STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

(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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 11/26/24. The area surveyed was resident rights regarding vaccinations. Avantara Groton was found to have past non-compliance at F578.	F 000		
F 578 SS=G	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	LNHA	12.12.24

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.

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F 578	Continued From page 1 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, and document review, the provider failed to ensure one of one resident's (1) right to refuse a vaccination was honored. Failure to do so resulted in the resident receiving the vaccine and voicing feelings of frustration as she was not able to make her own decision. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 10/22/24 SD DOH FRI and resident 1's electronic medical record revealed: *There was a COVID-19 vaccination clinic at the facility on 10/22/24. *Licensed practical nurse (LPN) D told resident 1 that "you can't refuse it" when she referenced the COVID-19 vaccine. *"The resident was upset and asked, 'I can't even make my own decisions?'" *The resident was given the vaccine after voicing that she did not want the vaccine. *Resident 1's power of attorney (POA) declined	F 578	Past noncompliance: no plan of correction required.	

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F 578	Continued From page 2 the COVID-19 vaccine on 9/11/24. *LPN D misread the vaccine declination form and mistakenly thought that resident 1's POA consented for resident 1 to receive the COVID-19 vaccine. *Facility staff were re-educated on resident rights. 2. Interview on 11/26/24 at 1:18 p.m. with resident 1 revealed: *When asked if staff allow her to make choices about her life that matter to her, she stated, "You have to do what they say." *She was able to recall the incident with the COVID-19 vaccine and expressed her frustration verbally by saying, "I felt like I couldn't make any decisions for myself," and physically by grimacing. *She said that LPN D insisted on giving her the vaccine, stating that her family wanted her to receive the vaccine. 3. Interview on 11/26/24 at 2:12 p.m. with LPN D revealed: *To prepare for the vaccination clinic, she printed a resident list and marked which residents had a vaccination consent form on file. *She misread resident 1's form and mistakenly thought that the resident's POA had consented for her to receive the COVID-19 vaccine. *She confirmed that resident 1 verbalized that she did not want the vaccine. *She told the resident that her family wanted her to receive the vaccine. *Resident 1 brought herself to the vaccine station and received the COVID-19 vaccine. *After it was discovered that resident 1 received the unwanted vaccine, she received verbal education about resident rights and double-checking orders and consent forms if a	F 578		

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F 578	Continued From page 3 resident refused. *She was also assigned additional online education about resident rights and their abuse/neglect policy. 4. Interview on 11/26/24 at 2:43 p.m. with social services designee C revealed: *She noticed that resident 1 was upset and asked what was going on. *The resident told her about having received the COVID-19 vaccination when she did not want to. *She immediately informed director of nursing (DON) B about the situation. *They contacted resident 1's POA to explain the situation and the POA verbalized acceptance that she had received the vaccine. *She worked with DON B to conduct a facility-wide audit to determine if there were any other vaccination errors. -They did not find any other errors. *All staff were assigned additional online training about resident rights and the abuse/neglect policy. *Resident 1 had not verbalized any further frustrations regarding the incident. 5. Interviews with other residents throughout the survey revealed no other concerns regarding resident rights and choices. 6. Interviews with other staff members throughout the survey revealed appropriate follow-up actions about resident refusals and resident rights were completed. 7. Interview on 11/26/24 at around 3:30 p.m. with administrator A and DON B revealed: *An investigation was initiated immediately to determine the extent of the situation.	F 578		

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F 578	Continued From page 4	F 578		

*LPN D was suspended pending the investigation.
*No other vaccination errors were identified.
*They determined that LPN D made a medication error.
*LPN D, along with all staff, were re-educated about resident rights and how to respond to a resident if they refuse a service.

8. Review of staff training records revealed all staff were assigned and re-educated about resident rights and the provider's abuse/neglect policy.

9. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/26/24 after record review revealed the facility had followed their quality assurance process, education was provided to all staff about resident rights, and interviews revealed staff understood the education provided regarding those topics.

Based on the above information, non-compliance at F578 was discovered on 10/22/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 11/26/24, the non-compliance is considered past non-compliance.