylenol with positive results. Physician made aware and ordered to be sent out for X-ray.Review of Facility 5-day Follow Up, dated 08/21/25 at 5:50 PM and provided by the facility, revealed the allegation of improper transfer was confirmed. They found that staff transferred the resident using a stand-pivot but not a Hoyer lift. X-rays were completed with no findings of injury. During an interview on 02/08/2026 at 1:38 PM, R83 stated on 08/11/25 a new CNA (CNA3) came into her room to provide care. After CNA3 bathed and dressed her, CNA3 told her she was going to get her up out of the bed and place her in the chair. CNA3 placed the wheelchair next to the bed. CNA3 wrapped her arms around R83's waist, lifted her up out of the bed, and R83 stood on her feet. R83 said she yelled, It's painful then CNA3 placed her in the chair. R83 told the nurse what happened.During an interview on 02/10/26 at 12:45 PM, CNA3 said she was unfamiliar with R83 when she provided care to her on 08/11/25. She also stated she was unaware that she could go into the computer and access the resident's plan of care. She went into R83's room by herself, spoke with the resident, cleaned her, provided care, and got her dressed. CNA3 told R83 that she was going to put her in the chair. CNA3 placed the wheelchair next to the bed, had R83 on the side of the bed, put her arms around R83, and had R83 place her arms around her. CNA3 placed her in the wheelchair next to the bed. She said after R83 was in the wheelchair, R83 pointed to the corner of the room at the blue sling that was placed in the chair under some items and told CNA3 that she was supposed to use that to put R83 in the chair. She was unaware that R83 required a Hoyer left for transfers and that two staff were always required to provide care to R83. During an interview on 02/11/26 at 3:42 PM, the Administrator said that during the facility's investigation, they did find that R83 was transferred inappropriately. The CNA transferred R83 by herself without the use of a Hoyer lift. She stated that places both the resident and staff at risk of being hurt.

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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 interviews, record review, and facility policy review, the facility failed to provide evidence that residents or their representatives were informed of the risks, potential side effects, and available treatment options for two of five residents (Resident (R) 12, and R66) reviewed for unnecessary medications who received antipsychotic and/or psychotropic medications This deficient practice resulted in residents receiving medications that may not have been clinically necessary.Findings include:1. Review of R12's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed an admission date of 11/03/25 with diagnoses of major depressive disorder, other recurrent depressive disorders, and dementia.Review of R12's Physician Orders, located in the EMR under the Orders tab, revealed orders dated 11/03/25 for Rexulti (an antipsychotic medication) 0.5 milligrams (mg) at bedtime for agitation associated with dementia and Cymbalta (an antidepressant medication) 60mg one time a day for depression. Also ordered on 11/03/25 was Side Effect Assessment: Does resident have any noted side effects from Depression medication? Y or N. Then indicate Type by letter: [A=voluntary movements, B=tremors, C=dry mouth, D=urinary retention, E=seizures, F=blurred vision, G=rashes, H=sedation, I=dystonia or rigidity, or J=other side effects, please note in progress note] IF YES CALL PHYSICIAN. every shift.Review of R12's admission Minimum Data Set (MDS) assessment, located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS also indicated antipsychotic and antidepressant medications were received during the assessment period.During an interview on 02/10/26 at 4:57 PM, The Director of Nursing (DON) was asked about consents or any evidence that the resident received education of the risks, benefits, or other options available for treatment with antipsychotic and psychotropic medications. The DON replied that the resident came into the facility already on those medications and confirmed there was no evidence that education was provided to the resident.2. Review of R66's admission Record, located under the Profile tab in the EMR, revealed an admission date of 03/06/25 with diagnoses of major depressive disorder, dementia, and metabolic encephalopathy.Review of R12's Physician Orders, located in the EMR under the Orders tab, revealed an order dated 03/06/25, Side Effect Assessment: Does resident have any noted side effects from Depression medication? Y or N. Then indicate Type by letter: [A=voluntary movements, B=tremors, C=dry mouth, D=urinary retention, E=seizures, F=blurred vision, G=rashes, H=sedation, I=dystonia or rigidity, or J=other side effects, please note in progress note] IF YES CALL PHYSICIAN. every shift. On 07/10/25, sertraline (an antidepressant medication) 50mg by mouth one time a day for depression and anxiety was ordered. On 11/19/25, buspirone (an anti-anxiety medication) 5mg one tablet by mouth two times a day for anxiety was ordered.Review of R66's quarterly MDS assessment, located in the EMR under