Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

RE: CCN: 245414
Cycle Start Date: June 2, 2026

Dear Administrator:

On June 2, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 2, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 2, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Viewcrest Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 2, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice.
A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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,

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

Re: Event ID: 234204-H1

Dear Administrator:

The above facility survey was completed on June 2, 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 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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	INITIAL COMMENTS On 6/1/26 - 6/2/26 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. The following complaints were reviewed H54142542C/MN3019481 with deficiencies issued at F689. 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.	F0000		06/22/2026
F0689 SS = G	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 observation, interview, and record review the facility failed to follow its policy to adequately supervise 1 of 3 residents (R1) prior to a successful elopement who was reviewed for accidents. R1 eloped from the facility wearing a WanderGuard system, was found four blocks away and was hospitalized with abrasions.	F0689	PLAN OF CORRECTION F689 – Free of Accident Hazards/Supervision/Devices 1. How corrective action was accomplished for the resident found to have been affected by the deficient practice Upon identification of the elopement event, Resident #1 was located, transported to the hospital for evaluation and treatment, and the resident's responsible party and physician were notified. Residents family decided to look for a locked memory care unit for residents safety. 2. How the facility identified other residents having the potential to be affected by the same deficient practice An audit of all current residents with diagnoses of cognitive impairment, wandering behaviors, exit-seeking behaviors, WanderGuard use, or identified elopement risk was completed by the Director of Nursing or designee. Each resident's assessment, care plan, supervision interventions,	07/03/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 1 Findings include: Upon observation on 6/2/26 at 8:30 a.m. the facilities camera recording revealed at 3:52 p.m. on 5/19/26 the maintenance director checked the WanderGuard that was going to be placed on R1. The WanderGuard set off the door alarm, a staff member in the front office heard the alarm and ran to the door. At 5:35 p.m. R1 walked up to the front door and the magnetic light came on. R1 turned around and walked away. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door. At 5:42 p.m. R1 walked up to the door, no staff or visitors were in sight of the camara. R1 opened the door and walked through it taking a left turn and proceeded down the sidewalk outside the door. The magnetic light came on. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door. R1’s elopement risk dated 5/6/26 indicated R1 was not physically mobile, was new to the facility, and had no history of elopement. Analysis of the risk and interventions indicated R1 was in the facility for respite with her husband, sitting with her husband all day as he is the primary caregiver. R1 was not an elopement risk at the time of assessment. R1’s care plan dated 5/6/26 – 5/19/26 lacked any interventions of staff supervision for R1. R1’s progress note dated 5/6/26 indicated R1 was chronically confused and disoriented. R1 had severe cognitive impairment (affecting all areas of judgement). She was coherent with clear speech and no language barrier and was able to make herself understood. R1 was at the facility as a respite resident due to her husband who was admitted for rehabilitation, and he was her primary caregiver. R1’s admission Minimum Data Set (MDS) dated 5/12/26 indicated R1’s Brief Inventory of Mental Status (BIMS) score was a six indicating severe cognitive impairment. R1 was independent with dressing, hygiene, and transferring. R1’s pertinent diagnosis was dementia. R1’s admission assessment dated 5/12/26 indicated R1 had cognitive concerns that could affect her ability to leave the facility independently. She did not have physical concerns that could affect her ability to leave the facility independently. She was unable to identify where she was going or with whom she was going. R1 did not have the ability to utilize the call pendant or cellphone if she needed assistance	F0689	Continued from page 1 and WanderGuard status were reviewed to ensure they accurately reflected current resident needs. Any identified deficiencies were immediately corrected through reassessment, care plan revision, and staff notification. 3. What measures were put into place or systemic changes made to ensure the deficient practice will not recur The facility implemented the following: Immediate reassessment of residents exhibiting new or worsening wandering, exit-seeking, confusion, or behavioral changes. Care plan updates within 24 hours of identifying a change in elopement risk. Documentation of individualized supervision interventions for residents at risk for elopement. Communication of new elopement interventions during shift report and through the electronic health record. Verification and documentation of WanderGuard functionality at placement and per facility policy. Securitas Healthcare was dispatched out to review wanderguard system was functioning properly and extended the range for triggering the locks to engage on the doors. Education for all licensed nurses, nursing assistants, social services staff, activities staff, maintenance staff, and department managers regarding: Elopement risk factors. Resident reassessment requirements. Care plan update requirements. Staff supervision expectations.	