

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Libby Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's pain was managed in accordance with the resident's care plan and preferences for 1 (#57) of 23 sampled residents. This deficient practice resulted in resident #57 having moderate to severe pain from a fracture. This deficient practice increased the likelihood of other residents with pain not being managed. Findings include: During an observation and interview on 6/27/26 at 3:48 p.m., resident #57 was sitting in her recliner in her room. Resident #57 stated she was in pain due to a fractured elbow. Resident #57 rated her pain level as 6 out of 10 (moderate pain). Resident #57 stated the facility did not understand her pain management program, which her primary physician had set up before her admission to the facility. Resident #57 stated her pain was not being managed, and she was continuously in pain at 6 out of 10 or greater. Resident #57 grimaced and held her arm up to her chest during the interview. During an interview on 6/28/26 at 12:45 p.m., staff member E stated resident #57 had reported her pain as 8 out of 10 (severe pain) in her elbow. Staff member E stated resident #57 was given her scheduled oxycodone at approximately 6:30 a.m., and she was not able to give her any additional pain medication for eight hours. Staff member E stated she did not do anything more when resident #57 was reporting severe pain and had no additional pain medication available. Staff member E stated she had not offered resident #57 any non-pharmacological interventions to address her pain. Staff member E stated she had not contacted the physician for additional orders or treatment for the severe pain. During an interview on 6/28/26 at 1:03 p.m., resident #57 stated she was having pain at a 10 out of 10 (severe pain). Resident #57 was sitting in her recliner watching television, holding her arm. Resident #57 stated she tried to wear the arm sling provided by the facility, but it was very hot and did not make her arm feel any better. Resident #57 stated the staff told her she could not have any medication until mid-afternoon. Resident #57 stated that no other treatments or care were provided to ease her pain. During an interview on 6/28/26 at 3:15 p.m., staff member B stated resident #57 had an IV drug history, and this likely played a role in staff member E's reasoning for not reaching out to the physician for pain management. Staff member B stated she contacted the physician after this surveyor reported the pain management concerns for resident #57. Staff member B stated the physician did provide orders for a higher dose of pain medication and increased the frequency of the oxycodone upon request. Review of resident #57's, Care Plan, dated 6/28/26, showed:- . [Resident #57] has acute/chronic pain related to history of fracture of pelvis, and left elbow and right hand.- Interventions: . non-pharmacological interventions attempted prior to PRN pain medication administration. 1=Reposition; 2=Reduced stimuli; 3=Warm towel/ice; 4=Relaxation techniques; 5=Distraction; 6=Music; 7=Massage; 8=Other (document in progress notes) R=Refusal.- For Acute Pain: provide with reassurance that pain is time limited. Encourage attempts at different non-pharmacologic pain-relieving methods as well as timely use of ordered pain medications early in the recovery process. - For Chronic Pain: teach management of the stress response to pain, (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 0697 Level of Harm - Actual harm Residents Affected - Few	mind-body practices (yoga/tai chi), enjoyable activities, increase movement, determine effective non-pharmacological interventions to pain.- For Subacute Pain: teach inflammatory process is resolving and pain will resolve. Encourage exercise, non-pharmacologic interventions, and use of non-opioid medication therapy. Review of the facility's policy, Pain Assessment and Management, dated 9/2/25, showed:- . This facility is committed to recognizing and respecting each resident's right to be free from unnecessary pain and to receive timely, individualized pain management in accordance with professional standards of practice, the resident's comprehensive care plan, and personal preferences to help the resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain to the extent possible.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the washer area of the laundry room was clean and kept free of debris; and the facility staff failed to ensure proper glove use and hand hygiene during glucose testing process for 1 (#65) of 23 sampled residents. This failure had a likelihood of contaminating resident clothes and facility linens while being washed and transferred to the dryer and increased the risk of bloodborne pathogen contamination and/or infection for residents receiving care on the 100-hall unit. Findings include:1. During an observation and interview on 6/28/26 at 8:00 a.m., staff member F was preparing to check the blood sugar of resident #65. Staff member F pulled a bottle of test strips out of the medication cart, opened the bottle with gloves on, and put a strip into the glucose testing machine. Staff member F entered resident #65's room and used a lancet to draw blood from resident #65. Staff member F then stated she forgot to grab cotton balls and left the room with the gloves still intact on her hands. Staff member F then brought a handful of cotton balls in her gloved hands and placed the cotton balls in the community tray of supplies for glucose monitoring. Staff member F then pressed on the resident's finger to draw blood into the test strip. Staff member F reached into the community supply for a cotton ball to place on the resident's bleeding finger. At that time, it was observed that there was dried blood on the side of the bottle of the test strips. Staff member F then returned to her cart and placed the test strip bottle into the cart drawer. During the interview, staff member F stated she did not notice the dried blood on the bottle, and the blood appeared to her to be old. Staff member F then took an alcohol wipe