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	06/02/2026

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent a resident elopement for 1 (#3) of 13 sampled residents. This failure resulted in resident #3 exiting the alarmed facility and walking four blocks, and facility staff returning him to the facility uninjured. The facility had corrected the deficient practice resulting in past non-compliance. Findings include:A review of a facility reported incident submitted to the State Survey Agency showed, on 1/25/26, a staff member was alerted to a door alarm that was going off at an exit door at the end of the hall on the [NAME] side of the building. There was a resident standing by the door who was wearing a Wanderguard. The staff member redirected the resident and checked outside the door and did not see any other residents outside the building. Resident #3 was noted to not be in his room. A search for resident #3 was initiated. During the search time, resident #3?s family member, called the facility and reported resident #3 was at the laundry mat four blocks from the facility.During an interview on 6/2/26 at 11:04 a.m., staff member B stated when resident #3 set off the door alarm on 1/25/26, staff member D came to the hall the door was located to find resident #5 standing by the door. After staff member D disabled the alarm, she checked outside and did not see any other residents. Resident #5 was wearing a Wanderguard and had a history of setting off door alarms in the facility. Staff member B stated the resident was assessed for elopement on 1/20/25 and was determined to be an elopement risk. Interventions were initiated including a wanderguard placement on resident #3. Staff member B stated after resident #3 eloped his care plan was updated to include an actual elopement with interventions. Staff member B further stated that staff were educated on resident #3's elopement, other residents were assessed for elopement risk, and the QAPI committee reviewed the incident. POLICYIt is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement.A review of resident #3's care plan showed: Focus[Resident #3] is an elopement risk/wanderer r/t decreased cognition, decreased safety awareness, new admission/poor adjustment. Verbalization of wanting to leave. History of attempts to leave facility unattended. Date initiated: 1/20/26.Interventions/Task .Elopement on 1/25/26- Placed on Q 15 minute safety checks. Date initiated: 1/25/26.A review of a facility document titled, Resident Elopement Investigation and Conclusion, for resident #3, with a date of occurrence of 1/25/26 at 4:30 p.m., showed: Wandering/Elopement Evaluationsadmission Clinical Evaluation on 1/13/26: Not at risk for wandering or elopementWandering/Elopement evaluation on 1/20/26: Risk for elopement completed due to resident attempting to leave facility unattended to go to local hospital to ?find wife' who was actually in Kalispell, MT at hospital having a surgical procedure.Wandering/Elopement evaluation on 1/25/26: Risk for elopement 9completed post elopement) .Immediate Interventions: .Checked for injury, none noted, [Resident #3] interviewed and state he needed fresh air, he was bored and it was beautiful outside and wanted to be in the sunshine.Wandering/elopement evaluation completed and positive for ongoing risk for elopement.Wanderguard was checked for working condition, working condition noted.[Resident #3] was placed on 15 minute safety checks.Plan to prevent Reoccurrence: .Continue (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	secure care bracelet to the left wrist with continued function and placement checks.Activity department to interview and address [Resident #3's] request and preferences of activities for outside activities. Activity staff to show resident and encourage to use inner courtyard for outdoor activities.[Resident #3] will continue 15 minute safety checks at this time and this will be discontinued with review of behaviors over the course of 72 hours.Continue to support [Resident #3] and his family with difficulty adjusting to nursing home placement.Education provided to staff to ensure that outside is checked and monitored with Wanderguard alarm, alarming. [sic]A review of the facility QAPI agenda dated 2/19/26, showed: . Elopements: 1[Resident #3] 1/25/26, no injury-discussed prior elopement, post elopement and interventions put into place, continue with other placement and family support along with activity evaluation to meet needs and family support.A review of a facility policy titled, Elopement, with a release date of 9/16/25, showed:During an observation on 6/2/26 at 11:15 a.m., the door on the west side of the facility was noted to have an armed delayed egress alarm.Resident #3 had no further elopements up to the date of his discharge from the facility on 2/13/26.