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 2 outside the facility. R1 needed staff or family with her to leave the facility as her dementia had progressively made her more confused. R1's nursing progress note dated 5/15/26 at 11:25 a.m. indicated R1 was walking in and out of her room wanting to know where her husband was. R1 was redirected and told he was in the hospital. R1 was redirectable and asked if she could walk up and down the unit. The effectiveness of the intervention and follow-up was R1 was calm and redirectable, walking the unit and did not leave the unit area. R1's nursing progress note dated 5/15/26 at 3:40 p.m. indicated R1 was repeatedly asking where her husband was and would forget in a few seconds and asked again. R1 was redirected with activities, meals, and visitors. R1's nursing progress note dated 5/19/26 at 12:52 a.m. indicated R1 had lots of anxiety that shift. She had been wandering the halls looking for her husband. Staff verbally redirected her as able. She was assured her husband was safe. R1 had wandered into other resident rooms to look for her husband. R1's nursing progress note dated 5/19/26 at 4:48 a.m. indicated R1 was confused about where her husband was. She stated she wanted to go home and packed her and her husband's room. Staff tried to keep her from hauling it out into the hallway. She was offered snacks and encouraged to go to bed. She had been up all night and refused to lay down. R1's nursing progress note dated 5/19/26 at 2:26 p.m. indicated R1 had been wandering up most of the shift looking for her husband and a ride home. R1's son had visited that morning and had explained to her she had to stay at the facility. Staff continued to redirect R1 and attempted to engage her in activities which she would attend for a very short time. R1's nursing progress note dated 5/19/26 at 4:00 p.m. indicated R1 had a WanderGuard placed on her right ankle due to increased statements of wanting to leave the facility. R1 was agreeable and chose the location of the placement. R1's nursing progress note dated 5/19/26 at 11:59 p.m. indicated R1's morning nurse, licensed practical nurse (LPN)-A stated she had placed a WanderGuard on R1 in the afternoon due to her persistent exit seeking behaviors. R1 was last seen walking by the nursing station at around 6:00 p.m.	F0689	Continued from page 2 WanderGuard monitoring and response procedures. Elopement prevention policy requirements. Education will be completed prior to the date of compliance for all current staff and incorporated into orientation for new employees. 4. How the corrective actions will be monitored to ensure the deficient practice is corrected and will not recur The Director of Nursing or designee will conduct: Weekly audits of residents identified as having wandering or elopement risk to verify assessments, care plans, supervision interventions, and staff communication are in place for four weeks, beginning the week of June 29, 2026. Weekly audits of WanderGuard checks and documentation for four weeks. Monthly audits thereafter for two additional months. Audit results will be reviewed at the Quality Assurance and Performance Improvement (QAPI) Committee meetings monthly for three months. Any identified concerns will result in immediate corrective action, additional staff education, and continued monitoring until substantial compliance is maintained. Date of Compliance: July 3, 2026 Responsible Person: Director of Nursing/Administrator	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 3 All staff were looking for R1 after 6:00 p.m. and were unable to locate her within the facility. The director of nurse (DON) called 911 at 6:20 p.m. and reported R1 could not be located in the facility and a description of her was given to the officer. The facility staff within the facility and the nearby vicinity outside the facility and a nearby church. R1's family member (FM)-A was called, and he stated R1 would try to walk home. The DON received a call from the police at 7:00 p.m. saying R1 had been found several blocks away and ambulance personnel had assessed R1 and had taken her to the emergency department (ED) for evaluation. At 11:47 p.m. the DON was updated that R1 had been admitted to the hospital. R1's admission hospital note dated 5/19/26 indicated R1 resided at a nursing facility where she walked out the door. R1 had a tracker/device that would monitor her. Somehow the alarm did not go off or alert the facility. R1 was found to be missing and found approximately four blocks away on a gravel road and had fallen on the ground. She had numerous abrasions and bruising. R1 was given pain medication and admitted to the hospital. R1's assessment and plan indicated R1 had a fall with numerous abrasions, most notable on her right forehead and knee. She did not have any fractures. She would continue to be reassessed as she was at a high risk for fractures. Her plan was to have physical therapy (PT), occupation therapy (OT), pain control, and a social worker for her unclear disposition for a new facility vs. home vs. other arrangements. R1's care plan revised dated 5/20/26 indicated R1 was an elopement risk with goal not to elope from the facility. Interventions included changing the WanderGuard device per manufacture recommendations, performing WanderGuard checks per facility policy, using distraction from wandering, offering diversions, structured activity such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, food, television, books. Staff observe for wandering and redirecting if attempting to enter another resident's room without permission. Identified wander alert and elopement risk. Upon interview on 6/1/26 at 1:59 p.m., nursing assistant, (NA)-A stated she worked with R1 the morning she eloped, and it was difficult to redirect her that day and ever since her husband went to the hospital a few days prior to that. NA-A denied any formal supervision of R1. She stated she was not aware that a WanderGuard had been placed on R1.	