and cleaned the blood off the bottle and placed the bottle back in the cart. Staff member F stated she did not realize she had touched the door handle and cart drawers with contaminated gloves or that she had reached into the cotton balls with a contaminated glove until she was interviewed, because she was focused on cleaning the glucometer. Staff member F stated that the bottle of test strips and the glucose testing tray were used for all residents requiring blood glucose testing on the 100-hall unit. During an interview on 6/28/26 at 12:24 p.m., staff member B stated staff member F should know better than to leave a resident's room with contaminated gloves. Staff member B stated the staff had received training on infection control practices, including hand hygiene, glove use, and blood-borne pathogens. Review of the facility's policy, Hand Hygiene, dated 9/15/26, showed:- . All healthcare workers should perform hand hygiene at critical moments during resident care, according to CDC guidelines. These moments include but are not limited to:- . f. After contact with blood, bodily fluids, or visibly contaminated surfaces. - g. Immediately after PPE removal (e.g., gloves, gown, eye protection, facemasks) .Review of the, CDC Clean Hands Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/#cdc_clinical_safety_best_practices_recomm-recommend showed:- . When to change gloves and clean hands- . Before exiting a patient room. 2. During an observation on 6/29/26 at 7:46 a.m., there were several large white buckets of detergent on the floor with hoses through the holes on the lids. There were large gaps in the holes between the hoses and the lids. The detergent lids had lint and debris on them. The wall above the detergent, in between the washers, on top of the washers, and the door hinges of the washers had lint buildup. The washer doors were both open, and the seals at the opening had a buildup of white hard water patches and dark brown congealed substance around the edge. During an interview on 6/29/26 at 7:51 a.m., staff member H stated the washers had preset wash (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cycles that pulled from the buckets of detergent on the floor through the hoses. Staff member H stated she had asked the company that services the detergent for caps for the lids where the hoses go in three months prior, but they had not received any to date. Staff member H stated the lint was hard to keep under control and hard to reach on top of and around the washers. Review of the facility policy titled Laundry Services, dated 10/8/25, showed, This facility ensures laundry services are provided in a manner that maintains a clean and sufficient supply of linens to meet resident needs. Soiled laundry is managed to prevent accumulation and minimize infection risk, supporting a safe and functional environment.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, the facility failed to ensure the interdisciplinary team assessed and determined residents were safe to self-administer medications prior to residents self-administering medications for 2 (#s 30 and 66) of 5 residents observed for medication administration. This deficient practice increased the likelihood of medication errors for all residents receiving medication in the facility, including failure to take clinically significant medications. Findings include: During an observation on 6/28/26 at 7:47 a.m., staff member F prepared medications for resident #30. Staff member F placed a multivitamin, Farxiga, Glimepiride, Januvia, metformin, Risperdal, and Rybelsus in a medication cup and took the medications to resident #30's room. Staff member F spoke to resident #30 and told her she had her medicine and placed the cup of pills on her bedside table. Resident #30 stated, Ok. Staff member F left the room without observing the medications being taken by resident #30. During an observation and interview on 6/28/26 at 7:59 a.m., staff member F prepared medications for resident #66. Staff member F placed Tylenol, aspirin, Entresto, meloxicam, metoprolol, and Farxiga in a medication cup. Staff member F prepared a half a cup of med pass liquid. Staff member F took the medication cup and cup of med pass liquid to resident #66's room. Staff member F told resident #66 she had his supplement drink and pills. Staff member F placed the medication cup of pills and med pass liquid on his bedside table. Resident #66 acknowledged staff member F and stated, Thank you. Staff member F left the room without observing resident #66 taking the medications or the med pass liquid. Staff member F stated she knew her residents would be fine to take their medications on their own. Staff member F stated she was not sure if the residents had an evaluation or orders for self-administration of medication. Staff member F stated she could not remember if she was trained on self-administration of medication procedures because she had been working at the facility for many years, but she stated she, probably did train on it at some point. Review of resident #30's and #66's EHRs, dated 6/28/26, did not reflect an evaluation for self-administration of medications, orders for self-administration of medications, or physician orders for self-administration of medications. During an interview on 6/28/26 at 12:24 p.m., staff member B stated the facility did not have self-administration set up for resident #30 or resident #66. Staff member B stated that resident #30 and #66 should not be self-administering medications and staff member F needed to be re-educated. During an interview on 6/28/26 at 12:45 p.m., resident #66 stated he did not know what the medications he was given were that morning, or what they were to treat. Resident #66 stated he took whatever medications were brought to him by the staff. Review of the facility's policy, Self-Administration of Medications, dated 9/16/25, showed:- 1. When a resident expresses interest in self-administering medications, nursing staff will notify the resident's physician and initiate an interdisciplinary assessment. - 2. The assessment will evaluate the resident's: a. Physical ability to handle and take medications b. Cognitive understanding of medication purpose, timing, and side effects c. Ability to follow instructions and recognize when to seek help d. Capacity to store medications securely and prevent access by others - 3. If the team determines the resident can safely self-administer, the assessment will be documented in the Resident's medical record, a physician's order will be obtained, and the care plan will reflect the decision. [sic]		

