



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 2, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

RE: CCN: 245414
Cycle Start Date: August 4, 2026

Dear Administrator:

On September 1, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 2, 2026

Administrator
VIEWCREST HEALTH CENTER
3111 CHURCH STREET
DULUTH, MN 55811

Re: Reinspection Results
Event ID: 2F5364-H2

Dear Administrator:

On September 1, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 4, 2026. At this time these correction orders were found corrected.

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

An equal opportunity employer.

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 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 8/4/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed: H54142894C (3041231), H54143546C (3117670); with non-compliance cited 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/07/2026
F0689 SS = D	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 document review, the facility failed to ensure interventions for safety and the prevention of elopement were consistently completed and recorded in the record to help prevent future elopements for 1 of 3 residents (R2) reviewed. R2 had a history of exit-seeking			F0689	The facility must ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action for the Resident Affected R2 was immediately identified as requiring focused review due to her history of wandering and elopement and the finding that daily Wanderguard checks were not consistently documented. The Director of Nursing/designee will complete and document a comprehensive review of R2's current elopement and wandering risk, care plan, physician/NP orders, Wanderguard placement, and required supervision interventions. The Wanderguard device will be verified for proper placement and function. Staff will ensure that the Wanderguard remains with R2 and is attached to the designated device/person identified in the resident's current plan of care. R2's wheelchair/device		08/14/2026

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 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 = D	Continued from page 1 behavior and wore a “wanderguard” device (alarms if someone with one tries to exit) for safety; however, this was not checked for placement and function everyday as directed by the plan of care. Findings include: A facility-submitted Vulnerable Adult Maltreatment Report (FRI), dated 7/25/26, identified R2 was found outside of the care center by staff unattended on 7/25/26. R2 was brought back inside the care center and was uninjured. On 8/4/26 at 10:06 AM, a tour of the care center was completed. The main entry doors consisted of two double doors with magnetic locks present on the inner doors along the top. The doors had a white-colored keypad on the wall next to them which had a status, “READY.” The device was a Stanley Healthcare wander management system and was working correctly at this time. Later, at 12:56 p.m., R2 was observed seated in a standard wheelchair in the commons area of the Island Lake unit. R2 was unable to answer how long she’d lived at the care center and responded to many questions with, “I don’t know.” R2’s wheelchair had a white-colored wanderguard bracelet attached to the rear frame. R2’s quarterly Minimum Data Set (MDS), dated 6/16/26, identified R2 had severe cognitive impairment and demonstrated wandering behavior(s) during the review period. R2’s care plan, revised 7/31/26, identified R2 had an ADL self-care deficit but was able to reposition in bed without help and used only a standby assist (SBA) for transfers. R1 had a history of self-transfers and was able to propel her wheelchair by herself. The care plan identified R1 as an elopement risk due to disorientation and a history of attempts to leave the campus. A goal was listed, “My safety will be maintained through the review date,” along with multiple interventions including treating pain promptly, conducting frequent visual checks of R2, and use of a wanderguard bracelet on her wheelchair. The plan outlined R2’s family member would, at times, cut off the bracelet and discard it. Further, R2’s Order Summary Report, signed 5/12/26, identified an order which read, “Wanderguard check function & placement at bedtime ... under wheelchair on right side.” A start date of 3/6/25 was listed and nurse practitioner (NP)-A signed the report. R2’s Treatment Administration Records (TAR), dated			F0689	Continued from page 1 assignment will also be verified to ensure the alarm device is not inadvertently separated from the resident. R2's care plan will be reviewed and revised as necessary to clearly identify: R2's elopement/wandering risk; Required Wanderguard placement; Required daily testing of the Wanderguard for proper function; Required documentation of each completed check; Required supervision/visual monitoring interventions; Actions to be taken if the device is missing, removed, damaged, or does not function properly; and Appropriate notification and follow-up when an elopement-prevention intervention is not completed. The resident's representative/family will be educated regarding the purpose and importance of the Wanderguard and the risks associated with removal or disabling of the device. Education will be documented. Identification of Other Residents Who May Be Affected The Director of Nursing/designee will complete an audit of all residents identified as having wandering or elopement risk, including residents with Wanderguard or other elopement-prevention interventions. The audit will verify that each resident has: A current wandering/elopement risk assessment; Appropriate interventions identified in the care plan;		08/14/2026

