South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61655	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE ESTATE	10905 SOURDOUGH RD BELLE FOURCHE, SD 57717

(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) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/27/25 through 10/28/25. Belle Estate was found not in compliance with the following requirements: S315, S650 and S651.	S 000		
S 315	44:70:04:07 Prevention And Control Of Influenza Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to document a refusal or an administration of an influenza vaccination for one of four sampled residents (2). Findings include: 1. Review of resident 2's care record revealed he had an admission date of 3/16/22. There was no documentation of either the resident's refusal or the administration of an influenza vaccination during the 2023 or 2024 influenza seasons. Interview on 10/28/25 at 8:31 a.m. with administrator A regarding resident 2 confirmed there was no documentation that the influenza vaccination had given or refused during the 2023 or 2024 influenza seasons. She stated it was the	S 315	Unable to correct non-compliance of documented refusal for resident #2. Corrective action for Resident #2 was completed by updating the The resident's immunization record to accurately reflect the vaccination status, including Documentation of the influenza vaccine decline for this season 11/05/2025. To prevent recurrence and ensure sustained compliance, the facility's Immunization Policy has been revised to require documentation of both accepted and declined influenza vaccinations each year when the annual flu vaccine is offered, and at time of admission. The Director of Nursing (DON) is responsible for maintaining complete immunization records for each resident at the time of admission and annually thereafter. The DON and the administrator will conduct a quality assurance (QA) review of all influenza vaccination consents, completed vaccinations, documented declines each year during the facility's flu vaccination period, and at time of admission.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsey Sansbury — TITLE: Administrator — (X6) DATE: 11/21/25

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S 315	Continued From page 1 responsibility of the registered nurse (RN) to fill out the refusal form when a resident refused and that document was to be recorded in the resident's care record. Review of the provider's undated Flu Vaccination policy revealed: "1. All employees and residents will be offered the opportunity to receive a flu vaccination every fall." "2. Employees and residents are informed of the benefits/risk to themselves and to those around them if they are protected." "6. Documentation of the vaccination or its waiver shall be recorded in the resident's medical or care record.'	S 315		
S 650	44:70:07:06 Drug Disposal Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, observation, and policy review, the provider failed to ensure one of one sampled residents (1) controlled medications had been disposed of by two licensed staff members. Findings include: 1. Review of resident 1's care record revealed:	S 650		

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S 650	Continued From page 2 *He was admitted on 8/14/24. *He had a 7/20/25 physician order for a Fentanyl patch (adhesive bandage that releases the opioid through the skin and into the bloodstream). *The provider utilized a form "Fentanyl Patch Disposal Record" that included instructions: -"Disposal must be witnessed by 2 CMA's [certified medication aides], a CMA and nurse, or 2 nurses." 2. Interview on 10/28/25 at 9:46 a.m. with registered nurse (RN) B revealed that she confirmed their process for disposing of Fentanyl patches could involve any two staff members to witness the disposal. 3. Observation and interview on 10/28/25 at 11:36 a.m. with CMA C revealed that she would dispose of Fentanyl patches with a second CMA as a witness. 4. Interview on 10/28/25 at 1:57 p.m. with administrator A revealed: *She stated that she believed that two CMAs could dispose of Fentanyl patches. *She was not aware that Fentanyl patches required two licensed personnel, either two nurses or a nurse and a pharmacist, to witness disposal. 5. Review of the provider's undated Medication Disposal policy revealed: *"Destruction/disposal of narcotics will be witnessed by two persons, both of whom are a nurse and or a pharmacist." -"Will be chemically destroyed, unless otherwise indicated per pharmacist recommendations."	S 650	Unable to correct noncompliance of destruction of medication by two persons, both of whom are nurses or pharmacists for resident #1. Corrective action for Resident #1 was completed by ensuring that the used fentanyl patch was removed by two staff one of whom is a medication aide, patch was verified, and secured in a labeled bag in the narcotic safe on 10/28/2025. The patch will remain secured until it can be destroyed by two licensed nurses in accordance with facility policy. The administrator will observe that the destruction of all controlled substances is being done properly. All facility staff were educated on the new process. To ensure sustained compliance, the facility purchased and is installing a new locked cabinet door for the medication room. The cabinet includes a secured drop slot large enough for all medications awaiting destruction, including used fentanyl patches. Once installed, all medications requiring destruction will be placed in this locked cabinet immediately after removal, holds, or discontinuation. Only licensed nursing staff and administrator will have access to the medication destruction cabinet. All facility staff will be educated once the new cabinet door is installed. The facility's policy for handling and destroying Narcotic patches were reviewed and revised on 11/4/2025 to reflect required procedures, including two staff verifications and proper secure storage prior to destruction. Audit monitoring will be conducted by the Director of Nursing (DON) and Administrator; each will review all narcotic patch removals and destruction logs weekly for 12 weeks, and then monthly for 6 months. The DON and Administrator will report findings to the QA Committee.	