the MDS tab with an ARD of 12/12/25, revealed a BIMS score of nine out of 15, which indicated moderate cognitive impairment. The MDS also indicated antidepressants and anxiety agents were received during the assessment period.During an interview on 02/10/26 at 4:57 PM, the DON was asked about consents or any evidence that the resident received education of the risks, benefits, or other options available for treatment with psychotropic medications. The DON replied there was no evidence that education was provided to the resident.During an interview on 02/11/26 at 9:46 AM, the Administrator was asked what the expectation was about evidence of education provided for antipsychotic and psychotropic medications. The Administrator stated there should be consents signed to confirm education. Review of the facility's policy titled Antipsychotic Medication Use, with a revision date of 07/2022, revealed, 5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will . b. re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks [at the initial MDS assessment] to consider whether or not the medication can be reduced, tapered, or discontinued . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Psychotropic Medication Use, with a revised date of 02/2025, revealed, Policy Statement: Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical Record . informed Consent or Refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal:a. non-pharmacological alternatives; b. the indications and rationale for the recommendation;c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); andd. the resident's/representative's right to accept or decline the treatment .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to provide the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) notifications to three of three residents (Residents (R) 109, R81 and R110) reviewed for beneficiary notification. This failure had the potential to affect all residents who continued residing in the facility after the end of their Medicare Part A services by limiting their ability to make informed decisions regarding their financial responsibility. Findings include:1. Review of R109's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including muscle weakness and difficulty in walking, and that she remained in the facility after her Medicare Part A covered services ended on 11/04/25.Review of R109's SNF (Skilled Nursing Facility) Beneficiary Notification Review form revealed Medicare Part A skilled services start date was 10/09/25 and the last day covered was 11/04/25. Further review revealed no SNF ABN notification was provided prior to the last date of services.2. Review of R81's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including muscle wasting, difficulty in walking, and lack of coordination and that she remained in the facility after her Medicare Part A covered services ended on 08/02/25. Review of R81's SNF Beneficiary Notification Review form revealed Medicare Part A skilled services start date was 06/28/25 and the last day covered was 08/02/25. Further review revealed no SNF ABN notification was provided prior to the last date of services.3. Review of R110's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including muscle wasting and lack of coordination and that she remained in the facility after her Medicare Part A covered services ended on 09/22/25. Review of R110's SNF Beneficiary Notification Review form revealed Medicare Part A skilled services start date was 08/08/25 and the last day covered was 09/22/25. Further review revealed no ABN notification was provided prior to the last date of services.During an interview on 02/11/26 at 6:09 PM, the Social Worker (SW) said she was unaware that she was supposed to issue the SNF ABN form when a resident's Medicare Part A benefits were ended and they remained in the facility. During an interview on 02/11/26 at 6:57 PM, the Administrator stated she was unaware that SNF ABN notices were not being provided. She said she expected that the policy would be followed and that beneficiaries would be notified timely. Review of the facility's policy titled Beneficiary Notice - NOMNC [Notice of Medicare Non-Coverage] and SNF ABN - Policy and Procedure, dated 2025, revealed, . to ensure that the Facility fulfils its responsibility to inform its residents about potential Medicaid and Medicare noncoverage and the option to continue services with the resident accepting financial liability for those services. Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage [SNF ABN] The Facility will only issue the SNF ABN, CMS-10055 if the resident intends to continue services and the Facility believes the services may not be covered under Medicare. The Facility will inform the resident about potential non-coverage and the option to continue services with the resident accepting financial liability for those services. The SNF ABN provides information to residents so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. If the Facility provides the resident with the SNF ABN, the Facility has met its obligation to inform the resident of his or her potential financial liability and related standard claim appeal rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, facility document review, and policy review, the facility failed to follow its abuse policy and did not conduct a thorough investigation into allegations of abuse involving two of five residents (Resident (R) 59 and R72) reviewed for abuse out of 32 sampled residents. This failure had the potential to result in unrecognized or ongoing abuse that puts other residents in the facility at risk.Findings include:1. Review of R59's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted on [DATE] with diagnoses of cerebrovascular accident (stroke), seizure disorder, and depression.Review of R59's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R59 was cognitively intact. 