STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 431513	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH HOME PLUS HOSPICE	931 E COLORADO BLVD , SPEARFISH, South Dakota, 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L0000	INITIAL COMMENTS A recertification survey for compliance with 42 CFR Part 418, Subparts C-D, requirements for hospice, was conducted from 7/1/24 through 7/3/24. Monument Health Home Plus Hospice was found not in compliance with the following requirement: L683.	L0000	The Homecare Director developed policy "Hospice Live Discharge/Transfer" on 7/30/2024. This policy addresses the requirements of the hospice staff to complete a hospice live discharge. These requiremetns include a physician's order signed by the hospice medical director to discontinue hospice services, documentation to support the patient's attending physician was consulted before hospice services are discontinued, and docuemntation to support the rationale for discontination of hospice services.	8/17/2024
L0683	DISCHARGE OR TRANSFER OF CARE CFR(s): 418.104(e)(2) (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. This STANDARD is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure their policies had been followed for one of one closed record sampled patient (1) whose Medicare hospice benefit. The provider did not have: *A physician's order signed by the hospice medical director to discontinue her hospice services. *Documentation to support the patient's attending physician was consulted before hospice services were discontinued. *Documentation to support the rationale for discontinuation of hospice services. Findings include: 1. Review of patient 1's 5/16/23 certificate of terminal illness (CTI) attestation statement verbally ordered by hospice medical director B revealed: *The patient was terminally ill and had a life expectancy of six months or less based on medical	L0683	The Homecare Director or designee will provide education on policy to all nurses, MSW's, chaplains, aides, volunteer coordinator, and Medical Director by August 17, 2024. Caregivers who are on leave will complete the education prior to their first shift. Homecare Director will report education completion to the President of Home Plus by August 19, 2024. Monitoring: Homecare Director or designee will audit 100% of live discharges/transfers each month to ensure the correct process for hospice live discharges/transfers has been followed. Auditing will continue until 100% compliance has been achieved for 3 consecutive months in which a live hospice discharge/transfer has occurred. Homecare Director will report these results monthly to the President of Home Plus.	

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 reverse for further 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
Michael Tilles	VP Operations	7/30/24

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L0683	Continued from page 1 director B's clinical judgment. *Her initial hospice benefit period was from 5/16/23 through 8/13/23. *Her terminal diagnosis was end-stage liver disease and other hospice diagnoses included hypertensive heart disease with chronic systolic congestive heart failure, other cerebrovascular disease, vascular dementia, and a moderate episode of a major depressive disorder. *"Patient is a 97-year-old with history of hepatitis A with elevating liver enzymes. She has had a overall decline in function and has underlying dementia as well. We had a decreased responsiveness to stimulus. Eating bites to occasionally 25%. Has developed new abdominal pain. Has had overall decrease in function." *The CTI was co-signed by attending physician C. *Patient 1 resided in a local nursing home facility. Review of patient 1's electronic medical record (EMR) revealed: *Registered nurse (RN) E's 8/9/23 nurse visit progress notes: -Clinical findings related to the patient's need for care: "Patient lying in bed with eyes closed. Opens eyes to verbal stimulus but closes eyes during remainder of assessment. No nonverbal s/s [signs or symptoms] pain present. LTC [long term care] staff relays no changes to pain status. LTC staff relay patient's appetite varies, does eat better for daughter and certain staff than others. No falls reported by LTC staff. No alterations in skin integrity. General assessment complete. Anticipate discharge this week. Phone call to daughter who verbalizes understanding with hospice discharge and is in agreement with plan of care. LTC staff deny needs or concerns." -Assessment: "Progress toward previous goals: care/treatment is still necessary." -Plan: "Plan for next visit to include discharge from hospice." -Plan of Care Updates: "Plan of care in development was verbally reviewed with the family and caregiver and included discharge from agency next visit." *RN E's 8/11/23 nurse visit progress note:	L0683		

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L0683	Continued from page 2 -Clinical findings: "Conferenced with LTC social worker, [name], regarding patient's discharge live (on) this date as patient no longer terminally ill. Patient's daughter, [name], contacted again and verbalizes consent and agreement with patient discharge." -Assessment: "Response to care: patient no longer terminally ill and discharged live (on) this date." -Education/instructions: "Education provided to patient, family and caregiver through explanation. Caregivers demonstrated acceptance and understanding verbalizes understanding." -Plan: "Care plan reviewed and appropriate." Review of patient 1's Interdisciplinary Group (IDG) meeting notes and hospice plans of care (POC) revealed: *On 7/20/23: -An IDG note completed by home health aide F: -"1xwk [one time weekly] bed bath. Doing ok. POC is update." -RN E's skilled nurse note: "Patient [1] has been sleeping more per daughter report and has been refusing to get up for some meals. Opened eyes to verbal and physical stimulus last sn [skilled nurse] visit but did not answer questions. Arm circ [circumference] unchanged, but weight is down to 165 from 169 lbs. No falls reported. No nonverbal s/s [signs or symptoms] pain present. Bowels moving daily to every other day. No respiratory distress noted. Patient remains totally dependent on LTC staff for all cares." -There was no documented discussion related to changes in the patient's terminal diagnosis or the discontinuation of hospice services and there was no discharge planning goal. *On 8/3/23: -RN E's skilled nurse note: "Patient [1] has been sleeping more per daughter report and has been refusing to get up for some meals. Opened eyes to verbal and physical stimulus last sn visit but did not answer questions. Arm circ unchanged, but weight is down to 165 from 169 lbs. No falls reported. No nonverbal s/s pain present. Bowels moving daily to every other day. No respiratory distress noted. Patient remains totally dependent on LTC [long term care] staff for all cares."	L0683		

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L0683	Continued from page 3 -There was no documented discussion related to changes in the patient's terminal diagnosis or the discontinuation of hospice services and no discharge planning goal. Review of patient 1's hospice revocation form revealed: *It was signed by RN E and co-signed by hospice case manager G on 8/11/23. -A verbal consent from the patient's daughter was documented on the form. *The patient received hospice services 5/16/23 through 8/11/23. -She was discharged from hospice services on 8/11/23 because she was "No longer terminally ill." -The summary of care she was provided while receiving hospice services included "end-of-life cares." Interviews on 7/2/24 at 3:45 p.m. and on 7/3/24 at 9:49 a.m. with director A, nurse manager D, and accreditation specialist H regarding patient 1's revocation of hospice services revealed: *There was no documentation to support RN E had discussed with medical director B any concerns about patient 1 no longer meeting hospice criteria before hospice services were discontinued. -It exceeded RN E's scope of nursing practice to have discontinued those services before an order was received from medical director B to have done so. -RN E was no longer an employee of the hospice agency. *There was no documentation to support attending physician C was consulted before hospice was discontinued. *It was uncommon for hospice patients to no longer qualify for services during the initial hospice certification period. -Neither the patient's POC nor progress notes reflected why she was considered to no longer be terminally ill. *There was no quality assurance process to ensure hospice discharge expectations were followed.	L0683		

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L0683	Continued from page 4 *Patient 1 expired on 9/6/23 at the nursing home facility. Review of the July 2023 Transfers and Discharges from Hospice policy revealed: *B. 2. Discharges: -"The patient may be discharged if they are determined through the Medical Director to no longer be terminally ill." -"The clinical notes will reflect that the patient has improved." Review of the February 2024 Interdisciplinary Team Conference policy revealed: *"E. Ongoing assessment and evaluation of the individual is documented as the record is reviewed. The Plan of Care is continued and/or revised as appropriate to the individual." *"F. The primary staff nurse reports significant changes in the care plan to the attending physician."	L0683		