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S 651	Continued From page 3	S 651		
S 651	44:70:07:06(1-3) Drug Disposal Methods of destruction or disposal may include: (1) Disposal by using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal, all medications must be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction or disposal according to federal and state regulations; or (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interviews, observation, and policy review, the provider failed to ensure that controlled medications for one of one sampled residents (1) were destroyed in an approved manner. Findings include: 1. Review of resident 1's care record revealed: *He was admitted on 8/14/24. *He had a 7/20/25 physician order for a Fentanyl patch (an adhesive bandage that releases the opioid through the skin and into the bloodstream). *The provider utilized a form "Fentanyl Patch	S 651	Unable to correct noncompliance with ensuring that controlled medications were destroyed in an approved manner. The facility has reviewed and revised its Controlled Medication Destruction Policy to ensure that it clearly includes fentanyl patches and all other controlled medication patches. The revised policy states that controlled medications will be destroyed using flour and vinegar, and that the destruction must be witnessed by two licensed nurses. The Director of Nursing (DON) and Administrator will conduct a quality assurance review of all controlled medication destructions weekly for 12 weeks, and then monthly for 6 months. The DON and Administrator audits will include verification that: Destructions were completed using the approved flour-and-vinegar method, Two licensed nurses signed the destruction record, and All controlled patches (including fentanyl) were included in the destruction log. All findings will be documented on the Controlled Medication Destruction QA Tool. The DON and Administrator will report audit results to the QA monthly during the monitoring period. All nursing staff have been trained on the destruction procedure and solution for narcotics and all medications. All management staff have been trained on the destruction procedure and solution for non-narcotic medications.	

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S 651	Continued From page 4 Disposal Record" that included instructions: -"Wear gloves when disposing; fold in half and place in sharps container." 2. Interview on 10/28/25 at 9:46 a.m. with registered nurse (RN) B revealed that she confirmed their process for disposing of Fentanyl patches was to fold them in half and put them in a sharps container in a cabinet in the medication room. 3. Observation and interview on 10/28/25 at 11:36 a.m. with CMA C in the medication room revealed that she would dispose of Fentanyl patches in a sharps container. -She opened a cabinet door and identified the sharps container. It was a small, portable container that was not attached to the cabinet and could be picked up and carried. 4. Interview on 10/28/25 at 1:57 p.m. with administrator A revealed: *She confirmed the process for disposing of Fentanyl patches was to fold them in half and put them in a sharps container. *She thought that putting the Fentanyl patch in the sharps container was an acceptable disposal method. *She agreed that putting the Fentanyl patch in the sharps container did not alter or dissolve the Fentanyl patch. 5. Review of the provider's undated Medication Disposal policy revealed: *"Medications waiting to be destroyed will be placed in a separate area in the locked medication room." -"Narcotics will be kept in a locked container, in the locked medication room." *"Destruction/disposal of narcotics will be	S 651		

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S 651	Continued From page 5 witnessed by two persons, both of whom are a nurse and or a pharmacist." -"Will be chemically destroyed, unless otherwise indicated per pharmacist recommendations."	S 651		