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 4 Upon interview on 6/1/26 at 2:15 p.m. (NA)-B stated 5-6 days before R1 was admitted to the hospital she was hard to contain, she would pack her bags. She would look for and ask about her husband and stated she was going home. NA-B stated she tried to redirect R1 or give her a snack but had never been told any specific interventions by the nursing staff. Upon interview on 6/1/26 at 2:41 p.m. registered nurse, (RN)-A stated when R1's husband was at the facility she was fine; she barely left his side. When he went to the hospital her exit seeking behavior got worse by the day. RN-A stated she gave R1 reassurance that her husband was alright and returning. On the day R1 eloped the facility placed a WanderGuard on her hours before the elopement happened, and the alarm failed. Upon interview on 6/1/26 at 4:10 p.m. LPN-A stated she worked the evening R1 eloped. She was the nurse who initiated the WanderGuard after attempting visiting one-on-one with her, calling her husband to the hospital, and giving her activities. She stated around 4:00 p.m. she reached out to maintenance and had a WanderGuard placed on R1. LPN-A stated R1 had tried to get out the back doors of the facility, but the alarm sounded and R1 was redirected back to her room. She last saw R1 at 5:45 p.m. in the dining room. LPN-A stated she went to give medications to another resident and around 6:00 p.m. she asked staff where R1 was. The staff searched the unit. The facility called (FM)-A to see if he had taken her out and forgot to sign the book. When she realized he did not take her out she called the DON and reported R1 as missing. LPN-A stated she did not check the WanderGuard when it was placed on R1, however maintenance had checked it prior to giving it to her. She denied telling other staff to supervise R1 due to her exit seeking behaviors since she had placed the alarm on her. Upon interview on 6/1/26 at 4:38 p.m. registered nurse (RN)-B stated R1 was completely fine at the facility until her husband was hospitalized. On 5/19 at around 4:00 p.m. (LPN)-A requested R1 to have a WanderGuard because R1 was attempting to leave the facility. A WanderGuard was placed on her immediately. RN-A was not certain of any supervisory interventions for R1 from the time the behaviors started until the elopement. Upon interview on 6/1/26 at 6:30 p.m. R1's family member (FM)-B stated she was aware R1 had been packing her bags at the facility and threatening to	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 5 leave ever since her husband was in the hospital. The family visited her often to tell her where her husband was, and she had to stay at the facility until he returned. She was not aware the facility had placed a WanderGuard on R1. FM-B started on the night R1 eloped (FM)-A called her and told her, so she met R1 at the hospital. She described R1 as being “banged up.” Her face was a mess, one of her eyes could not been seen due to the swelling and R1 was complaining about knee pain. She had to use a walker while in the hospital which she had never used prior. Upon interview on 6/2/26 at 11:49 a.m. the director or nursing (DON) stated R1 required a lot of redirection and activities. R1 liked movies. The DON was aware the staff had to reiterate again that her husband was in the hospital, and she could not leave the facility. Her family visited often. She stated she was updated that staff had placed a WanderGuard on R1 that failed at the time of the elopement. The DON denied any supervision interventions on R1’s care plan. Upon interview on 6/2/26 at 12:55 p.m. the Administrator stated he was aware R1 had been packing her bags, wandering with exit seeking. He stated his expectation was that staff reassess with any changes and update the care plan as needed to keep residents safe. He was not certain whether R1 had supervision on her care plan or not. A facility policy titled Elopement with a revision date of 7/29/25 indicated that when a resident is determined at risk for elopement, an elopement risk assessment will be performed (see electronic health record (EHR)) and a corresponding care plan developed that addresses the following: Cognitive status Ambulation and Mobility Status: Includes evaluation of ambulation or wheelchair use, as well as their ability to open doors independently, since greater independence may increase risk. History of wandering and/or attempts to leave the building. Wandering patterns: Frequency, specific locations, time(s) of day, and duration of wandering episodes. Supervision: The level of oversight required when leaving the building. Prevention strategies may involve measures such as:	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 6 Placing the resident's room in proximity to the nursing station or in an area farther from exit doors. Incorporating activity-based programs during peak wandering periods. Conducting more frequent checks or scheduling them at times when the resident is most likely to wander. Equipping the residents and/or their mobility