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 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 = D	Continued from page 2 7/2026 and 8/2026, identified the intervention to check placement and function of R2’s wanderguard bracelet every day along with spacing for staff to record the task as completed. However, multiple dates were left blank and had no recorded evidence that the device had been checked to ensure it was present still or working. The dates left blank were: 7/9/26, 7/22/26, 7/27/26, 7/31/26, and 8/1/26. Further, R2’s entire medical record lacked evidence that the wanderguard bracelet had been checked on those dates to show it remained present and working correctly, including on multiple dates after R2 had been found outside unsupervised (7/25/26). When interviewed on 8/4/26 at 12:59 p.m., nursing assistant (NA)-B stated R2 had several behaviors and was resistive to care at times. R2 was able to self-propel in her wheelchair and would, at times, try to leave the unit and head down other hallways. R2 was also able to walk by herself although unsafely. NA-B stated the white-colored bracelet on R2’s wheelchair was the wanderguard system used to alert staff if she tried to leave the building by alarming at the doorway. R2 didn’t wear it on her physical body as the family member didn’t like it placed there and would remove it. NA-B stated R2 had just recently been found outside, and the door apparently had not alarmed as R2 had somehow got seated in a wheelchair which was not hers, so there was no bracelet to activate the alarm system. NA-B stated the night shift was responsible for checking to ensure the bracelets were on the person or wheelchair but was unsure where or if that process was recorded in the medical record or not. NA-B confirmed R2 did not sustain any injuries from being found outside on 7/25/26. When interviewed on 8/4/26 at 1:14 p.m., registered nurse (RN)-D stated they were the floor nurse covering R2’s unit and had worked with R2 multiple times prior. RN-D explained wandering and elopement risk were evaluated upon admission and quarterly thereafter, and if the person was at risk, then a wanderguard bracelet would be applied to them. The night shift then checked the bracelets every day to ensure they were present and working correctly; with those checks being recorded on the TAR. RN-D stated they were unsure anywhere else in the record such checks would be recorded. RN-D reviewed R2’s TAR (dated 7/2026, 8/2026) and verified the blank spaces. RN-D stated the spaces being blank either meant nobody completed the task or didn’t document it. RN-D stated it should be completed adding, “I don’t understand why it wouldn’t be done, they [nurses] can delegate it.” RN-D stated it was important to check the			F0689	Continued from page 2 Current physician/NP orders when applicable; Properly functioning safety devices; Appropriate placement of the device; Daily checks completed as ordered; and Evidence of completion documented in the medical record/TAR. Any identified concerns will be corrected immediately and referred to the interdisciplinary team for further review and care plan revision as indicated. Systemic Changes to Prevent Recurrence The facility will reinforce its Elopement/Wandering Prevention policy and procedures with all licensed nursing staff and nursing assistants. Education will include, but will not be limited to: Identification of residents at risk for wandering and elopement; Review of resident-specific elopement interventions; Proper placement and use of Wanderguard devices; Daily testing of Wanderguard devices for proper function; Verification that the device remains with the correct resident; The importance of completing the assigned intervention every day; Accurate and timely documentation of each completed safety check;		08/14/2026

