



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
April 3, 2025

Administrator  
Viewcrest Health Center  
3111 Church Street  
Duluth, MN 55811

RE: CCN: 245414  
Cycle Start Date: March 21, 2025

Dear Administrator:

On March 21, 2025, 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 immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

#### REMOVAL OF IMMEDIATE JEOPARDY

On March 14, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed.

#### REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

#### SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have

Viewcrest Health Center

April 3, 2025

Page 2

received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Viewcrest Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 21, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### DEPARTMENT CONTACT

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

**Shannon Gilb, ROM**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**705 5<sup>th</sup> Street NW, Suite A**  
**Bemidji, Minnesota 56601-2933**  
**Email: [shannon.gilb@state.mn.us](mailto:shannon.gilb@state.mn.us)**  
**Office: 651-201-4445**

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

Viewcrest Health Center

April 3, 2025

Page 3

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](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>		
(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	
F 000	INITIAL COMMENTS  On 3/20/25 through 3/21/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.  The following complaint was reviewed: H54141306C (MN00111481) with a deficiency issued at F689 as an immediate jeopardy at PAST NON-COMPLIANCE.  Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow manufacturer's recommendation on EZ Way sling usage, facility policy, and transfer care plan for 1 of 3 (R1) residents reviewed for mechanical lift transfers. Additionally, the facility lacked a system to assess	F 689	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>		
(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
F 689	<p>Continued From page 1</p> <p>and document appropriate resident sling size. R1 fell out of the sling, sustained a laceration to the back of her head and was sent to the Emergency Department (ED).</p> <p>The IJ began on 3/13/25 at 11:00 p.m., when R1 fell from a mechanical lift causing a laceration to her head and the likelihood for potnetial serious harm. The administrator and director of nursing (DON) were informed of the IJ on 3/21/25 at 10:30 a.m. The facility had implemented corrective action on 3/14/25, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Findings include:</p> <p>R1's Face Sheet dated 2/4/25, indicated R1 had cerebral palsy, abnormal posture, functional quadriplegia, and scoliosis.</p> <p>R1's annual minimum data set (MDS) dated 2/14/25, indicated R1 was cognitively intact, needed extensive assistance with two people for transfers.</p> <p>R1's care plan dated 2/26/25, indicated R1 needed a mechanical lift with two staff assistance for transfers. R1 used a size small sling.</p> <p>R1's weight on 3/12/25, was 115.5 lbs.</p> <p>R1's medical record did not have evidence that a sling assessment had been completed.</p> <p>R1's encounter summary dated 3/14/25, indicated R1 fell roughly 4-5 feet. R1 had a contusion noted to the lower back of head.</p>	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>		
(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
F 689	<p>Continued From page 2</p> <p>R1's progress note dated 3/14/25 at 8:33 a.m., written by registered nurse (RN) -B indicated R1 was being transfers with an EZ Way smart lift from her wheelchair to her bed. R1 had an inappropriate sling on and was transferred with assist of one staff instead of two staff. R1 had laceration to the back of R1s head and was sent to the ED.</p> <p>During an interview on 3/20/25 at 9:35 a.m., R1 stated nursing assistant (NA)-A was transferring her with the EZ Way smart lift from her wheelchair to her bed and R1 slid out of the sling when it was in the air and hit her back and head on the floor. R1 stated NA-A was the only staff in the room.</p> <p>During an interview on 3/20/25 at 12:24 p.m., NA-A stated on 3/13/25 at around 11:00 p.m., NA-A transferred R1 by herself with a green sling. NA-A was not aware the sling was not appropriate or that two staff were needed to assist with an EZ Way smart lift. NA-A placed the sling on R1 correctly and attached the sling correctly to the lift. NA-A lifted R1 into the air and she started to move the EZ Way lift towards R1's bed when R1 started to slide out of the opening where R1's buttocks were. NA-A left R1 and ran to get help as R1 was falling out of the sling. When NA-A got back to the room R1 was on the floor bleeding from her head. NA-A stated she asked other nursing assistants how R1 transfers but did not look at the care plan. NA-A also indicated that she received safe-transfer training but denied knowing she should have transferred R1 with two people.</p> <p>During an interview on 3/20/25 at 12:42 p.m., RN-A stated on 3/13/25 around 11:40 p.m., NA-A</p>	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>		
(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