2. Review of R72's Face Sheet, located in the EMR under the Profile tab, revealed the resident was admitted on [DATE] with diagnoses of diabetes mellitus, anxiety disorder, and depression.Review of R72's quarterly MDS with an ARD of 11/27/25, located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15 which indicated R72 was cognitively intact. Review of Facility Reported Incident (FRI), signed and dated 08/27/25 by the previous Director of Nursing (PDON) and provided by the facility, revealed the facility received allegations of verbal abuse by a housekeeper from R59 and R70. An investigation was initiated promptly in accordance with facility policy. Interviews were conducted with the involved housekeeper, one staff present on the unit, and the two alert and oriented residents who made the report. There were no indications of any other interviews conducted. During an interview on 02/11/26 at 1:40 PM, the Assistant Director of Nursing (ADON) stated that during an investigation the facility should interview the resident making the complaint, staff working with the resident at the time, and other residents from the floor where the allegation was made. The ADON verified, after reviewing the FRI, that only R59 and R70 were interviewed and stated the PDON should have completed additional resident interviews for a complete and thorough investigation. During an interview on 02/11/26 at 1:50PM, the DON stated that for a thorough investigation, similar residents should be interviewed. Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with a revision date of 04/21, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental,sexual or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms . The individual conducting the investigation will, as a minimum: Interview the person(s) reporting the incident . Interview staff members [on all shifts] who have had contact with the resident during the period of the alleged incident . interview other residents to whom the accused employee provides care or services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interviews, and facility policy review, the facility failed to ensure a person-centered comprehensive care plan was developed for three residents (Resident (R) 6, R52, and R108) out of a total of 32 sampled residents. This deficient practice placed the residents at risk for unmet care needs, ongoing assessment, and provider notification.Findings include: 1. Review of R6's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R6 was admitted to the facility on [DATE], with the most current re-entry on 12/22/25, with diagnoses that included essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, and transient cerebral ischemic attack (stroke symptoms that resolve). Review of R6's Order Summary Report, located under the Order tab of the EMR, reflected an order dated 01/19/26 to Check [NAME] monitor placement each shift every shift for Cardiac monitoring for 30 days. There were no other orders related to the [NAME] monitor. Review of R6's current Care Plan, located in the EMR under the Care Plan tab did not address the [NAME] monitor or any specific, measurable, achievable, relevant, and time-bound goals and interventions to ensure effective, patient-centered, and actionable healthcare outcomes for R6's cardiac monitoring. During an interview on 02/11/26 at 2:16 PM, the Registered Nurse Unit Manager (RNUM) 1 said that any care, treatment, and services provided to a resident should be reflected in the care plan to ensure continuity of care. The interventions would ensure nursing staff assessed the resident's skin for potential reaction to the electrode contact adhesive and that the cardiac [NAME] monitor was in place and did not get wet. RNUM1 said that any nurse could update the care plan to address specific care needs and appropriate interventions. During an interview and record review on 02/11/26 at 3:42 PM, the Minimum Data Set (MDS) Coordinator (MDSC) said that she initiated the comprehensive care plan based on a Care Area Assessment (CAA) that was triggered. The MDSC reviewed the comprehensive care plan and confirmed that the care plan did not reflect objectives and interventions for monitoring the cardiac [NAME] monitor to address the risk of actual wounds. The MDSC said that the care plan should reflect resident goals, desired outcomes, care/services provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC said that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC said that the Unit Managers reviewed the care plans for changes and updates. 2. Review of R52's admission Record, located under the Profile tab of the EMR, revealed R52 was admitted to the facility on [DATE], with the most current re-entry on 01/27/26, with diagnoses that included cellulitis (a common infection of the skin and the soft tissues underneath), unspecified dementia, carcinoma in situ (cancer that remains in the original cells where it started, without spreading to nearby tissues) of skin of scalp and neck and actinic keratosis (precancerous skin lesions that form on sun-exposed areas of the body). Review of R52's Order Summary Report, located under the Order tab of the EMR, reflected an order (continued on next page)

