STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on interview and record review, the facility failed to follow admission physician orders related to TED hose/antiembolism stockings for a post op patient for 1 (#2) of 3 rehab patients sampled. Findings include: During an interview on 3/25/25 at 9:30 a.m., NF1 stated resident #2 had a left total knee surgery on 2/25/25. Resident #2 was admitted on [DATE]. NF1 stated the first night after admitted , the facility staff took resident #2's TED hose stockings off and told her it was the facility policy to prevent skin breakdown. The next morning the stockings were still observed to be off. During an interview on 3/25/25 at 3:15 p.m., staff member D stated they had removed resident #2's TED hose stockings because it was facility policy to remove them at night to prevent skin ulcers. During an interview on 3/27/25 at 11:00 a.m., staff member F stated a physician's order related to TED hose would override a facility policy. Review of resident #2's admission orders, dated 2/26/25, showed, TED Hose on at all times. Review of the facility policy, Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, with a revision date of 10/15/25, failed to show the removal of TED hose/antiembolism stockings at night for pressure ulcer prevention.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41952 Based on observation, interview, and record review, the facility failed to prevent the elopement of 3 (#s 4, 6, and 7) of 6 sampled residents for elopement; and failed to implement an effective elopement prevention and monitoring system for 6 (#s 4, 6, 7, 8, 9, and 10) of 6 sampled residents for elopement risk. This deficient practice increased the risk of an elopement or negative outcome for a resident who was at risk of eloping, due to the system failure. Findings include: Review of facility reported incident for elopements showed: 1. On 8/17/24, resident #6 had been out in the courtyard with another resident. The other resident went back into the building, and resident #6 was found wandering around the outside of the building, by a staff member on break. The resident had stated she got lost and did not know how to get back in the building. A wanderguard bracelet was placed for elopement risk. 2. On 1/1/25, resident #4 was found by an off-duty staff member, across town, by a local restaurant. They notified the facility, and staff picked resident #4 up and returned her to the facility. Resident #4 had a wanderguard bracelet and was on 15-minute checks due to behaviors at the time of the elopement. The facility did not identify how resident #4 eloped. Resident #4 was placed on continued 15-minute checks with a 1:1 monitor while out of her room. 3. On 1/11/25, the facility received a call from the [Hospital Name] stating resident #4 was at their facility. Resident #4 was brought back to the facility after several staff attempts to assist. Facility staff noted resident #4 had popped the screen out of her room window and had eloped through the window. The resident was wearing her wanderguard bracelet and placed on 1:1 (monitor) at all times. 4. On 3/17/25, resident #7 self-propelled out the north exit door, down the ramp, to the sidewalk. Another resident's family member was outside and went to alert facility staff. Resident #7 had a wanderguard bracelet on and it did not set off the system alerts. The bracelet was checked, had a low battery, and the bracelet was changed for a new wanderguard bracelet. During an interview on 3/25/25 at 10:22 a.m., staff member J stated she was on a smoke break when she saw resident #6 walking along the building outside. Resident #6 stated to staff member J she got lost trying to get back into the building after sitting in the courtyard with another resident. Staff member J stated she brought resident #6 back into the building and told the nurse. Staff member J stated resident #4 was difficult to handle because she was exit seeking, being combative, and had eloped. Staff member J stated the elopements happened on the evening and night shifts. Staff member J stated resident #4 had a wanderguard and frequent checks in place. It wasn't until after the elopements that resident #4 was on frequent checks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/25 at 10:31 a.m., staff member G stated he checked all of the wanderguard doors weekly. A tablet was used to monitor the exit door's function, adjust the sensitivity to wanderguard bracelets, and lock/unlock the doors. Staff member G stated the exit with a ramp was currently locked at all times while the facility figured out a way to handle a recent elopement for resident #7. During an observation on 3/25/25 at 4:23 p.m., resident #10 was seen leaving the facility through the main entrance with a family member. When they exited the building alarms were set off. Staff member A walked out and asked to check the resident and found a wanderguard bracelet on him. Staff member A went into the building to grab scissors and had resident #10 sit on a bench outside so the bracelet could be cut off and he could leave. During an interview on 3/26/25 at 3:36 p.m., staff member E stated the nurses documented the wanderguard bracelet(s) functioning each shift, usually by the residents wandering by the doors to set them off. Staff member E stated there was a tool to check the bracelets but believed the housekeeping staff or maintenance had the tool to do that. During an interview on 3/26/25 at 3:58 p.m., staff member A stated the facility had not been tracking the resident's wanderguard 'activate by' dates to show when the battery would expire for any residents wearing the elopement bracelets. The facility did not currently keep a list of residents with wanderguards, to ensure staff were aware of who they were and to monitor them. Staff were to monitor the placement of the wanderguard bracelets, and that the skin was intact surrounding the bracelets. Maintenance checked the doors weekly. During an interview on 3/27/25 at 8:54 a.m., staff member I stated staff knew who to check for the wanderguard for when the task was on the TAR to document the check. Staff member I stated 15-minute checks were done, which meant every 15-minutes staff would visually check the resident and document the check on the hardcopy flow sheet. The 1:1 monitor was always within eight feet of the resident, visually watching them. The :1 was documented on the TAR. The elopements of the residents did not happen when she was working. Staff member I stated the nurses would check the wanderguard bracelets by the resident wandering near a door to set off the alarms, and then the nurse would document the check for their shift. Review of resident #4's nurse progress notes, from 12/3/24 through 2/23/25, showed after a hospital return, on 12/28/24 through 2/23/25, resident #4 exhibited multiple behaviors of calling 911, exit seeking, and elopements, among others. Review of a facility provided document titled, Wander Guard Procedure, not dated, showed it was not a formal policy, and the document did not specify how residents were