



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54163629M
Compliance #: H54162931C

Date Concluded: August 24, 2026

Name, Address, and County of Licensee

Investigated:

Cura Le Seuer
621 South Fourth Street
Le Seuer, MN 56058
Le Seuer County

Facility Type: Nursing Home

Evaluator's Name:

Katherine Barnhardt, RN Special Investigator

Finding: Not Substantiated

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The alleged perpetrator (AP), a facility employee, neglected the resident when anti-diuretic (prevents fluid retention) medication orders were incorrectly transcribed and the medication was not administered for three consecutive days.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the AP made a transcription error by discontinuing the resident's Bumex medication the AP thought the Bumex order was the same discontinued order from the day before. The AP accidentally discontinued the resident's medication order. The resident missed two doses of medication and had symptoms of fluid overload. The AP notified the provider, and the resident was sent to the emergency room. The resident was hospitalized overnight and returned to the facility the next day at baseline. The preponderance of evidence did not meet the definition of maltreatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included acute and chronic kidney disease and congestive heart failure. The resident's service plan included assistance with medication management and administration. The resident's assessment indicated recent cognitive changes, communication problems and physical limitations.

The resident's record indicated the resident was weighed and monitored daily for fluid retention. Over a four-day period the AP documented the resident gained 7.8-pounds and the resident was seen by a rounding provider. The provider increased the resident's anti-diuretic medication from two milligrams daily to three milligrams daily. The AP was the second licensed staff to sign off the new order. The resident developed fluid overload symptoms when he did not receive the new three milligram anti-diuretic medication daily as ordered for two days. The resident developed shortness of breath, oxygen saturation levels dropped, and the AP sent the resident to the emergency room.

Medical records indicated a provider wrote orders to start a three milligram anti-diuretic daily and discontinue a daily two-milligram dose. Medical records indicated the AP entered the three-milligram order into the resident's electronic medication record and pharmacy steps were completed. The three-milligram dose of Bumex was in the medication cart and available for administration the following morning after the two-milligram was discontinued.

Incident records indicated the resident was taken to the emergency room for shortness of breath and low oxygen when two doses of an anti-diuretic were not administered. Emergency room staff completed a medication reconciliation and notified the facility that the medication ordered was not on the list. Incident records indicated inadequate safeguards within the facility's system to ensure timely medication delivery and follow-up.

Internal investigation records indicated the AP relied on his memory and thought the Bumex three milligram order was the two-milligram order that had been discontinued the previous day. The AP did not review the prior days processed medication orders and discontinued the three-milligram dose of Bumex. Provider orders were not followed, and the resident was hospitalized overnight.

During an interview, licensed leadership stated the resident was hospitalized overnight for shortness of breath and low oxygen levels. Licensed leadership stated when she got to work and the emergency room phoned her and asked why a three-milligram dose of Bumex was not on the medication list. An investigation found a licensed staff had rounded with a provider,

entered the new order, handed it off to a second licensed staff for signature and the pharmacy had delivered the three-milligram dose. The next day the AP discontinued the new order when it popped up in the electronic system assuming it was the discontinued two-milligram dose. Licensed leadership stated the AP had not verified orders before he discontinued the three-milligram dose, and a second licensed staff had not signed off to discontinue the medication before it was stopped.

During an interview, management stated an audit was completed after the medication error and there were no other transcription or medication errors found. Management stated all licensed staff were re-educated on medication related policies and procedures after the error.

During an interview, the AP stated a provider had discontinued a two-milligram dose of Bumex on Friday afternoon, and he had signed off as the second licensed staff to stop that medication. The AP stated when he went to administer medications the next morning a Bumex medication popped up to be administered and he thought it was the two milligram that had been stopped the prior day. He did not verify the medication orders and discontinued the medication that popped up. It was a human error and he took full responsibility. The AP stated one licensed staff could discontinue a medication; however, it took two licensed staff to sign off and start a medication. The AP stated when he returned from a disciplinary action many facility processes changed and it was the only medication error he ever had.

During an interview, a family member stated a medication error occurred and they were unsure where the miscommunication happened. The resident had a rare medical condition that caused fluids to build up very quickly and the fluid buildup had happened to the resident before, prior to the resident moving into the facility. A family member stated facility licensed staff took good care of the resident and family had no concerns.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility:

The AP sent the resident to the emergency room, and the facility took corrective steps to prevent a reoccurrence.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/17/2026	
NAME OF PROVIDER OR SUPPLIER CURA OF LE SUEUR				STREET ADDRESS, CITY, STATE, ZIP CODE 621 SOUTH 4TH STREET , LE SUEUR, Minnesota, 56058			
(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
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54163629M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 electronic documents.			20000			