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	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 02/04/26 for Contact Isolation: MRSA ([Methicillin-resistant Staphylococcus aureus] type of bacteria that is resistant to several antibiotics) Skin, nares every shift for MRSA. Review of an order written by R52's dermatologist, dated 02/04/26, located under the Misc tab of the EMR revealed, Patient is MRSA positive, needs respiratory and contact isolation. Review of R52's Care Plan, located in the EMR under the Care Plan tab, initiated on 02/09/26, revealed it did not reflect interventions specific and relevant to respiratory isolation precautions to ensure appropriate personal protective equipment was worn to prevent airborne and droplet transmission of MRSA. During an interview on 02/11/26 at 2:16 PM, RNUM1 said that she did not normally work on the unit where R52 currently resides and was notified that R52 was only on contact precautions for MRSA. RNUM1 said the risk of not wearing a mask and eye protection when entering an isolation room for respiratory precaution would be becoming infected with the pathogens transmitted by the resident when talking, coughing, or sneezing. RNUM1 said that any care, treatment, and services provided to a resident on a transmission-based precaution should be reflected in the care plan to ensure safety of the residents and staff. RNUM1 said that any nurse could update the care plan to address specific care needs and appropriate interventions. During an interview and record review on 02/11/26 at 3:42 PM, the MDSC said that she initiated the comprehensive care plan based on a CAA that was triggered. The MDSC reviewed the comprehensive care plan and confirmed that the care plan did not reflect objectives and interventions for respiratory isolation. The MDSC said that the care plan should reflect resident goals, desired outcomes, care/services provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC said that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC said that the Unit Managers reviewed the care plans for changes and updates. 3. Review of R108's admission Record, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included history of falling, muscle weakness, and abnormalities of gait and mobility. Review of R108's Elopement Evaluation, dated 08/21/25 and located in the EMR under the Assessments tab, revealed a score of three, indicating the resident was at risk of elopement. Review of R108's Care Plan, dated 08/21/25 and located in EMR under the Care Plan tab, revealed that it did not include his elopement risk or any interventions.Review of R108's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/28/25, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated severe cognitive impairment. During an interview on 02/11/26 at 3:42 PM, The Administrator said the nurse who completed R108's admission elopement should have implemented a care plan and put in an immediate intervention, and the Interdisciplinary Team (IDT) should have met the following day to see what else if anything needed to be put in place. Review of the facility's policy titled Wandering and Elopements, revised April 2024, revealed, If identified as at risk on admission for wandering/elopement, or other safety issues, a wandering/elopement assessment is completed . A wanderguard is placed on resident. A care plan is initiated that will include the wanderguard and strategies and interventions to maintain the resident's safety.Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised (continued on next page)

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	02/11/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 2022, revealed, 2. The comprehensive, person-centered care plan is developed within seven [7] days after the completion of the comprehensive MDS assessment [Admission, Annual, or Significant Change in Status]. All CAAs triggered by the MDS will be considered in developing the plan of care . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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	085058	A. Building B. Wing	02/11/2026

