STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dakota Alpha	1303 27th Street NW Mandan, ND 58554

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, policy review, and staff interview, the facility failed to provide medication in accordance with professional standards for 1 of 5 residents (Resident #5) observed during medication pass. Failure to ensure the facility's stock medication formulary accommodated physicians' orders and/or staff clarified orders to match the formulary stock medication supply resulted in Resident #5 and possibly other residents receiving an inaccurate medication dose and may result in unintended therapeutic results. Findings include: Review of the facility policy titled Administration of Medications occurred on 07/09/25. This policy, dated 07/01/25, stated, Procedure: Medications are administered . as ordered by the physician . Ensure that the six rights of medication administration are followed: . Right dosage . Review of Resident #5's medical record occurred on 07/08/25. A physician's order, dated 06/01/23, stated, Calcium-Vitamin D Tablet 600-200 MG [milligrams]-UNIT [Calcium 600 mg with Vitamin D 200 units (equivalent to 5 micrograms)] Give 1 tablet by mouth two times a day for OTHER SPECIFIED DISORDERS OF BONE DENSITY AND STRUCTURE. Observation on 07/08/25 at 8:23 a.m. showed a nurse (#1) administered one tablet of Calcium 600 mg with Vitamin D 400 units (equivalent to 10 micrograms) to Resident #5 from the supply of stock medications. The nurse later verified this as the only Calcium with Vitamin D available in the facility's stock supply. During an interview on 07/08/25 at 11:21 a.m., an administrative nurse (#2) stated the facility used the stock Calcium with Vitamin D the consultant pharmacy provided. At 11:55 a.m., the nurse (#2) stated the facility provided stock medications as part of a resident's care and the nurse should have contacted the provider to update the order to match the stock medication available.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 1 supplemental resident (Resident #7) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the Centers of Disease Control (CDC) guidance at https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations/enhanced-barrier-precautions-nursing-homes-prevent-spread-multidrug-resistant-organisms-mdros, dated March 20, 2024, titled Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), stated, EBP are indicated for residents with . indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical device examples . feeding tubes . Review of Resident #7's medical record occurred on all days of survey. The care plan identified the resident required EBP. Observation on 07/07/25 at 10:47 a.m. showed a sign on Resident #7's door identifying enhanced barrier precautions. A certified nurse aide (CNA #3) completed hand hygiene, applied gloves, performed perineal cares, and transferred Resident #7 from the toilet to the wheelchair using a mechanical sit to stand lift. The CNA (#3) failed to apply a gown before providing perineal cares. During an interview on 07/08/25 at 4:40 p.m., an administrative nurse (#2) stated she expected staff to wear gowns when providing toileting assistance for residents requiring enhanced barrier precautions.