to be monitored. Review of the facility provided list of residents who had wanderguard bracelets or were elopement risks showed resident #s 4, 6, 7, 8, 9, and the list did not show resident #10. Review of the facility wanderguard manual showed it was recommended to check the 'activate by' dates so the facility would know when the battery would expire. The manual had assessments and checklists for monitoring and testing the wanderguard system, identifying areas to address for wandering, and elopement risk residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41952 Based on interview and record review, the facility failed to ensure it provided behavioral health services to meet the needs of 1 (#4) of 6 sampled residents for behaviors. Findings include: During an interview on 3/25/25 at 3:49 p.m., staff member C stated the trauma informed care assessment was completed on admission, quarterly, and with significant changes. Resident #4 had not triggered on her trauma informed care assessment on admission, which would show if interventions were necessary. Staff member C stated the facility had a contract with a telehealth psychiatrist who was available to residents if they were willing to see the psychiatrist. Staff member C stated resident #4 had a noticeable mental and physical decline in mid-December which was after the initial course of antibiotics. Resident #4 had no involved family, POA, or guardian. The resident's next of kin was a son who lived across the state. Staff member C stated the goal was to discharge resident #4 back to the treatment center she had been at. After resident #4's hospitalization , she was not capable of attending mental health appointments, or signing advance directives. The treatment center resident #4 had been at would no longer take her back. During an interview on 3/26/25 at 4:28 p.m., staff member A stated resident #4's admission assessment showed no trauma, there was a low PHQ-9 score for depression, and high score in the Brief Interview of Mental Status assessment. After her decline, they did a Significant Change MDS in February 2025. The facility had their contracted psychiatrist review resident #4's chart to give suggestions to implement, but they did not work. Behavior monitoring was documented on the TAR. Staff member A stated resident #4 was given a 30-day discharge notice and was scheduled to discharge home, with her son, on 3/1/25, but she went to the hospital and passed away. Review of resident #4's nurse progress notes, from 12/3/24 through 2/23/25, showed after her hospital return, on 12/28/24 through 2/23/25, resident #4 exhibited multiple behaviors of calling 911, being combative to staff, offering sexual favors, attempting to take sanitizer dispensers off the walls, having vape supplies, alcohol, having non-prescribed medications in her room, exit seeking, and laying self on the floor, among others. Review of resident #4's 30-day discharge notice, dated 1/28/25, showed the reason as, Unable to manage addiction and mental health needs. The notice was given verbally to resident #4's son, with a note of sending referrals to other facilities, for a possible admission. Review of resident #4's Significant Change MDS, with an ARD of 2/19/25, showed resident #4 had a significant decline in her mental and physical health.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on interview and record review, the facility failed to have a process in place to ensure pill contents, contained in personal prescription medication bottles brought from resident homes, were verified before dispensing, for 1 (#2) of 3 rehab residents sampled. Findings include: Review of resident #2's admission orders showed he was admitted on [DATE], arriving around 4:00 p.m., for acute rehab, following a knee surgery on [DATE]. His additional diagnoses included Parkinson's. Review of resident #2's admission orders, dated [DATE], showed the following new medication orders: - Colace 100 mg twice daily, - Acetaminophen 1,000 mg three times daily, - Oxycodone 5 mg every 4 hours as needed for pain, and - Aspirin 81 mg twice daily. Below those medications were resident #2's home medications which the resident would continue taking, which were: - Carbidopa 25 mg-levodopa 100 mg three times daily, - Flomax 0.4 mg daily, - Clonazepam 2 mg at bedtime, - Meloxicam 15 mg daily, - Rivastigmine tartrate 1.5 mg twice daily, - Carbidopa ER 50 mg-levodopa 200 mg twice daily, and - Entacapone 200 mg three times daily. Review of resident #2's MAR, dated [DATE] - [DATE], showed he received all of these medications. During an interview on [DATE] at 9:30 a.m., NF1 stated they brought in some of resident #2's medication from home as they were not being covered by their insurance during the rehab stay. NF1 stated the prescription label on the bottle for resident #2's clonazepam showed to take 1 mg at night. Facility nursing staff who checked the medications in did not clarify this discrepancy with the physician order, which was for 2 mg at night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275040	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Libby Care Center	308 E Third St Libby, MT 59923

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:50 p.m., staff member C stated resident #2's admission was paid for by workers compensation, and they would only cover medications related to the post op of his knee. All other medications were to be supplied by the family. Staff member C stated resident medications brought from home had to be in their original prescription bottles and not expired. During an interview on [DATE] at 3:15 p.m., staff member D stated the pharmacy did not examine the pills in the bottles brought in by family members, and nursing reviewed the dosages on the labels, against the physician order. During an interview on [DATE] at 9:45 a.m., staff member E stated there were some family members that brought in medication from home, but the staff member was unsure on the process for reconciliation. During an interview on [DATE] at 11:14 a.m., NF2 stated the pharmacy had only filled orders for oxycodone, carbidopa, and tamsulosin for resident #2. These were delivered early the morning of [DATE]. During an interview on [DATE] at 11:20 a.m., NF3 stated they would refer to the facility policies and procedures regarding accepting medications brought in by family. During an interview on [DATE] at 8:50 a.m., staff member A stated there was a pill finder application in PCC that nurses could use if one of the pills in the bottles did not look correct. During an interview on [DATE] at 11:00 a.m., staff member F was unaware the resident family was bringing in personal medications to be dispensed by the facility, as this practice would not be allowed in a hospital setting. Review of the facility policy, Pharmacy Services, dated [DATE], showed, . 31. Medications that are received from the resident, family, responsible, party and/or significant other are not accepted because we are unable to reconcile the medication with the prescriber order and the requisitions for the medication .