



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 23, 2026

Administrator

APPLE VALLEY VILLAGE HEALTH CARE CENTER
14650 GARRETT AVENUE
APPLE VALLEY, MN 55124

RE: CCN: 245264

Cycle Start Date: March 6, 2026

Dear Administrator:

On April 8, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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April 23, 2026

Administrator
APPLE VALLEY VILLAGE HEALTH CARE CENTER
14650 GARRETT AVENUE
APPLE VALLEY, MN 55124

Re: Reinspection Results
Event ID: 1F2445-H2

Dear Administrator:

On April 8, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 6, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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March 16, 2026

Administrator
APPLE VALLEY VILLAGE HEALTH CARE CENTER
14650 GARRETT AVENUE
APPLE VALLEY, MN 55124

RE: CCN:245264
Cycle Start Date: March 6, 2026

Dear Administrator:

On Cycle March 6, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 6, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 6, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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March 16, 2026

Administrator

APPLE VALLEY VILLAGE HEALTH CARE CENTER

14650 GARRETT AVENUE

APPLE VALLEY, MN 55124

Re: State Nursing Home Licensing Orders

Event ID: 1F2445-H1

Dear Administrator:

The above facility survey was completed on March 6, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

**Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER APPLE VALLEY VILLAGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE , APPLE VALLEY, Minnesota, 55124	
(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
F0000	<p>INITIAL COMMENTS</p> <p>On 3/5/26 through 3/6/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed. H52647260C (2788032) with a deficiency issued at F692.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F0000		04/06/2026
F0692 SS = D	<p>Nutrition/Hydration Status Maintenance</p> <p>CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration.</p> <p>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to</p>	F0692	<p>F692</p> <p>This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>It is the policy of Cassia Apple Valley Village Health Care Center to comply with F692-Nutrition/Hydration Status Maintenance.</p> <p>To assure continued compliance, the following plan has been put into place;</p> <p>Regarding cited resident:</p> <p>Facility failed to ensure a physician order was processed timely for R1 who was ordered scheduled tube</p>	04/06/2026

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
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F0692 SS = D	<p>Continued from page 1 maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>A hospital Discharge Summary, dated 2/11/26, 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.</p> <p>An order, dated 2/11/26, indicated a new order for 150ml free water flushes six times a day.</p> <p>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.</p> <p>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.</p>	F0692	<p>Continued from page 1 feeding free water flushes to mitigate the risk of dehydration.</p> <p>Actions taken to identify other potential residents having similar occurrences:</p> <p>All residents receiving tube feeding free water flushes orders were reviewed and orders remain current and accurate.</p> <p>Measures put in place to ensure deficient practice does not recur:</p> <p>Licensed floor nurses were provided education regarding expectation of timely verification and accuracy of orders. Order sheet was updated to provide sections for date and time of transcription, fax and verification of orders.</p> <p>Effective implementation of actions will be monitored by:</p> <p>Nurse Manager/Supervisor or designee will audit 10 orders per day for 5 days per week x 3 weeks then 10 audits 3 x per week x 3 weeks then 10 audits per week x 3 months to confirm orders are verified, correct and implemented timely to ensure that F692 is in compliance. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.</p> <p>Those responsible to maintain compliance will be:</p> <p>The Nurse Managers/Supervisor or designee is responsible for maintain compliance.</p> <p>Completion date for certification purposes only is: 4/6/2026</p>	

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F0692 SS = D	<p>Continued from page 2</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>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).</p> <p>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.</p> <p>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 she</p>	F0692		

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F0692 SS = D	<p>Continued from page 3 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.</p> <p>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 2/18/26, 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.</p> <p>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,</p>	F0692		

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F0692 SS = D	<p>Continued from page 4 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.</p> <p>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]."</p> <p>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 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</p>	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026
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F0692 SS = D	<p>Continued from page 5</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	F0692		

