STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Valley Village Health Care Center	14650 Garrett Avenue Apple Valley, MN 55124

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a physician order was processed timely for 1 of 3 residents (R1) who was ordered scheduled tube feeding free water flushes to mitigate the risk of dehydration. This resulted in R1 not being administered these flushes for approximately 48 hours.Findings include: R1's Nutritional Assessment, dated 12/11/25, identified R1 as NPO (nothing by mouth) and dependent on tube feeding for fluid and nutritional intake in response to swallowing difficulties associated with Alzheimer's dementia and severe protein/calorie malnutrition. R1's estimated daily fluid needs averaged from 1440 to 1800ml (milliliters). Approximately 821ml of her daily fluid intake was provided via tube feeding formula, and the remaining 619ml to 979ml was from a combination of scheduled free water flushes and flushes provided in relation to medication administration. A hospital Discharge summary, dated [DATE], identified R1 returned to the facility after being treated for, but not limited to, sepsis (severe immune response to infection or injury that can lead to organ failure and death), pneumonia, and severe dehydration. R1 was ordered free water flushes 60ml every four hours. An order, dated 2/11/26, indicated a new order for 150ml free water flushes six times a day. R1's February 2026, Medication Administration Record (MAR), identified that on 2/12/26, at 8:00 a.m., R1 was administered a 150ml free water flush. A progress note, dated 2/12/26, identified R1's fluid needs were assessed by the registered dietitian (RD), and indicated R1's fluid needs would be better met with 225ml free water flushes four times a day, and to avoid flushes at night. A telephone order (TO), dated 2/12/26, ordered by physician assistant (PA)-A, and transcribed by RD-A, directed R1 to be administered 225ml free water flushes four times a day via her feeding tube and the 150ml flushes were discontinued. The order identified this was verified; however, the date, and time, of verification was not present. A General Order audit report, identified that on 2/12/26, at 12:03 p.m., RD-A created/transcribed the flush order into the electronic medical record MAR. This order directed the flushes to be administered four times a day (between 7:00 a.m. - 8:00 a.m., 10:00 a.m. - 11:00 a.m., 1:00 p.m. - 2:00 p.m., and 4:00 p.m. - 6:00 p.m.). Based on the order entry time, there was potential for R1 to receive the first flush with this order between 1:00 p.m. and 2:00 p.m. R1's February 2026 MAR, identified 2/12/26's administration time frames for 1:00 p.m. to 2:00 p.m., and 4:00 p.m. to 6:00 p.m. had an x symbol for each time frame. Additionally, 2/13/26's time frames for 7:00 a.m. - 8:00 a.m., 10:00 a.m. to 11:00 a.m., and 1:00 p.m. to 2:00 p.m., were blank. The 2/13/26, 4:00 p.m. to 6:00 p.m., time frame indicated: Reason: Not Administered: Other Comment: pm shift. The General Order audit report for the 2/12/26 flush order change, identified that on 2/13/26, at 11:16 p.m., licensed practical nurse (LPN)-A verified the order (approximately 35 hours after the order was placed). R1's February 2026 MAR, identified it was not until the following morning on 2/14/26, between 7:00 a.m. and 8:00 a.m., that R1 received a scheduled free water flush after the last administered scheduled flush on 2/12/26, at 8:00 a.m. (approximately 48 hours later). This resulted in a potential 1350ml fluid deficit for R1 in relation to the untimely order processing. When interviewed on 3/5/26, at 1:11 p.m., RD-A stated that once she assessed the resident's nutritional and fluid needs and determined, often with consultation of the primary provider, an adjustment was needed, she entered the order into the system and alerted the floor nurse so that the order could be verified, which (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she expected to occur the same day as the order was provided. RD-A was unaware of any order processing concerns related to R1 and was not aware that R1 potentially missed seven free water flushes after she transcribed the order. RD-A identified she alerted R1's primary nurse of the order change on 2/12/26 but was unable to remember which nurse. RD-A stated, as R1 received approximately 800ml of water from the tube feeding formula each day, and water during the medication administration process, she was not overly concerned about R1 having become dehydrated to the point of needing hospitalization. When interviewed on 3/5/26, at 1:39 p.m., the director of nursing (DON) stated that an order entered around 12:00 p.m. was expected to be verified by a nurse within a couple of hours. Once an order was transcribed into the system, i.e. MAR, the system flagged staff with an alert when the MAR was opened. The DON identified R1 for sure should have had the order verified on 2/12/26 in prep for the 4:00 p.m. to 6:00 p.m. free water flush time frame, as the facility was expected to ensure residents who require tube feeding for hydration received the fluids as ordered and were adequately hydrated. She added that R1's flushes would not have been ordered if not needed. The DON explained, after R1 was readmitted to the hospital on [DATE], hospital staff contacted her about possible feeding and flush concerns for R1. She stated her investigation into this was concern free; however, she stated she was more focused on looking for any administration refusals and that staff signed off the feeding and flushes versus reviewing order processing. When the DON was updated on the order verification timeliness, she stated this was not their process and again she expected such orders to be processed timely as expected. The DON denied a routine audit process for such concerns but identified this was completed if there was a need such as noticed trends or identified issues. She denied any recent audits, or any recent trends or identified issues. When interviewed on 3/5/26, at 1:58 p.m., LPN-B stated once she was updated by the RD that orders were adjusted, she was expected to ensure the order was verified as soon as possible, or at least for sure before the end of her shift. At times, this was unable to be accomplished, and the task was then passed on to the next nurse for verification. LPN-B indicated there was a notification in the MAR for pending orders. Once she acknowledged this after verifying the order, the order would be pushed to the MAR for administration, and the notification would go away. LPN-B stated there was a shift where RD-A updated her about changes to R1's increased fluids after R1's return on 2/11/26; however, she did not remember the date details but did not think it was right after R1 returned. LPN-B explained she double checked this order in the system and followed the expected