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 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 = D	Continued from page 3 wanderguard bracelets every day to ensure resident safety. When interviewed on 8/4/26 at 2:23 p.m., registered nurse manager (RN)-A stated R2 had worn a wanderguard bracelet “long term” as she was “very, very exit-seeking.” RN-A verified the TAR intervention was the facility’s process to ensure the bracelet was present and working each day and acknowledged the multiple missing dates of data on the TAR. RN-A stated they were unsure if that meant the task wasn’t completed or just not documented. RN-A agreed the signed Order Summary Report would be considered part of R2’s plan of care and reiterated they were unsure why staff were not recording that intervention on the TAR for those dates. However, RN-A stated it was important to ensure a wanderguard bracelet was checked every day as it helped to keep the residents, including R2, safe from elopement. RN-A added, “Safety is number one.” The director of nursing (DON) was away from the campus on 8/4/26 and unavailable for interview. The facility Elopement policy, dated 6/2026, identified an elopement was considered to have occurred when a resident who is impaired left the care center unsupervised and/or unnoticed. Each resident would be assessed for risk of elopement and wandering and, if a wanderguard was used, then nursing staff would test the notification bracelet daily for proper function.			F0689	Continued from page 3 Procedures to follow when a Wanderguard is missing, removed, damaged, or fails to function; Immediate notification of the nurse when an ordered safety intervention has not been completed; Appropriate follow-up after an elopement or attempted elopement; and Communication of resident-specific elopement precautions during shift-to-shift report. Staff will be instructed that a blank TAR entry does not demonstrate completion of an assigned intervention. If a required safety check cannot be completed, the nurse must be notified and appropriate corrective action taken. The facility will also clarify responsibility for completion of the daily Wanderguard check. The nurse will ensure that the task is completed and documented each day, whether completed by the nurse or appropriately delegated to a qualified staff member. The nurse remains responsible for follow-up when the task is not completed or documented. The facility will review the current electronic/clinical documentation process to ensure that the daily Wanderguard check is readily identifiable and that staff have a clear location in which to document completion. Monitoring and Quality Assurance For four consecutive weeks, the nurse manager/designee will audit 100% of residents with Wanderguard devices at least weekly to verify: The resident continues to be identified as an elopement risk when applicable; The Wanderguard is present; The device is correctly placed;		08/14/2026