aid (e.g., walker or wheelchair) with a WanderGuard bracelet that alerts staff if the resident attempts to leave. The nurse will document this plan into the resident's care plan in the EHR. Findings include: R1’s care plan dated 5/6/26 – 5/19/26 lacked any interventions of staff supervision for R1. R1’s progress note dated 5/6/26 indicated R1 was chronically confused and disoriented. R1 had severe cognitive impairment (affecting all areas of judgement). She was coherent with clear speech and no language barrier and was able to make herself understood. R1 was at the facility as a respite resident due to her husband who was admitted for rehabilitation, and he was her primary caregiver. R1’s admission Minimum Data Set (MDS) dated 5/12/26 indicated R1’s Brief Inventory of Mental Status (BIMS) score was a 6 indicating severe cognitive impairment. R1 was independent with dressing, hygiene, and transferring. R1’s pertinent diagnosis was dementia. R1’s admission assessment dated 5/12/26 indicated R1 had cognitive concerns that could affect her ability to leave the facility independently. She did not have physical concerns that could affect her ability to leave the facility independently. She was unable to identify where she was going or who she was going with. R1 did not have the ability to utilize the call pendant or cellphone if she needed assistance outside the facility. R1 needed staff or family with her to leave the facility as her dementia had progressively made her more confused. R1’s nursing progress note dated 5/15/26 at 11:25 a.m. indicated R1 was walking in and out of her room wanting to know where her husband was. R1 was redirected and told he was in the hospital. R1	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 7 was redirectable and asked if she could walk up and down the unit. The effectiveness of the intervention and follow-up was R1 was calm and redirectable, walking the unit and did not leave the unit area. R1's nursing progress note dated 5/15/26 at 3:40 p.m. indicated R1 was repeatedly asking where her husband was and would forget in a few seconds and asked again. R1 was redirected with activities, meals and visitors. R1's nursing progress note dated 5/19/26 at 12:52 a.m. indicated R1 had lots of anxiety that shift. She had been wandering the halls looking for her husband. Staff verbally redirected her as able. She was assured her husband was safe. R1 had wandered into other resident rooms to look for her husband. R1's nursing progress note dated 5/19/26 at 4:48 a.m. indicated R1 was confused about where her husband was. She stated she wanted to go home and packed her and her husband's room. Staff tried to keep her from hauling it out into the hallway. She was offered snacks and encouraged to go to bed. She had been up all night and refused to lay down. R1's nursing progress note dated 5/19/26 at 2:26 p.m. indicated R1 had been up wandering most of the shift looking for her husband and a ride home. R1's son had visited that morning and had explained to her she had to stay at the facility. Staff continued to redirect R1 and attempted to engage her in activities which she would attend for a very short time. R1's nursing progress note dated 5/19/26 at 4:00 p.m. indicated R1 had a wander guard placed on her right ankle due to increased statements of wanting to leave the facility. R1 was agreeable and chose the location of the placement. R1's nursing progress note dated 5/19/26 at 11:59 p.m. indicated R1's a.m. nurse, licensed practical nurse (LPN)-A stated she had placed a wander guard on R1 in the afternoon due to her persistent exit seeking behaviors. R1 was last seen walking by the nursing station at around 6:00 p.m. All staff were looking for R1 after 6:00 p.m. and were unable to locate her within the facility. The director of nurse (DON) called 911 at 6:20 p.m. and reported R1 could not be located in the facility and a description of her was given to the officer. The facility staff within the facility and the nearby vicinity outside the facility and a nearby church. R1's family member (FM)-A was called, and he stated R1 would try to walk	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 8 home. The DON received a call from the police at 7:00 p.m. saying R1 had been found several blocks away and ambulance personnel had assessed R1 and had taken her to the emergency department (ED) for evaluation. At 11:47 p.m. the DON was updated that R1 had been admitted to the hospital. R1's admission hospital note dated 5/19/26 indicated R1 resided at a nursing facility where she walked out the door. R1 reportedly had a tracker/device that would monitored her. Somehow the alarm did not go off or alert the facility. R1 was found to be missing and found approximately four blocks away on a gravel road and had fallen on the ground. She had numerous abrasions and bruising. R1 was given pain medications and admitted to the hospital. R1's assessment and plan indicated R1 had a fall with numerous abrasions, most notable on her right forehead and knee. She did not have any fractures. She would continue to be reassessed as she was at a high risk for fractures. Her plan was to have physical therapy (PT), occupation therapy (OT), pain control, and a social worker for her unclear disposition for a new facility vs. home vs. other arrangements. Upon interview on 6/1/26 at 1:59 p.m., nursing assistant, (NA)-A stated she worked with R1 the morning she eloped, and it was difficult to redirect her that day and ever since her husband went to the hospital a few days prior to that. NA-A denied any formal supervision of R1. She stated she was not aware that a wander guard had been on placed on R1. Upon interview on 6/1/26 at 