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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 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 observation, interviews, record reviews, and facility policy review, the facility failed to follow professional standards or its own established tracheostomy care procedures for cleaning the stoma site, replacing the inner cannula, and ensuring two staff members were present during care for one of six residents (Resident (R) 93) reviewed for respiratory care out of a total of 32 sampled residents. This deficient practice placed the residents at risk for respiratory distress or infection.Findings include:Review of R93's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R93 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (not enough oxygen in blood), tracheostomy status, and hemorrhage from tracheostomy stoma (bleeding from a tracheostomy site).Review of R93's Order Summary Report, located under the Order tab of the EMR, reflected an order dated 09/23/25 to Change inner cannula . Tracheostomy Care - trach ties - change every Monday and Thursday one time a day every Mon, Thu . Tracheostomy Care - pulse ox [pulse oximetry- a measure of the oxygen saturation in the blood] every shift and prn [as needed] every shift . Tracheostomy Care - trach care/Shiley disposable inner cannula 5IC70every shift . Tracheostomy Care - trach care every shift . Change Inner Cannula every 24 hours trach care.Review of R93's Treatment Administration Record (TAR), located under the Order tab of the EMR, on 02/09/26 at 2:10 PM, revealed Licensed Practical Nurse (LPN) 1 initialed the TAR for tracheostomy care - pulse ox every shift, tracheostomy care - trach care/Shiley disposable inner cannula 5IC70every shift, and Tracheostomy Care - tach care every shift on 02/09/26 for the 7a-3p shift.During an interview and record review on Monday, 02/09/26, at 2:10 PM, LPN1 said that she had not performed tracheostomy (trach) care yet. LPN1 said that she was responsible for trach care every Monday and Thursday only. LPN1 could not verbalize the procedure for trach care. LPN1 said that the respiratory therapist (RT) performed trach care that included changing ties and she (LPN1) was only responsible for cleaning the inner cannula. LPN1 reviewed R93's TAR and said that she probably clicked on the orders by accident and pointed out that the order for Tracheostomy Care - trach ties - change every Monday and Thursday one time a day was to be performed on Mondays and Thursdays. LPN1 was informed that it was currently Monday. LPN1 said that she did not realize that it was Monday and agreed to be observed performing trach care.During an observation and interview on 02/09/26 at 2:33 PM, LPN1 obtained a package containing a Shiley 5IC70 disposable inner cannula and a package containing split gauze. LPN1 opened the gauze package and placed it as well as the inner cannula package, on R93's blanket, which covered the resident, without setting up a sterile field. LPN1 did not ensure the procedure area was clean and did not use an antiseptic (liquid that kills germs) solution to clean R93's skin at the stoma site when she removed the old inner cannula and placed the new inner cannula. LPN1 replaced the trach ties with new ties and a foam collar. LPN1 performed the trach care alone and without securing the trach site to prevent dislodgment. LPN1 said that trach care meant to suction if needed, replace the gauze and change ties . only clean around the trach site with saline if drainage was noted.During an interview on 02/11/26 at 5:28 PM, the Director of Nursing (DON) said that the nurses were checked off on skills during on-the-job training (OJT). The DON went on to say that the nurses were responsible for performing the care correctly and it was not her responsibility to oversee the nurses' practice, that she delegated the responsibility to the Staff Development Coordinator (SDC), the Infection Preventionist, and the unit managers to monitor that the nurses performed tasks accurately. The DON said that the nurse could perform trach care without a second person if the nurse performing the task was competent.Review of LPN1's personnel file provided by the Administrator revealed a Classroom Orientation Checklist, Day 3, dated 04/22/25, covered the topic of Trach Care and Emergency Dislodgement during orientation. A Competency Assessment Tracheostomy Care, dated 12/09/25, signed by LPN1 and the SDC, that reflected LPN1 demonstrated (continued on next page)

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	02/11/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	competency. Procedure guidelines outlined Assess resident for respiratory distress . Set up supplies on sterile field . Site and Stoma Care: Clean the stoma with two peroxide-soaked gauze pads [using a single sweep for each side] . Rinse the stoma with saline-soaked gauze pads [using a single sweep for each side] . Wipe with dry gauze [using a single sweep for each side].Review of the facility policy titled, Tracheostomy Care, revised November 2023, revealed Site and Stoma Care: 1. Apply clean gloves. 2. Clean the stoma with two peroxide-soaked gauze pads [using a single sweep for each side] 3. Rinse the stoma with saline-soaked gauze pads [using a single sweep for each side] 4. Wipe with dry gauze [using a single sweep for each side] 5. Disinfect the stoma with the antiseptic-soaked gauze pads [using a single sweep for each side]. Allow to air dry or wipe with clean, dry gauze. 6. With two staff members present, remove neck ties and replace with clean ones 7. Apply a fenestrated [split] gauze pad around the insertion site .

