DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Polaris Healthcare & Rehab Center LLC **DATE SURVEY COMPLETED:** April 3, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint and Follow-up Survey to the Annual, Complaint, Emergency Preparedness and Extended Survey ending January 28, 2025, was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection on March 27, 2025 thru April 3, 2025. The facility census on the first day of the survey was ninety-three (93). The sample size was thirty-four (34) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** The facility was found not to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of April 4, 2025. **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed April 4, 2025: F609, F610 and F842.	Cross-reference ePOC Submission of Plan of Correction. Thank you.	

Provider's Signature _____ Title NHA Date 5/1/2025

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 _____	R-C 04/03/2025

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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{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unnanounced Complaint and Follow-up Survey to the Annual, Complaint, Emergency Preparedness and Extended Survey ending January 28, 2025 was conducted by the State of Delaware Division of Health Care Quality, office of Long Term Care Residents protection on March 27,2024 thru April 3, 2025. The facility census on the first day of the survey was ninety-three (93). The sample size was thirty-four (34) residents. The facility was found not to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of April 3, 2025. Abbreviations/definitions used in this report are as follows: AD - Actives Director; ADON - Assistant Director of Nursing; BOM - Business Office Manager; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; Social Worker; UM - Unit Manager; Misappropriation of resident property - the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s	{F 000}		

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

Electronically Signed | 04/22/2025

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.

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{F 000}	Continued From page 1 belongings or money without the resident ' s consent. Mistreatment - inappropriate treatment or exploitation of a resident.	{F 000}		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		4/24/25

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F 609	Continued From page 2 Based on record review and interview, it was determined that for one (R18) out of two (2) residents reviewed for misappropriation of resident property, the facility failed to recognize and consequently report an allegation of misappropriation of resident property/funds no later than 24 hours. Findings include: The facility policy on abuse dated 12/2016 indicated "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Investigate and report any allegations of abuse within timeframe's as required by federal requirements." 3/4/25 - A grievance form was completed on behalf of R18 by E8 (AD) that documented, "[R18] said he saw charges that were not his own on his credit card. He also said that someone has taken out a loan in his name. He was assisted with calling customer service." Further documentation on the grievance indicated the investigation was assigned by E7 (SW) to E5 (BOM) to complete the investigation of the grievance. E5 documented, "[R18] was approached by BOM and a security officer. We asked if he would like to call the police and file a report. He declined." The grievance documented the resolution date as 3/6/25 and was signed by E1 (former NHA). 4/2/25 1:30 PM - During an interview E5 (BOM) confirmed being assigned to review R18's grievance related to missing money and stated that E1 (former NHA) was aware of R18's allegations. 4/2/25 1:54 PM - During an interview E4 (DON) stated he was previously unaware of R18's	F 609	R85 was interviewed by the Director of Nursing or designee regarding misappropriation of his funds. Resident denies missing any funds due to misappropriation or exploitation. All residents that reside at the facility have the potential to be affected. The Nursing Home Administrator or designee will hold an AD HOC Resident Council Meeting to review the process for misappropriation of resident goods or exploitation. The Root Cause Analysis indicates R85 was interviewed by the Business Office Manager regarding missing funds via transactions that he did not make in February 2025. At the time the resident did not allege thief of these funds of any kind and reported that it is fine. In March 2025 the resident reported that a previous employee was stealing his money. The accusation was reported to the Department of Health and the Police were called. The resident denied accusation to the police. The Director of Nursing or designee will educate staff on Identifying exploitation, theft and misappropriation of resident property. The Director of Nursing or designee will interview five residents weekly for three weeks until 100% compliance is achieved, then monthly for three months with the goal of compliance to be achieved and sustained to ensure there are no allegations of misappropriation	

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F 609	Continued From page 3 grievance related to an allegation of misappropriation of resident funds. 4/2/25 2:21 PM - During an interview E1 (former NHA) confirmed knowledge of R18's allegation of misappropriation of resident funds. E1 stated, "I thought it was an old allegation of money way before I was there don't recall the resident or details. 4/3/25 11:45 AM - During an interview E5 (BOM) confirmed that R18's grievance related to missing money was not recognized as an allegation of misappropriation of funds and therefore was not reported to the State Agency. 4/3/25 2:12 PM - During an interview E7 (SW) confirmed that R18's grievance related to missing money was not recognized as an allegation of misappropriation of funds and therefore was not reported to the State Agency. 4/3/25 3:45 PM - Findings were reviewed during the exit meeting with E2 (NHA) and E4 (DON).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		4/24/25