2:15 p.m. (NA)-B stated 5-6 days before R1 was admitted to the hospital she was hard to contain, she would pack her bags. She would look for and ask about her husband and stated she was going home. NA-B stated she tried to redirect R1 or give her a snack but had never been told any specific interventions by the nursing staff. Upon interview on 6/1/26 at 2:41 p.m. registered nurse, (RN)-A stated when R1's husband was at the facility she was fine; she barely left his side. When he went to the hospital her exit seeking behaviors got worse by the day. RN-A stated she mainly gave R1 reassurance that her husband was alright and returning. On the day R1 eloped the facility placed a wander guard on her hours before the elopement happened, and the alarm failed. Upon interview on 6/1/26 at 6:30 p.m. R1's family member (FM)-B stated she was aware R1 had been	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 9 packing her bags at the facility and threatening to leave ever since her husband was in the hospital. The family visited her often to tell her where her husband was, and she had to stay at the facility until he returned. She was not aware the facility had placed a wander guard on R1. FM-B stated on the night R1 eloped (FM)-A called her and told her, so she met R1 at the hospital. She described R1 as being “banged up.” Her face was a mess, one of her eyes could not been seen due to the swelling and R1 was complaining about knee pain. She had to use a walker while in the hospital which she had never used prior. Upon interview on 6/1/26 at 4:10 p.m. LPN-A stated she worked the evening R1 eloped. She was the nurse who initiated the wander guard after attempting visiting one-on-one with her, calling her husband in the hospital, and giving her activities. She stated around 4:00 p.m. she reached out to maintenance and had a wander guard placed on R1. LPN-A stated R1 had tried to get out the back doors of the facility, but the alarm sounded and R1 was redirected back to her room. She last saw R1 at 5:45 p.m. in the dining room. LPN-A stated she went to give medications to another resident and around 6:00 p.m. she asked staff where R1 was. The staff searched the unit. The facility called (FM)-A to see if he had taken her out and forgot to sign the sign out book. When she realized he did not take her out she called the DON and reported R1 as missing. LPN-A stated she did not check the wander guard when it was placed on R1, however maintenance had checked it prior to giving it to her. She denied telling other staff to supervise R1 due to her exit seeking behaviors since she had the placed the alarm on her. Upon interview on 6/1/26 at 4:38 p.m. registered nurse (RN)-B stated R1 was completely fine at the facility until her husband was hospitalized. On 5/19 at around 4:00 p.m. (LPN)-A requested R1 have a wander guard because R1 was attempting to leave the facility. A wander guard was placed on her immediately. RN-A was not certain of any supervisory interventions for R1 from the time the behaviors started until the elopement. Upon observation on 6/2/26 at 8:30 a.m. the facilities camera recording revealed at 3:52 p.m. on 5/19/26 the maintenance director checked the wander guard that was going to be placed on R1. The wander guard set off the door alarm, a staff member in the front office heard the alarm and ran to the door. At 5:35 p.m. R1 walked up to the front door and the magnetic light came on. R1 turned	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 10 around and walked away. The footage had no audio so it could not be confirmed if the alarm sounded. No staff arrived at the door due to hearing an alarm sound. At 5:42 p.m. R1 walked up to the door, no staff or visitors were in sight. R1 opened the door and walked through it taking a left turn and proceeded down the side walk outside the door. The same small magnetic light was visualized as it was 5:35 p.m., again no staff arrived at the door due to hearing an alarm. Upon interview on 6/2/26 at 11:49 a.m. the director or nursing (DON) stated R1 required a lot of redirection and activities. R1 liked movies. The DON was aware the staff had to reiterate over and over that her husband was in the hospital, and she could not leave the facility. Her family visited often. She stated she was updated that staff had placed a wander guard on R1 that failed at the time of the elopement. The DON denied any supervision interventions on R1's care plan. Upon interview on 6/2/26 at 12:55 p.m. the Administrator stated he was aware R1 had been packing her bags, wandering with exit seeking. He stated his expectation was that staff reassess with any changes and update the care plan as needed to keep residents safe. He was not certain if R1 had supervision on her care plan or not. A facility policy titled Elopement with a revision date of 7/29/25 indicated that when a resident is determined at risk for elopement, an elopement risk assessment will be performed (see electronic health record (EHR)) and a corresponding care plan developed that addresses the following: Cognitive status Ambulation and Mobility Status: Includes evaluation of ambulation or wheelchair use, as well as their ability to open doors independently, since greater independence may increase risk. History of wandering and/or attempts to leave the building. Wandering patterns: Frequency, specific locations, time(s) of day, and duration of wandering episodes. Supervision: The level of oversight required when leaving the building. Prevention strategies may involve measures such as: Placing the resident's room in proximity to the	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	3111 CHURCH STREET , DULUTH, Minnesota, 55811