F 689	<p>Continued From page 3</p> <p>came running down the hall stating R1 was falling out of her sling. RN-A stated she went to R1's room and found her on the floor bleeding for her head. RN-A stated the sling was green in color and straps were still attached to the lift correctly but R1 was no longer in the sling. RN-A indicated she was unsure if that's how the straps were attached at the time of the fall.</p> <p>During an interview on 3/20/25 at 1:14 p.m., EZ Way representative stated EZ Way had never made a completely green sling for any lifts. EZ Way lifts should have only been used with EZ Way brand slings as no other brand would have been safe to use.</p> <p>During an interview on 3/20/25 at 1:54 p.m., certified nurse practitioner (CNP)-A stated she would have excepted the facility staff to have followed the policies and care plans put in place for R1.</p> <p>During an interview on 3/20/25 at 2:06 p.m., the director or nursing (DON) stated the green sling used on R1 was not an EZ Way brand and should not have been used and R1 should have been transferred per policy and care plan with two staff. DON further stated on 3/21/25 at 8:01 a.m., since her time at the facility, starting in May of 2023, the facility has not had a process for assessing appropriate sling type and size until following R1's incident on 3/13/25.</p> <p>During an interview on 3/21/25 at 8:36 a.m., RN-B stated a week and a half ago RN-B started overseeing R1's care at the facility. RN-B stated she was not sure why R1's sling was not an EZ Way brand and was unaware of the sling issue until R1 had fallen. The only slings that should've</p>	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET</b> <b>DULUTH, MN 55811</b>		
(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
F 689	<p>Continued From page 4 been used were EZ Way brand slings.</p> <p>During an interview on 3/21/25 at 9:14 a.m., medical director (MD)-A stated he would have expected the facility staff to follow facility policy and manufactures instructions for EZ Way products.</p> <p>EZ Way Smart Life Operator's Instructions revised 6/13/2011, indicated EZ Way slings were made specifically for EZ Way Smart Lifts. For the safety of the patient and the caregiver, only EZ Way slings should be used with EZ Way lifts.</p> <p>EZ Way Sling Sizing Chart undated, indicated a small sling should've been used for residents who weighed 70 to 100 pounds. Residents who weighed 90-220 pounds should've use a medium sling. R1's recorded weight at the time of the incident was 115.5lbs.</p> <p>Mechanical Lift Policy revised 9/11/23, indicated two staff would assist with all full body mechanical lift transfers, nursing and therapy staff would assess residents' needs for transfer assistance on an on going basis, and the mechanical lift assessment would identify the type and size of sling to use.</p> <p>The past noncompliance immediate jeopardy began on 3/13/25. The immediate jeopardy was removed, and the deficient practice was corrected by 3/14/25, after the facility implemented a systemic plan that included the following actions: Reviewed their policies on use of mechanical lifts, including the assessment and size of the slings. The facility has re-assessed all residents who utilize a mechanical lift to ensure they have the proper brand and size sling.</p>	F 689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245414</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET</b> <b>DULUTH, MN 55811</b>		
(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
F 689	Continued From page 5 Resident care plans had been updated. Sling assessments would be completed at least quarterly and with significant change. Non EZ Way brand slings had been removed from the facility so that they were not inadvertently used. The facility has re-educated all staff who use the mechanical lift on the policy and procedure and did competency testing. The facility completed audits three times weekly observing staff transferring residents with mechanical lifts results will then be brought to QAPI committee. Verification of corrective action was confirmed by observation, interview, and document review on 3/20/25 and 3/21/25.	F 689		



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

April 3, 2025

Administrator  
Viewcrest Health Center  
3111 Church Street  
Duluth, MN 55811

Re: Event ID: MIFL11

Dear Administrator:

The above facility survey was completed on March 21, 2025 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00602</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p><b>Initial Comments</b></p> <p><b>*****ATTENTION*****</b></p> <p><b>NH LICENSING CORRECTION ORDER</b></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><b>INITIAL COMMENTS:</b> On 3/20/25 through 3/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed during</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE
---	-------	-----------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00602</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/21/2025</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>VIEWCREST HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHURCH STREET DULUTH, MN 55811</b>
--	---

(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) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>the survey: H54141306C (MN00111481)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		