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F0692 SS = D	<p>Continued from page 6</p> <p>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.</p> <p>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 received and direct the viewer to see the chart. The policy lacked information as to when order transcription and/or verification was to be completed.</p>	F0692		

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 3/5/26 through 3/6/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed this order and identify the date when it will be completed.</p>	20000		04/06/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1 The following complaint was reviewed. H52647260C (2788032) with a licensing order issued at 20940. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20940	Rehab - Hydration CFR(s): MN Rule 4658.0525 Subp. 9 Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20940	F692 This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	04/06/2026

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20940	<p>Continued from page 2</p> <p>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.</p> <p>Findings include:</p> <p>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 1800 ml (milliliters). Approximately 821 ml of her daily fluid intake was provided via tube feeding formula, and the remaining 619 ml to 979 ml was from a combination of scheduled free water flushes and flushes provided in relation to medication administration.</p> <p>A hospital Discharge Summary, dated 2/11/26, 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 60 ml every four hours.</p> <p>An order, dated 2/11/26, indicated a new order for 150 ml free water flushes six times a day.</p> <p>R1's February 2026, Medication Administration Record (MAR), identified that on 2/12/26, at 8:00 a.m., R1 was administered a 150 ml free water flush.</p> <p>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 225 ml free water flushes four times a day, and to avoid flushes at night.</p> <p>A telephone order (TO), dated 2/12/26, ordered by physician assistant (PA)-A, and transcribed by RD-A, directed R1 to be administered 225 ml free water flushes four times a day via her feeding tube and the 150 ml flushes were discontinued. The order identified this was verified; however, the date, and time, of</p>	20940	<p>Continued from page 2</p> <p>It is the policy of Cassia Apple Valley Village Health Care Center to comply with F692-Nutrition/Hydration Status Maintenance.</p> <p>To assure continued compliance, the following plan has been put into place;</p> <p>Regarding cited resident:</p> <p>Facility failed to ensure a physician order was processed timely for R1 who was ordered scheduled tube feeding free water flushes to mitigate the risk of dehydration.</p> <p>Actions taken to identify other potential residents having similar occurrences:</p> <p>All residents receiving tube feeding free water flushes orders were reviewed and orders remain current and accurate.</p> <p>Measures put in place to ensure deficient practice does not recur:</p> <p>Licensed floor nurses were provided education regarding expectation of timely verification and accuracy of orders. Order sheet was updated to provide sections for date and time of transcription, fax and verification of orders.</p> <p>Effective implementation of actions will be monitored by:</p> <p>Nurse Manager/Supervisor or designee will audit 10 orders per day for 5 days per week x 3 weeks then 10 audits 3 x per week x 3 weeks then 10 audits per week x 3 months to confirm orders are verified, correct and implemented timely to ensure that F692 is in compliance. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.</p> <p>Those responsible to maintain compliance will be:</p> <p>The Nurse Managers/Supervisor or designee is responsible for maintain compliance.</p>	

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20940	<p>Continued from page 3 verification was not present.</p> <p>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.</p> <p>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."</p> <p>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).</p> <p>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 1350 ml fluid deficit for R1 in relation to the untimely order processing.</p> <p>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 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 800 ml of water from the tube</p>	20940	<p>Continued from page 3 Completion date for certification purposes only is: 4/6/2026</p>	

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20940	<p>Continued from page 5</p> <p>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.</p> <p>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 would be the same if she were 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]."</p> <p>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 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 were but identified if a dietary order were transcribed by the RD at noon, there was no reason 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.</p>	20940		

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20940	<p>Continued from page 6</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	20940		

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20940	<p>Continued from page 7 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.</p> <p>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 received and direct the viewer to see the chart. The policy lacked information as to when order transcription and/or verification was to be completed.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The Director of Nursing, or designee, could review the order transcription policy and revise as needed while also conducting an audit of resident orders to verify orders are processed correctly and timely. Any findings could be followed up on and staff education provided as applicable.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	20940		