(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
F0689 SS = G	Continued from page 11 nursing station or in an area farther from exit doors. Incorporating activity-based programs during peak wandering periods. Conducting more frequent checks or scheduling them at times when the resident is most likely to wander. Equipping the resident and/or their mobility aid (e.g., walker or wheelchair) with a wander guard bracelet that alerts staff if the resident attempts to leave. The nurse will document this plan into the resident's care plan in the EHR.	F0689		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	**3111 CHURCH STREET , DULUTH, Minnesota, 55811**

(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: On 6/1/26 - 6/2/26 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. The following complaints were reviewed during the survey. H54142542C/MN3019481 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		06/22/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEWCREST HEALTH CENTER	**3111 CHURCH STREET , DULUTH, Minnesota, 55811**

(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	Continued from page 1 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.	20000		06/22/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

RE: CCN: 245414
Cycle Start Date: June 2, 2026

Dear Administrator:

On June 17, 2026, we notified you a remedy was imposed. On July 7, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 7, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2026, be discontinued as of July 7, 2026. (42 CFR 488.417 (b))

In our letter of June 17, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

RE: CCN: 245414
Cycle Start Date: June 2, 2026

Dear Administrator:

On June 17, 2026, we notified you a remedy was imposed. On July 7, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 7, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 2, 2026, be discontinued as of July 7, 2026. (42 CFR 488.417 (b))

In our letter of June 17, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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