DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH HOME PLUS HOME HEALTH	224 ELK ST PO BOX 6000 , RAPID CITY, South Dakota, 57709

(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
G0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 484, Subparts B-C, requirements for Home Health Agencies, was conducted from 11/24/25 through 11/26/25. Monument Health Home Plus Home Health was found not in compliance with the following requirement: G536.	G0000		
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure required documentation was in the electronic medical record (EMR) related to a potentially clinically significant medication issue identified during the drug regimen review. Specifically, the provider did not document the identified medication issue, did not document follow-up with the physician, and did not document any physician-prescribed or recommended actions associated with the issue noted in the Skilled Nurse Outcome and Assessment Information Set (OASIS) Start of Care (SOC) assessment completed on 7/15/24 for 1 of 17 records reviewed (patient 17). Findings include: 1. Review of patient 17's EMR revealed: *She was admitted to home health services on 7/15/24. *Her primary reason for home health care was the need for enteral feeding (a method of providing nutrition directly into the gastrointestinal tract through a feeding tube).	G0536	Home Health Director and Home Health Nurse Manager reviewed and revised the "Medication Management in Home Care" policy to include documentation of medication interventions. The electronic health record admission narrative was reviewed and updated to include a prompt for staff to document medication intervention follow up to correlate with the OASIS M2001 assessment. Education will include policy revision and documentation changes which will be provided via email with read receipt, staff meetings, and huddle to all RNs, PTs, OTs and STs by 1/10/2026. Any RNs, PTs, OTs and STs on leave will be required to complete education prior to the first worked shift. The Home Health Manager or designee will monitor education completion and report to the Home Health Director and Vice President of Operations by 1/10/2026. Monitoring: The Home Health Manager or designee will review a minimum of 10 charts per month marked yes on the OASIS M2001 assessment to ensure documentation of medication intervention follow up. If there are less than 10 charts, a 100% review of charts will be completed. Monitoring will continue until 100% compliance has been sustained for 3 consecutive months. Results will be reported monthly to the Home Health Director and Vice President of Operations.	1/10/2026

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
	VP operations	12-17-25

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G0536	Continued from page 1 *Her primary diagnosis was Bacteremia (a bloodstream infection). *The OASIS SOC dated 7/15/24 indicated: *Yes was marked for the question of whether the drug regimen review identified a potential clinically significant medication issue. *Yes was marked for the question on if the agency contacted a physician by midnight the next calendar day and completed prescribed/recommended actions in response to the identified potential clinically significant medication issue. *There was no documentation in the skilled nurse admission document or EMR describing what the identified medication issue was, any follow-up with the physician, or any physician-prescribed or recommended actions associated with the medication issue. 2. Interview and record review on 11/26/25 at 2:30 p.m. with director A and nurse manager B regarding patient 17's drug regimen review issue noted in the OASIS SOC completed on 7/15/24 revealed: *Registered nurse C, who completed the patient's OASIS SOC, was unavailable for interview. *There was no documentation in the patient's EMR related to the identified medication issue, any follow-up with the physician, any physician-prescribed or recommended actions associated with the drug regimen review issue noted in the OASIS SOC completed on 7/15/24. *They stated the expectation was that the above information should have been documented in the patient's EMR according to their requirement. *It was also stated that the skilled nurse admission document did not contain a specific section designated for documenting drug regimen review discrepancies. 3. Review of the provider's 3/2023 "Medication Management in Home Care" policy revealed: *"Safe and effective medication management will occur during the patient's Home Care admission." *"Reconciliation of Medications:" -"Discrepancies will be communicated to the provider	G0536		

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G0536	Continued from page 2 within 24 hours of admission by the admitting clinician." *The policy did not address documenting the drug regimen review. 4. Review of the provider's 3/2023 "Physician Notification in Home Care" policy revealed: *"The Home Care Agency is required to alert the physician responsible for the patient's care to any changes that suggest a need to alter the plan of care and/or when the plan of care is interrupted." -B. "Communications may occur through Epic (in-basket or case communication), fax, telephone, electronic communications, or direct communication." -C. "All communication will be documented and is considered part of the medical record."	G0536		