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	085058	A. Building B. Wing	02/11/2026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure use of personal protective equipment (PPE) in the implementation of respiratory isolation for one of one resident (Resident (R) 52) reviewed for transmission-based precautions out of a total sample of 32 residents. This failure had the potential to lead to the transmission of droplet pathogens from resident to staff not wearing a mask or eye protection.Findings include:Review of R52's admission Record, located under the Profile tab of the EMR, revealed R52 was admitted to the facility on [DATE], with the most current re-entry on 01/27/26, with diagnoses that included cellulitis (a common infection of the skin and the soft tissues underneath), unspecified dementia, carcinoma in situ (cancer that remains in the original cells where it started, without spreading to nearby tissues) of skin of scalp and neck and actinic keratosis (precancerous skin lesions that form on sun-exposed areas of the body).Review of R52's Order Summary Report, located under the Order tab of the EMR, reflected an order dated 02/04/26 for Contact Isolation: MRSA ([Methicillin-resistant Staphylococcus aureus] type of bacteria that is resistant to several antibiotics) Skin, nares every shift for MRSA.Review of an order written by R52's dermatologist, dated 02/04/26, located under the Misc tab of the EMR revealed, Patient is MRSA positive, needs respiratory and contact isolation.Review of R52's Care Plan, located in the EMR under the Care Plan tab, initiated on 02/09/26, did not reflect interventions specific and relevant to respiratory isolation precautions to ensure appropriate personal protective equipment was worn to prevent airborne and droplet transmission of MRSA.During an observation on 02/08/26 at 10:52 AM, an isolation sign was not posted outside of R52's room to inform of transmission-based precautions or of what PPE should be worn. At 2:48 PM, a contact precautions sign was posted outside of R52's room listing the required PPE (gown and gloves) staff should be put on before entering the room.During an interview on 02/11/26 at 9:45 AM, Certified Nurse Aide (CNA) 15 said that she wore a gown and gloves before entering R52's room because there was a contact precautions sign posted outside his room. CNA14 said that she did not know that she should wear a mask or that R52 should be on respiratory isolation.During an interview on 02/11/26 at 10:38 AM, Licensed Practical Nurse (LPN) 2 said that she was an agency nurse and reviewed orders and care plans to orient herself to residents. LPN2 was unaware of respiratory precautions as written on 02/04/26. LPN2 said that she received shift change report from the off-going nurse that R52 was on contact precautions for MRSA related to wounds on his legs. LPN2 said that she verified that by reviewing the orders and care plan that indicated contact precautions.During an interview on 02/11/26 at 12:35 PM, the Infection Preventionist (IP) stated that she was responsible for overseeing the tasks performed by Registered Nurse (RN) 2, the IP in training. The IP said that she was aware that R52 was on contact precautions for MRSA but did not conduct record review as part of oversight of RN2. The IP said that signs for respiratory and contact isolation should be posted as ordered for MRSA. The IP said that it was the responsibility of the nurses to communicate in change of shift report that R52 was on respiratory and contact isolation for MRSA.During a phone interview on 02/11/26 at 1:36 PM, the Doctor of Osteopathic Medicine ([DO] dermatologist) stated that the wound culture she performed on R52 legs resulted with MRSA. The DO said that she wrote the order to place R52 on respiratory and contact isolation for MRSA. The DO said that it was her medical professional opinion that R52 be placed on respiratory isolation in addition to contact isolation because MRSA could be dormant in the nares and spread by respiratory droplets. Review of the facility's policy titled, Isolation - Categories of Transmission-based Precautions, revised September 2022, indicated Policy Statement Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; . or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart (continued on next page)

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	085058	A. Building B. Wing	02/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC [Centers for Disease Control and Prevention] precaution[s], instructions for use of PPE, and/or instructions to see a nurse before entering the room . 1. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets [large-particle droplets larger than 5 microns in size that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning] . 3. Masks are worn when entering the room. 4. Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions.