STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cura of Le Sueur	621 South 4th Street Le Sueur, MN 56058

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident was comprehensively assessed and appropriately monitored for fluid volume status after a reported significant increase in daily weight for 1 of 3 residents (R2) reviewed for change in condition.Findings include: R2's face sheet dated 6/24/26, identified diagnoses of edema (swelling cause by excessive fluid trapped in the body's tissues), diabetes mellitus (condition that you body uses sugar as fuel), paraplegia (a condition where half of the body does not function), sick sinus syndrome (a group of heart rhythm disorders caused by a malfunctioning sinoatrial node (the hearts natural pacemaker). R2's Annual Minimum Data Set (MDS) dated [DATE], identified R2's cognition was intact, had no behaviors, no rejection of care, was dependent for bed mobility/transfers, and was administered a diuretic medication. R2's care plan dated 6/23/25, identified R2 had the potential for pacemaker malfunction/failure or altered cardiac output related to sinus sick syndrome. R2 had a pacemaker. R2's goal was to remain free of signs and symptoms. Interventions as follows:-Observe/report to medical doctor (MD) any signs and symptoms of altered cardiac output or pacemaker malfunction. -Perform pacemaker checks as ordered. If abnormal update MD as needed. R2's physician orders identified the following orders:-Lasix (diuretic) 40 milligrams (mg) twice daily for edema. (dated 6/6/25)-Daily weights: Update the provider if greater than 3 pounds weight gain in one day or 5 lbs. in one week. (dated 1/15/26) R2's nurse practitioner nursing home visit note dated 5/1/26, identified R2 was worried about the swelling in his legs and R2 wondered why no one will do anything about this. R2 had trace edema to bilateral lower extremities and explained the importance of elevating his legs. R2's weight was 225 lbs. with a range of 222 lbs. to 229 lbs. Review of R2's record which included May and June Treatment Administration Record (TAR) did not identify any completed edema monitoring. R2's weight warning progress note dated 6/23/26 at 11:47 a.m., identified R2's weight was 242 lbs. taken on 6/23/26 at 10:40 a.m., which was up 10.2 pounds (lbs.) in one day. Request sent to interdisciplinary team (IDT) for reweight as well as a request to inform the provider about weight gain if weight is correct. During an interview on 6/24/26 at 1:25 p.m., dietician (D)-F stated on 6/23/26 she had identified R2's weight had increased by 10.2 pounds from the previous day. D-F explained she had entered a progress note in R2's EHR at 11:47 a.m., however she had not contacted nursing to ask for a reweight but did send an email to the IDT around 3:20 p.m. but was unsure if the facility had seen the email. D-F explained her expectation would be that if a resident's weight was obtained and the weight revealed an increase from the day prior that the resident should be assessed for fluid overload and have a re-weigh completed immediately. During an interview on 6/23/26 at 2:48 p.m., registered nurse (RN)-B stated if resident's weight was off from one day to the next, they automatically have staff reweigh the resident to see if the weight was accurate. During an observation and interview on 6/23/26 at 4:26 p.m., licensed practical nurse (LPN)-B stated she was R2's nurse, however, had not been informed that R2's weight had increased by over 10 pounds. LPN-B reviewed R2's record and identified R2 did not have his weight rechecked. LPN-B then returned to passing medications on the medications cart but then entered R2's room and obtained blood pressure, temperature, and oxygen saturation. Although LPN-B took vital signs, she did not listen to lungs for (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluid presence nor evaluate for presence of edema. LPN-B informed R2 that his weight needed to be rechecked because it was way over what it was the day prior and propelled R2 to the scale in his wheelchair. R2's weight was 232.8 lbs. (R2's weight the day prior 231.8 lbs.) LPN-B then took R2 back to his room then left the room. LPN-B explained R2's weight must have been obtained in error due to the wheelchair weight possibly being subtracted incorrectly. LPN-B did not and was not able to articulate nor demonstrate checking for presence of edema to evaluate presence/absence of fluid overload. LPN-B was then prompted to complete an edema evaluation. LPN-B entered R2's room and LPN-B raised R2's pantlegs revealing bilateral lower extremities. Without pressing on R2's skin, LPN-B stated R2's edema was only 1+ edema (mild swelling where a slight indentation barely appears), however, when she pressed on R2's lower extremity, the result was 2+ pitting (mild to moderate fluid buildup in the body's tissue). LPN-B stated R2's edema in his legs was ongoing and had not changed. LPN-B reviewed R2's chart and was unable to identify any documentation of what R2's edema had been previously in his lower extremities. During an observation and interview on 6/23/26 at 4:58 p.m., director of nursing (DON) went into R2's room and assessed R2's bilateral lower extremities and identified 2+ pitting edema not 1+ pitting edema. DON stated she would need to provide some education to the nursing department to ensure they are able to know the difference in pitting edema. DON explained R2 should have had his weight rechecked immediately after it was identified in the morning that his weight was increased and had a comprehensive assessment in which would be paying special attention to edema, lung sound, and shortness of breath to ensure he was not going into fluid overload. DON further explained she had added edema/fluid overload monitoring into the resident with congestive heart failure, however, must have missed adding an order for edema monitoring for R2 since he does not have a diagnosis of congestive heart failure. Requested policy for daily weights and edema monitoring and did not obtain from the facility.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure medications were administered according to physician orders which resulted in a significant medication error for 1 of 3 residents (R1) reviewed for medication administration.ˆ This resulted in actual harm for R1 when an increased dose of a diuretic (water pill) had been ordered but was later discontinued without a physician order. R1 did not receive an increased dose, nor any doses of prescribed diuretic for two days and subsequently developed shortness of breath, had to be sent to the emergency department (ED) where he received intravenous diuretic and needed to be hospitalized . The facility implemented immediate corrective action and corrected the deficient practice by 6/18/26, so the citation was issued at past non-compliance.ˆ Findings include: R1's face sheet dated 6/24/26, identified diagnoses of chronic systolic congestive heart failure (heart failure that occurs at the bottom of the heart), chronic kidney disease (a long-term condition where the kidneys are damaged), and diabetes.ˆ R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, had no behaviors, no rejection of care, needed partial/moderate assistance for transfers, and was not taking a diuretic medication. Although R1's MDS indicated R1 was not administered a diuretic during the review period, R1's record identified R1 was prescribed and administered a diuretic medication. ˆˆ R1'a physician order for Bumex (diuretic medication) had a start date of 4/16/26. The order directed staff to administer Bumex 1 milligram (mg) daily related to hypertensive heart disease with heart failure (stop date of 5/18/26). ˆˆˆ R1's care plan dated 4/15/26, identified R1 had a diagnosis of CHF define. Goal to have no negative health effects from medical condition through next review.ˆ Interventions as follows: -Administer medications as ordered. Observe effectiveness and adverse effects.ˆ R1's nurse practitioner (NP) note dated 5/22/26, identified R1 was seen as a follow up for blood pressures, R1's blood pressure reviewed and noted to have hypertension (high blood pressure) with chronic kidney disease and heart failure.ˆ NP gave new orders toˆrestartˆBumex (diuretic used to treat excessive fluid retention caused by congestive heart failure) at 2 mg daily (increased from 1 mg). R1's physician orders identified the new order for Bumex 2 mg daily with a start date of 5/22/26 was transcribed into the electronic health record. R1's nurse practitioner nursing home visit note dated 6/12/26, indicated R1 was seen for a routine nursing home certification visit. R1 had a diagnosis of CHF and gained weight with a current weight of 197 pounds (lb.). R1's weight on 6/10/26 was 185 lb. and on 6/11/26 was 193 lb. (12 lb. weight gain since 6/10/26). ˆR1 was currently on Bumex 2 mg daily and did have increased edema in right lower leg but denied shortness of breath or difficulty breathing.ˆ New orders to discontinue Bumex 2mg and start Bumex 3mg daily for congestive heart failure.ˆ R1's printed physician order dated 6/12/26 included both the orders to stop the Bumex 2 mg and start the Bumex 3 mg daily; the order was noted by registered nurse (RN)-A on 6/12/26. However, the electronic physician orders identified Bumex 2 mg was discontinued on 6/12/26 at 1:12 p.m. and the order for Bumex 3 mg had been transcribed into the electronic physician order on 6/12/26 but the start date identified 6/13/26. However, R1's Administrative Order Summary dated 6/13/26 at 7:20 a.m., R1's Bumex 3 mg had been discontinued by RN-A even though there was no indication of a corresponding physician order to discontinue the Bumex 3 mg had been given or directed by the physician. Review of R1's June Medication Administration Record (MAR) identified the Bumex 2 mg had been discontinued on 6/12/26 and did not identify the Bumex order for 3 mg on 6/12/26. The MAR identified R1 had not received any doses of Bumex on 6/13/26 and on 6/14/26. R1's progress note dated 6/15/26 at 6:56 a.m., identified R1 was having shortness of breath and oxygen saturation was 82% on room air (according to Mayo Clinic normal oxygen saturation values for a healthy person would be 95-100%); 87 % on nasal cannula at 2 liters (L); and 94% on mask at 4L.ˆ and was sent to the emergency department (ED). R1's ED note dated 6/15/26, identified R1 presented to the ED due to shortness of breath. R1 reported an onset of difficult breathing that began in the morning. According (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	to the nursing home paperwork, R1's Bumex was discontinued on 6/12/26, and had not received any doses since then. ^R1 had a history of chronic systolic heart failure and had undergone a double thoracentesis (a procedure where a needle is used to remove excess fluid or air) in mid-January or early February of 2026 for pleural effusions (build up of excessive fluid between the layers of the thin membranes lining the lungs and chest cavity). A computed tomography (CT) Angiogram (imaging test that is used to diagnose blockages and/or blood clots) was performed and revealed findings in R1's lungs consistent of pulmonary edema (a condition defined by the abnormal buildup of excessive fluid in the lungs air sacs) and bilateral (both sides) pleural effusions.^ Acute shortness of breath is most likely due to fluid retention from chronic heart failure, attributed to recent discontinuation of Bumex rather than the intended dose increase.^ R1 received 3 mg of IV Bumex and oxygen requirement decreased from 6 liters/minute (l/min) to 3 l/min.^ R1 was not on oxygen at baseline.^ R1 kept in ED for observation and on 6/16/26 at 7:35 a.m., R1 remained hypoxic (a state of inadequate oxygen reaching the body's tissues and cells to maintain normal function), was requiring oxygen, and was admitted to the hospital.^ ^ R1's hospital ED nursing note dated 6/15/26 at 9:08 a.m., identified that a call was placed to the nursing home where it was verified that an error was made and that R1's Bumex order had been discontinued with the last dose given on 6/12/26 and had not received any dose of Bumex since then.^ R1's Medication Error (Omission) Report dated 6/15/26, identified R1 was on Bumetanide (Bumex) 2mg and was seen on 6/12/26 by the NP who increased dose to 3 mg by mouth one time a day related to hypertensive heart disease. Noted that medication had been discontinued which was noted on a medication review in the emergency room.^ R1 in the emergency room due to shortness of breath.^ Root cause identified on 6/16/26 that medication omission occurred due to failure in the medication administration and order transcription process, compounded by gaps in clinical understanding of CHF and inadequate system safeguards to ensure timely medication delivery and follow up.^ R1's progress note dated 6/16/26 at 2:44 p.m., identified R1 returned from hospital at 1:10 p.m. Diet change to low potassium, low sodium heart healthy and diabetic.^ Fluid restriction of 2000 milliliters.^ During an interview on 6/23/26 at 1:58 p.m., ED registered nurse (RN)-F stated she had called the facility on 6/15/26 after not identifying any Bumex on R1's medication administration record (MAR) from the nursing home. RN-F explained she had talked to the assistant director or nursing who had identified that R1's Bumex that had been increased to 3 mg on 6/12/26, had been discontinued on 6/13/26 and R1 had not received any doses of Bumex since 6/12/26. During an interview on 6/24/26 at 1:47 p.m., licensed practical nurse (LPN)-A stated on 6/12/26 she had transcribed R1's new Bumex order to discontinue Bumex 2 mg and increase the dose to Bumex 3 mg daily.^ LPN-A then explained she had given RN-A the order to have a second nurse verify the order was placed correctly in the record per facility protocol but was unable to verify if RN-A verified it in the record that it was accurate.^ LPN-A explained RN-A then signed the order and gave it back to her and told her she could file it in R1's medical record.^ LPN-A explained nurses should ensure they verified the order prior to discontinuing any medication or before they sign the order to indicate the order was transcribed accurately.^ During an interview on 6/24/26 at 10:17 a.m., RN-A stated he was working on 6/12/26 and had been responsible for completing the second check on a new order for R1's Bumex. On 6/13/26 while he passed medications for R1 he noticed the order for Bumex 3 mg however for some reason believed that was the order that the physician had been discontinued. RN-A explained he discontinued the Bumex 3 mg order but did not verify the discontinuation against or in the presence of a signed physician order to make sure he had discontinued the right dose. On 6/15/26, R1 became short of breath and had low oxygen saturation so RN-A sent R1 to the ED for evaluation.