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F 610	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R18) out of two (2) residents reviewed for allegations of misappropriation of resident property, the facility failed to provide evidence that the allegation was thoroughly investigated. Findings include: The facility policy on abuse dated 12/2016 indicated "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Investigate and report any allegations of abuse within timeframe's as required by federal requirements." 3/24/25 - The facility submitted an incident report to the State Agency that alleged "[R18] reported a previous employee was stealing money. Investigation started immediately. Police contacted." 4/1/25 9:07 AM - The surveyor requested a copy of the investigation related to R18's allegation of misappropriation of property. 4/3/25 12:32 PM - During an interview E4 (DON) confirmed the facility did not conduct interviews, obtain statements or complete an investigation regarding R18's allegation of misappropriation of property. E4 stated, "We called the police."	F 610	R85 was interviewed by the Director of Nursing or designee regarding misappropriation of his funds. Resident denies missing any funds due to misappropriation or exploitation. All residents that reside at the facility have the potential to be affected. The Director of Nursing or designee will audit reports of abuse for the past 30 days to ensure a thorough investigation occurred and conclusions have been drawn appropriately. The Root Cause Analysis indicates R85 was interviewed by the Business Office Manager regarding missing funds via transactions that he did not make in February 2025. At the time the resident did not allege thief of these funds of any kind and reported that it is fine. In March 2025 the resident reported that a previous employee was stealing his money. The allegation was reported to the Department of Health and the Police were called. The resident denied accusation to the police. The facility failed to continue their investigation after the allegation was denied to the police. The Director of Nursing will educate staff on investigating	

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F 610	Continued From page 5 4/3/25 3:45 PM - Findings were reviewed during the exit meeting with E2 (NHA) and E4 (DON).	F 610	incidents of thief and/or misappropriation of resident property. The Director of Nursing will audit events requiring reporting to the Department of Health residents weekly for three weeks until 100% compliance is achieved, then monthly for three months with the goal of compliance to be achieved and sustained to ensure a thorough investigation occurred and appropriate conclusions were drawn.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		4/24/25

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F 842	Continued From page 6	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 7 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R500) out of thirty-four (34) residents reviewed, the facility failed to ensure the residents medical record was complete, accurately documented and readily accessible. Findings include: The facility policy on charting and documentaion last updated 2001 indicated, "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." Review of R500's clinical record revealed; 3/21/25 7:45 PM - A fall incident report documented, that R500 a resident with some "baseline confusion" experienced an unwitnessed fall. 3/21/25 7:45 PM - A neurological assesment form was initiated by E6 (RN) related to R500's unwitnessed fall to be completed through 3/24/25. 3/21/25 7:45 PM - A progress note written by E6 (RN) in R500's clinical record documented, "Post fall this shift...Neuro checks done and in progress. Will continue to monitor." The progress note lacked specific information regarding the neurological checks. 3/21/25 7:47 PM - A progress note written by E6 (RN) in R500's clinical record documented, "Resident resting and neuro checks in progress." The progress note lacked specific information	F 842	R500 is no longer in the facility. The facility has no opportunity to resolve the alleged deficiency. All residents that reside in the facility have the potential to be affected. The Director of Nursing or designee will review residents who experienced a fall in the prior 30 days to ensure neuro checks were completed as ordered. The root cause analysis indicated that the neuro checks for the resident were recorded on two separate documents and only one of the two documents were scanned into the chart resulting in the neuro checks to appear incomplete. The second document was scanned into the chart resulting in all required neuro checks to be able to be viewed in the electronic medical record. The Director of Nursing or designee will educate staff on charting and documentation including the correct process for completing neuro checks for patients that are status post fall. The Director of Nursing or designee will audit neuro checks for patients that are status post fall weekly for three weeks until 100% compliance is achieved, then monthly for three months with the goal of compliance to be achieved and sustained to ensure neuro checks for patients that have experienced a fall are obtained and	

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F 842	Continued From page 8 regarding the neurological checks. 3/31/25 2:00 PM - Review of the neurological assesment form related to R500's unwitnessed fall lacked evidence of entries for completion of the neurological assessments from 3/21/25 at 7:45 PM through 11:30 PM. 3/31/25 3:01 PM - Surveyor attempted to contact E6 (RN) by telephone and received a text message that E6 was unavailable for interview due to air travel. 4/1/25 12:58 PM - During an interview E3 (DON) confirmed that the neurological assesment form related to R500's fall was incomplete. 4/3/25 3:07 PM - During an interview E6 (RN) confirmed that neurological assessments were completed on R500 following the residents fall on 3/21/25. E6 then produced neurological assessment documentaion on a green legal pad for the timeframe not documented on the neurological assessment form. E6 stated, "I always document on my pad. My goal was to write it and transfer it to that form. I was the supervisor that shift. As I was writing they called me and I had to stop. When I returned the nurse had taken the sheet." E4 then scanned a copy of the assessment documentation on the note pad to R500's clinical record. 4/3/25 3:45 PM - Findings were reviewed during the exit meeting with E2 (NHA) and E4 (DON).	F 842	documented correctly.	