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 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 = D				F0689	Continued from page 4 The device is functioning appropriately; The daily safety check is completed; The check is documented in the appropriate record; and Any identified failure to complete the intervention is immediately addressed. Audit results will be reported to the Director of Nursing and reviewed through the facility's Quality Assurance/Performance Improvement process as appropriate. Following the initial four-week monitoring period, the facility will continue monthly audits for an additional two months or until sustained compliance is demonstrated. If an audit identifies a missed Wanderguard check, missing device, improper placement, failed device, or lack of documentation, immediate corrective action will be taken. The staff members involved will receive additional education and the resident will be reassessed for safety needs. Patterns or trends will be reviewed by nursing leadership and addressed through QAPI as indicated. Responsible Persons The Director of Nursing or designee will be responsible for implementation, staff education, completion of audits, and follow-up monitoring. The Unit Nurse/Charge Nurse will be responsible for ensuring resident-specific elopement interventions are completed each shift/day as ordered, that Wanderguard checks are completed and documented, and that deficiencies are immediately reported and corrected. Completion Date August 14, 2026 for implementation of corrective actions and staff education.		08/14/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 8/4/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54142894C (3041231), H54143546C (3117670; with order cited at 0830.			20000			08/07/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 MDH documents the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.		20000			08/07/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as		20830	The facility must ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action for the Resident Affected R2 was immediately identified as requiring focused review due to her history of wandering and elopement and the finding that daily Wanderguard checks were not consistently documented. The Director of Nursing/designee will complete and document a comprehensive review of R2's current elopement and wandering risk, care plan,		08/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
20830	Continued from page 2 evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions for safety and the prevention of elopement were consistently completed and recorded in the record to help prevent future elopements for 1 of 3 residents (R2) reviewed. R2 had a history of exit-seeking behavior and wore a “wanderguard” device (alarms if someone with one tries to exit) for safety; however, this was not checked for placement and function everyday as directed by the plan of care. Findings include: A facility-submitted Vulnerable Adult Maltreatment Report (FRI), dated 7/25/26, identified R2 was found outside of the care center by staff unattended on 7/25/26. R2 was brought back inside the care center and was uninjured. On 8/4/26 at 10:06 AM, a tour of the care center was completed. The main entry doors consisted of two double doors with magnetic locks present on the inner doors along the top. The doors had a white-colored keypad on the wall next to them which had a status, “READY.” The device was a Stanley Healthcare wander management system and was working correctly at this time. Later, at 12:56 p.m., R2 was observed seated in a standard wheelchair in the commons area of the Island Lake unit. R2 was unable to answer how long she’d lived at the care center and responded to many questions with, “I don’t know.” R2’s wheelchair had a white-colored wanderguard bracelet attached to the rear frame. R2’s quarterly Minimum Data Set (MDS), dated 6/16/26, identified R2 had severe cognitive impairment and demonstrated wandering behavior(s) during the review period. R2’s care plan, revised 7/31/26, identified R2 had an ADL self-care deficit but was able to reposition in bed without help and used only a standby assist (SBA) for transfers. R1 had a history of self-transfers and was able to propel her wheelchair by herself. The care plan identified R1 as an elopement risk due to disorientation and a history of attempts to leave the campus. A goal was listed, “My safety will be maintained through the review date,” along with multiple interventions including treating pain promptly, conducting frequent visual checks of R2,		20830	Continued from page 2 physician/NP orders, Wanderguard placement, and required supervision interventions. The Wanderguard device will be verified for proper placement and function. Staff will ensure that the Wanderguard remains with R2 and is attached to the designated device/person identified in the resident's current plan of care. R2’s wheelchair/device assignment will also be verified to ensure the alarm device is not inadvertently separated from the resident. R2's care plan will be reviewed and revised as necessary to clearly identify: R2's elopement/wandering risk; Required Wanderguard placement; Required daily testing of the Wanderguard for proper function; Required documentation of each completed check; Required supervision/visual monitoring interventions; Actions to be taken if the device is missing, removed, damaged, or does not function properly; and Appropriate notification and follow-up when an elopement-prevention intervention is not completed. The resident's representative/family will be educated regarding the purpose and importance of the Wanderguard and the risks associated with removal or disabling of the device. Education will be documented. Identification of Other Residents Who May Be Affected The Director of Nursing/designee will complete an audit of all residents identified as having wandering or elopement risk, including residents with Wanderguard or other elopement-prevention interventions.		08/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
20830	Continued from page 3 and use of a wanderguard bracelet on her wheelchair. The plan outlined R2's family member would, at times, cut off the bracelet and discard it. Further, R2's Order Summary Report, signed 5/12/26, identified an order which read, "Wanderguard check function & placement at bedtime ... under wheelchair on right side." A start date of 3/6/25 was listed and nurse practitioner (NP)-A signed the report. R2's Treatment Administration Records (TAR), dated 7/2026 and 8/2026, identified the intervention to check placement and function of R2's wanderguard bracelet every day along with spacing for staff to record the task as completed. However, multiple dates were left blank and had no recorded evidence that the device had been checked to ensure it was present still or working. The dates left blank were: 7/9/26, 7/22/26, 7/27/26, 7/31/26, and 8/1/26. Further, R2's entire medical record lacked evidence that the wanderguard bracelet had been checked on those dates to show it remained present and working correctly, including on multiple dates after R2 had been found outside unsupervised (7/25/26). When interviewed on 8/4/26 at 12:59 p.m., nursing assistant (NA)-B stated R2 had several behaviors and was resistive to care at times. R2 was able to self-propel in her wheelchair and would, at times, try to leave the unit and head down other hallways. R2 was also able to walk by herself although unsafely. NA-B stated the white-colored bracelet on R2's wheelchair was the wanderguard system used to alert staff if she tried to leave the building by alarming at the