^ After the facility received a call from the ED confirming that the Bumex had been discontinued he realized he had inadvertently discontinued the current order for the increase in the Bumex and not the old order instead.^ RN-A stated he should have visualized the order instead of going off his memory with what the correct order was supposed to be. During an interview on 6/23/26 at 2:48 p.m., RN-B stated the policy of the facility was to have two nurses (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	verify every order that was transcribed into the EHR.ˆ One nurse would enter the order, then the second nurse would check for accuracy and sign the order which identified the second check had been completed. RN-B reviewed R1's EHR and identified R1's Bumex had been discontinued on 6/13/26 at 7:20 a.m., by RN-A, however, R1's order that was obtained on 6/12/26 for the increase in the Bumex had also been signed by RN-A indicating he had made sure the order was correct.ˆ RN-B stated that after learning R1's Bumex had been discontinued without a physician's order, she asked RN-A about it. According to RN-B, RN-A responded that he must have made a mistake and believed the medication had been discontinued. During an interview on 6/24/26 at 1:08 p.m., consulting pharmacist (CPharm) stated the discontinuation of R1's Bumex without a corresponding order was considered a significant medication error.ˆ CPharm further explained her expectation would be for any discontinuation of medication would have to have of a corresponding physician order before it could be discontinued.ˆ During an interview on 6/24/26 at 2:10 p, m., nurse practitioner (NP) stated she had completed a routine nursing home visit on 6/12/26 and due to an increase in weight she increased R1's Bumex from 2 mg daily to 3 mg daily.ˆ Because R1 had a diagnosis of congestive heart failure, the weight gain was indicative of fluid overload, and the increased Bumex dose was prescribed to reduce the excess fluid. However, the increased Bumex dose was never initiated because it had been discontinued without a corresponding physician order. As a result, R1 experienced actual harm, requiring transfer to the emergency department for intravenous diuretic therapy, increased oxygen support, and subsequent hospitalization. During an interview on 6/24/26 at 11:43 a.m., director of nursing (DON) stated her expectation would be that all nurses make sure there was a corresponding physician order prior to discontinuing the medication. DON further explained that when RN-A discontinued R1's Bumex without verifying the order he caused a significant medication error for R1.ˆ The following corrective actions were verified as implemented prior to the survey: -The facility reviewed the Transcription and Processing Provider Orders policy and deemed it to be accurate, and no changes needed.ˆ -R1 was hospitalized and returned on 6/16/26 with an order for Bumex 3 mg daily and was verified it was placed in the MAR correctly.ˆ -All current resident orders and MAR were reviewed to see if any orders had been discontinued without a physician order and no similar incidents were found.ˆ -Facility wide education began on 6/18/26 on transcription of orders and medication administration policies, including adherence to physician orders, the rights of medication administration and proper documentation.ˆ -Facility began audits began on 6/18/26 on medication transcription/discontinuation of medication to ensure orders were correctly transcribed or discontinued with a only a corresponding physician order. Audit will continue for 4 weeks and quarterly after that.ˆ Results and findings will be reviewed during the monthly quality meetings to ensure compliance is met.ˆ ˆ ˆ ˆReview of the facility's Transcription Processing Provider Orders-Long Term Care Policy dated 2/26, identified the following: Transcribing and processing provider order: -After each provider order the process must be followed as noted above. Two staff members will sign and date upon verification of order processing indicating that the steps to the order process have been completed. The second person double checking the order should: Look at the provider's order in the chart. -Confirm appropriate start/end date and time in the MAR/ treatment administration record (TAR) by running the Medication Administration Record to ensure the correct date/time -Verify that all steps of the order were processed as noted above. ˆ Review of the facility's Discontinued Medications Policy dated 11/21, identified that staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy.ˆ Policy Interpretation and Implementation: -A practitioner orders to discontinue a resident's medication must be documented in the resident's clinical record and on the MAR. -The nurse receiving the order to discontinue a medication is responsible for recording the information and notifying the dispensing pharmacy of the discontinuation.ˆ -Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with the established policies.ˆ ˆ