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	08/15/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41952 Based on interview and record review, the facility failed to include a resident's history and risk of suicide on the baseline care plan for 1 (#76) of 2 sampled residents. Findings include: Review of resident #76's admission assessment dated [DATE], noted he was being admitted post hospitalization from an overdose. During an interview on 8/14/24 at 4:16 p.m., staff member E stated the nurses did not have any care plan or orders to monitor for suicide risk for resident #76. During an interview on 8/15/24 at 9:12 a.m., staff member C stated resident #76 had a suicide risk assessment and depression screening on admission. Staff member C said due to the assessment results, they determined suicide was not a current issue. Review of resident #76's hospice visits notes, dated on 7/18/24, showed resident #76 was noted to be a suicide risk due to his prior attempts and expressions of not wanting any contact with other humans, or not knowing why he is on earth. Review of resident #76's facility care plan, iniated on 7/9/24, had no information for suicide risk or history of attempts; how to identify, monitor, or support #76 if the signs of risk did occur.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41952 Based on observation, interview and record review, the facility failed to coordinate care and communication with hospice, for 2 (#s 65 and 76) of 2 sampled residents for hospice. Findings include: During an interview on 8/14/24 at 11:24 a.m., NF2 stated hospice had its own documentation and care plan for resident #65 and #76. NF2 stated the hospice staff did not provide the care plan or visit notes to the facility; the documentation would have to come from the main office after they finished documenting their visits. NF2 stated hospice did their own care plan meeting every other week to go over their patients, so they did not attend the facility care conference meetings. During an observation and interview on 8/14/24 at 4:12 p.m., staff member E stated different hospice nurses came different days of the week. Staff member E stated she was not sure if there was a hospice care plan or if there were any copies of hospice visits for residents #65 and #76. Staff member E stated the hospice nurses would generally check in for medication order changes as there were a lot for both resident #65 and #76, especially for as needed medications. Staff member E stated the medications came in bottles, and the labels were not updated to reflect new physician orders. Staff member E showed a bottle of as needed Ativan that had new orders of either half tab or whole tab which did not match the original medication label. There were two tablets left. Staff member E stated she generally gave a whole tab of Ativan and could not tell what other nurses gave a half tab of Ativan did with the half not administered. Staff member E stated the medications usually came in bottles, but she had requested cards. Staff member E stated both residents had multiple as needed (medication) orders which would get confusing with the bottles and labels not being updated, as they were to continue using the bottles until they were empty. During an interview on 8/15/24 at 7:52 a.m., staff member A stated there was no documentation of who the designated facility staff member was to coordinate with hospice. Staff member A wrote on the survey request list it would be the 'Team Nurse' and explained it would be the nurse assigned to the unit each day, not a specific person at the facility. During an interview on 8/15/24 at 8:52 a.m., staff member C stated resident #76 did not have a current risk of suicide, so it was not on the care plan. Staff member C stated resident #76 had attempted suicide prior to his stay at the facility. Staff member C stated the facility would help with advance directives on admission and review at each care conference. Staff member C stated resident #65 only had a POLST with no other advance directives or plans to make any. Staff member C stated resident #65 had a friend for support and an estranged wife. Review of hospice social services notes, dated from 7/2/24 to 8/9/24, showed resident #65 had his wife as POA and managing his finances. Resident #65 wanted to switch to a friend because his wife was not paying his bills, causing him anxiety. Hospice social services noted they were helping resident #65 get his friend to be his POA. As of an 8/9/24 note, hospice was attempting to help resident #65 obtain conservatorship instead. Review of resident #76s pharmacy recommendation form, dated 7/15/24, showed: [Resident #76] receives potentially duplicate therapy of the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. morphine concentrate 20 m/mL 0.75mL Q1H PRN 2. morphine concentrate 20 m/mL 0.25mL Q1H PRN 3. oxycodone 5mg Q4H PRN 4. oxycodone 15mg Q4H PRN Recommendation: Please reevaluate the need for both types of opioid orders indicated above. Due to multiple PRN analgesic orders, highly recommend adding pain scales to help staff differentiate when to use what medication (i.e. morphine concentrate if resident cannot swallow for moderate to severe pain) . Handwritten in on 7/18/24 declining any changes to the orders because of hospice. Resident #76 physician orders showed: - Oxycodone 5MG 1 tablet every 4 hours as needed for pain - Oxycodone 5MG 2 tablets every 4 hours as needed for pain - Oxycodone 5MG 3 tablets every 4 hours as needed for pain - Oxycodone 5MG 4 tablets every 4 hours as needed for pain -None of the oxycodone had specific ranges for when to use which dose or parameters if they could be used in conjunction with each or not in the ordered time ranges. Resident #65's physician orders showed: -Oxycodone 10mg 1 tab every 2 hours for moderate pain -Oxycodone 10mg 2 tabs every 2 hours for moderate pain -Oxycodone 5mg 1 tabs every 2 hours for mild pain -Oxycodone 5mg 2 tabs every 2 hours for mild pain -None of the oxycodone had specific ranges for when to use which dose or parameters if they could be used in conjunction with each or not in the ordered time ranges. Review of hospice visit records provided on 8/14/24 for resident #76, showed multiple notes of resident #76 discussing his suicide attempts, including a note on 7/18/24, which showed resident #76 was considered to be a suicide risk due to his prior attempts and expressions of not wanting any contact with other humans, or not knowing why he is on earth. Review of resident #76's Hospice delineation of services form, signed 7/10/24, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice was responsible for: - Attending physician services. - Providing facility with copy of hospice plan of care and any revisions, hospice election form, hospice certification/recertification. - Hospice staff checks in with designated facility staff prior to and after providing care. - Hospice provides a copy of the daily visit note at the time of the visit. - Provide medical supplies related to terminal diagnosis. - DME related to terminal diagnosis. - Medications necessary for all palliation of pain and symptoms associated with the terminal illness and related conditions (list medications covered by hospice): [none listed] - Designate how hospice provided medications are ordered/delivered/renewed: [not specified] The facility was responsible for: - Hospice plan of care located in miscellaneous section of chart. - 24-hour room and board care, to meet the resident's personal care and nursing needs in coordination with hospice. - Designate facility IDT member to coordinate care with hospice. - Facility makes the resident's records available to the hospice professional for review of the patient needs related to the terminal diagnosis. - Medications not related to terminal diagnosis. Facility and hospice combined responsibility: - Facility staff and hospice communicate in person or by phone to ensure that the needs of the resident are addressed and met 24 hours a day and such communication to be documented in progress notes. - Provide medical direction and management of resident. - Counseling to include spiritual, dietary and bereavement. - Social work services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of both resident #65's and 76's electronic medical record, and the facility hardcopy charts on 8/12/24 and 8/13/24, showed no documentation of a hospice care plan or hospice visits from nurses, chaplain services, or social services, including the standard hospice contact and information sheet. The facility did not have any hospice care plan or visit records until requested by the survey team on 8/14/24.