doorway. R2 didn't wear it on her physical body as the family member didn't like it placed there and would remove it. NA-B stated R2 had just recently been found outside, and the door apparently had not alarmed as R2 had somehow got seated in a wheelchair which was not hers, so there was no bracelet to activate the alarm system. NA-B stated the night shift was responsible for checking to ensure the bracelets were on the person or wheelchair but was unsure where or if that process was recorded in the medical record or not. NA-B confirmed R2 did not sustain any injuries from being found outside on 7/25/26. When interviewed on 8/4/26 at 1:14 p.m., registered nurse (RN)-D stated they were the floor nurse covering R2's unit and had worked with R2 multiple times prior. RN-D explained wandering and elopement risk were evaluated upon admission and		20830	Continued from page 3 The audit will verify that each resident has: A current wandering/elopement risk assessment; Appropriate interventions identified in the care plan; Current physician/NP orders when applicable; Properly functioning safety devices; Appropriate placement of the device; Daily checks completed as ordered; and Evidence of completion documented in the medical record/TAR. Any identified concerns will be corrected immediately and referred to the interdisciplinary team for further review and care plan revision as indicated. Systemic Changes to Prevent Recurrence The facility will reinforce its Elopement/Wandering Prevention policy and procedures with all licensed nursing staff and nursing assistants. Education will include, but will not be limited to: Identification of residents at risk for wandering and elopement; Review of resident-specific elopement interventions; Proper placement and use of Wanderguard devices; Daily testing of Wanderguard devices for proper function; Verification that the device remains with the correct resident;		08/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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
20830	Continued from page 4 quarterly thereafter, and if the person was at risk, then a wanderguard bracelet would be applied to them. The night shift then checked the bracelets every day to ensure they were present and working correctly; with those checks being recorded on the TAR. RN-D stated they were unsure anywhere else in the record such checks would be recorded. RN-D reviewed R2’s TAR (dated 7/2026, 8/2026) and verified the blank spaces. RN-D stated the spaces being blank either meant nobody completed the task or didn’t document it. RN-D stated it should be completed adding, “I don’t understand why it wouldn’t be done, they [nurses] can delegate it.” RN-D stated it was important to check the wanderguard bracelets every day to ensure resident safety. When interviewed on 8/4/26 at 2:23 p.m., registered nurse manager (RN)-A stated R2 had worn a wanderguard bracelet “long term” as she was “very, very exit-seeking.” RN-A verified the TAR intervention was the facility’s process to ensure the bracelet was present and working each day and acknowledged the multiple missing dates of data on the TAR. RN-A stated they were unsure if that meant the task wasn’t completed or just not documented. RN-A agreed the signed Order Summary Report would be considered part of R2’s plan of care and reiterated they were unsure why staff were not recording that intervention on the TAR for those dates. However, RN-A stated it was important to ensure a wanderguard bracelet was checked every day as it helped to keep the residents, including R2, safe from elopement. RN-A added, “Safety is number one.” The director of nursing (DON) was away from the campus on 8/4/26 and unavailable for interview. The facility Elopement policy, dated 6/2026, identified an elopement was considered to have occurred when a resident who is impaired left the care center unsupervised and/or unnoticed. Each resident would be assessed for risk of elopement and wandering and, if a wanderguard was used, then nursing staff would test the notification bracelet daily for proper function. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on “Wanderguard” placement monitoring and			20830	Continued from page 4 The importance of completing the assigned intervention every day; Accurate and timely documentation of each completed safety check; Procedures to follow when a Wanderguard is missing, removed, damaged, or fails to function; Immediate notification of the nurse when an ordered safety intervention has not been completed; Appropriate follow-up after an elopement or attempted elopement; and Communication of resident-specific elopement precautions during shift-to-shift report. Staff will be instructed that a blank TAR entry does not demonstrate completion of an assigned intervention. If a required safety check cannot be completed, the nurse must be notified and appropriate corrective action taken. The facility will also clarify responsibility for completion of the daily Wanderguard check. The nurse will ensure that the task is completed and documented each day, whether completed by the nurse or appropriately delegated to a qualified staff member. The nurse remains responsible for follow-up when the task is not completed or documented. The facility will review the current electronic/clinical documentation process to ensure that the daily Wanderguard check is readily identifiable and that staff have a clear location in which to document completion. Monitoring and Quality Assurance For four consecutive weeks, the nurse manager/designee will audit 100% of residents with Wanderguard devices at least weekly to verify: The resident continues to be identified as an elopement risk when applicable;		08/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
20830	Continued from page 5 documentation, then educate staff on expectations and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days		20830	Continued from page 5 The Wanderguard is present; The device is correctly placed; The device is functioning appropriately; The daily safety check is completed; The check is documented in the appropriate record; and Any identified failure to complete the intervention is immediately addressed. Audit results will be reported to the Director of Nursing and reviewed through the facility's Quality Assurance/Performance Improvement process as appropriate. Following the initial four-week monitoring period, the facility will continue monthly audits for an additional two months or until sustained compliance is demonstrated. If an audit identifies a missed Wanderguard check, missing device, improper placement, failed device, or lack of documentation, immediate corrective action will be taken. The staff members involved will receive additional education and the resident will be reassessed for safety needs. Patterns or trends will be reviewed by nursing leadership and addressed through QAPI as indicated. Responsible Persons The Director of Nursing or designee will be responsible for implementation, staff education, completion of audits, and follow-up monitoring. The Unit Nurse/Charge Nurse will be responsible for ensuring resident-specific elopement interventions are completed each shift/day as ordered, that Wanderguard checks are completed and documented, and that deficiencies are immediately reported and corrected. Completion Date		08/14/2026	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
NAME OF PROVIDER OR SUPPLIER VIEWCREST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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
20830				20830	Continued from page 6 August 14, 2026 for implementation of corrective actions and staff education.		08/14/2026