processes. She does not recollect any concerns with the order. LPN-B stated, as R1 was NPO, missed water flushes were a concern due to the risk of dehydration but not a significant issue as she also received fluids from other sources throughout the day. When interviewed on 3/5/26, at 2:48 p.m., LPN-C stated orders were typically transcribed by the health unit coordinator (HUC) and once transcribed, nurses were expected to verify the order(s) as soon as possible, or at least by the end of their shift. This was the same if she was to see the MAR notification for pending orders. LPN-C explained there were days, about three out of the seven, where orders were left for the evening shift that she felt the day shift could have verified. LPN-C stated, if she noticed a resident did not have flushes ordered, she would look for any updated orders and if none, would update the provider immediately, as this would concern her from a resident dehydration standpoint. LPN-C was shown R1's MAR related to the missed flushes. She commented, That is very odd. I would have flushed her. I would have flushed her out of habit, as she very much knows [R1]. When interviewed on 3/6/26, at 10:24 a.m., HUC-A identified admission and readmission orders took priority over any other orders. Next, if stat order or time-sensitive orders were provided, she then processed those before the remaining orders. For dietary related orders, such as water flush adjustments, she stated the RD typically transcribed those into the system and then a nurse verified. Thus, she did not participate in those orders; however, when such orders were placed in the scanning bin after nurse verification, she double checked to see if the transcribed by and verified by sections on the order sheet were initialed. If not, she gave the sheet back to the nurse. She stated some of the dietary orders came back to her not verified and she again placed them in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be verified bin. She did not review this bin to ensure orders were being verified once she placed the transcribed orders into it. HUC-A was unaware of what the expectations for order processing timeliness was but identified if a dietary order was transcribed by the RD at noon, there was no reason why the nurse could not verify it by 4:00 p.m. or 5:00 p.m. that same day. HUC-A stated, due to high admissions and days when visiting providers dropped off orders closer to the end of her shift, she had to pass on the orders for the evening nurses to transcribe and verify. She did not follow up on these orders to ensure they were completed. HUC-A was unaware of any order processing concerns related to R1. When interviewed on 3/6/26, at 10:45 a.m., registered nurse (RN)-A stated the nurses were expected to verify orders as soon as possible when they were placed by the HUC in the verification bin, or when they were alerted of a pending order notification in the MAR. She stated that orders should not be sitting with a pending order status for days, as staff were expected to follow any new orders. RN-A explained this happens sometimes, when orders sit for longer than expected. RN-A identified R1 was at risk of dehydration and needed to have the flush order implemented as soon as possible after it was provided. RN-A explained there was a possible concern with R1 not receiving her fluids as ordered after she was re-hospitalized ; however, when she reviewed R1's chart upon investigation, concerns were not identified. When interviewed on 3/6/26, at 11:06 a.m., RN-B stated orders were to be verified right away. She explained that any transcribed order remained unfinished until the nurse verified it. Only then did the order flow into the MAR for the nurse to follow. RN-B stated any flush orders for R1 for sure needed to be processed as expected as R1 did not receive that many medications so her water flushes at those times did not provide her with much water during the day. This, along with her feeding being scheduled for the night hours, increased R1's risk for dehydration during the day hours. When interviewed on 3/6/26, at 11:22 a.m., physician assistant (PA)-A stated she was unaware of what the facility expectations were related to order process timeliness. She stated she would expect staff to follow whatever the facility's policy is. PA-A explained she did not review when orders were processed and/or verified, and she was unaware of any recent concerns related to this process. When R1's 2/12/26 flush order was reviewed with her, PA-A stated this order should have been verified before it was: two days seems long. PA-A indicated that if R1 truly did not get these flushes as ordered, this potentially increased her risk of dehydration. When interviewed on 3/6/26, at 12:41 p.m., LPN-A stated the order process was a disaster. She explained that often she had to fix orders when she verified them or had to process orders that were not done on the day shift by the HUC. She identified she had to process and/or verify orders every day when she worked, even orders for residents that were not hers, as some of the evening staff felt it was the HUC's responsibility to process orders, not theirs. LPN-A identified there often were times when she processed/verified orders from the day prior to time frames longer than that. She indicated there was one order in January or February that was left for a week before it was taken care of. LPN-A identified the HUC always appeared to only work on admission orders and LPN-A was unsure what the priority for order processing was and orders seemed secondary to other things the nurses were required to do. LPN-A stated she had yet to talk to the DON about her concerns; however, she had spoken to a charge nurse. When updated about R1's 2/12/26 flush order, she exclaimed, Oh my god! She explained R1 was NPO and thus a risk for dehydration. She stated, she felt there were some questions around a flush order, but she could not remember the details. Additionally, she could not recollect any concerns that surrounded the timeliness of any of the orders for R1 that she may have verified, but the situation explained to her during the interview did not surprise her. A Transcription of Orders policy, dated 2/12/24, directed that after an order was transcribed, the transcriber was to write 'transcribed by, their name, title, date, and time.' The facility was to have a system that allowed communication to the nurse when orders were entered and required verification. The nurse that verified the order was to review order documentation and ensure the full transcription of the orders were completed and accurate before they updated the electronic health record with an order acknowledgement verification. Additionally, they were to make a progress note that new orders were (continued on next page)

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