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. Based on observations, interviews, and record review, the facility failed to honor the residents' rights to choose their attending physician for 1 (#57) of 23 sampled residents. This deficient practice affected all residents wanting to choose their primary physician and resulted in resident #57 feeling she could not use her primary physician she had built a relationship with and was comfortable using. Findings include: During an observation and interview on 6/27/26 at 3:40 p.m., resident #57 was sitting in a recliner in her room, watching television. Resident #57 was grimacing and stated she was in pain from a fractured elbow. Resident #57 stated she was not happy with the physician she was assigned to when she was admitted and wanted her own physician to manage her care. Resident #57 stated it took her a long time to find a physician she was comfortable with because of childhood trauma and she did not know this new physician and was feeling unsafe. Resident #57 stated her primary physician knew her medications and what would be needed to manage her pain. Resident #57 stated she was not given any options to choose her primary physician and was assigned the facility physician. During an interview on 6/28/26 at 12:24 p.m., staff member B stated she did not know how residents were assigned a primary physician on admissions. During an interview on 6/28/26 at 2:21 p.m., staff member G stated the residents were not given a choice in their primary physician while they were in the facility, unless their primary was already affiliated with the local [Hospital Name] physician group. Staff member G stated that residents who were admitted outside the hospital were assigned the medical director as their primary physician. During an interview on 6/28/26 at 2:40 p.m., staff member A stated she had understood the regulation to mean the resident had a choice of physicians who were already affiliated with the facility and did not include other outside physicians. Staff member A stated that after re-reading the regulation, she could understand the requirement to offer outside physicians who were willing to follow the contract as a primary physician for a resident requesting their services. Review of the facility's policy, Physician Services, dated 9/12/25, showed: - 6. Resident Rights and Support- . c. Residents may choose their attending physician.- d. If a chosen physician cannot meet regulatory requirements, the facility will discuss alternatives and honor resident preferences whenever possible.- e. If a resident declines to designate a physician or the chosen physician fails to fulfil responsibilities, the Medical Director will consult with the attending physician before assigning an alternate provider.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to honor a resident's preference for three showers a week for 1 (#6) of 23 sampled residents. This deficient practice resulted in the resident frequently receiving only one shower a week. Findings include: During an interview on 6/27/26 at 3:47 p.m., resident #6 stated she had not been getting showers as often as she had wanted. During an interview on 6/28/26 at 2:33 p.m., resident #6 stated, My shower days are supposed to be Monday, Thursday, and Saturday. Most of the time I just get a shower on Monday. Resident #6 further stated last Thursday she had asked a CNA for a shower and the CNA told her, I can't give you one today. During an interview on 6/28/26 at 3:05 p.m., staff member D stated resident #6 wanted a shower three times a week. A review of resident #6's Care Plan in the resident's EHR, showed: Focus[Resident #6] has an ADL Self Care Performance Deficit r/t failed total right knee replacement and subsequent surgical repair. Date Initiated: 10/17/25 .Interventions/Tasks .Bathing (Shower/Bath) Monday/Thursday/Saturday day shift & PRN. Date Initiated: 1/05/26 Revision on: 5/29/26. A review of resident #6's bathing/shower task for May and June 2026 showed: Intervention/Task Bathing (Shower/Bath) Monday/Thursday/Saturday day shift & PRN. The document listed that a shower was done for resident #6 for May 2026, on 5/4, 5/11, 5/18, 5/25, and 5/30 (resident #6 received five showers for May, and there were 13 available shower days for that month) The document listed a shower was done for resident #6 for the month of June 2026, on 6/1, 6/8, 6/11, 6/13, 6/15, 6/22, and 6/27. (Resident #6 received seven showers for June, and there were 13 available shower days for that month) A review of a facility policy titled Resident Rights, with a revision date of 9/12/25, showed: Policy Residents will be cared for in a manner and in an environment that promotes maintenance or enhancement of each Resident's quality of life and is committed to assuring that the Resident's rights articulated under federal law are protected. Each resident has the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States without interference, coercion, discrimination, and reprisal and be supported by the facility in the exercise of those rights. Procedure The facility will inform each resident, orally and in writing, of the following rights at the time of admission and periodically throughout their stay: 1. The resident has a right to a dignified existence, self-determination. 6. The resident has the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. 19. The resident has the right to reside and receive services in the facility with reasonable accommodation of resident and preferences. 25. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessment, and plan of care. 26. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. [sic]		