

# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL24424042C

**Date Concluded:** March 9, 2021

**Name, Address, and County of Licensee Investigated:**

Twin Diamond Operator LLC  
1411 London Road  
Duluth, MN 55804  
St Louis County

**Name, Address, and County of Housing with Services location:**

Diamond Willow Lester Park 1  
6353 East Superior St D  
Duluth, MN 55804  
St Louis County

**Facility Type:** Home Care Provider

**Investigator's Name:** Carol Moroney, RN,  
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144 and 144A. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>H24424</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN DIAMOND OPERATOR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 LONDON ROAD DULUTH, MN 55805</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p><b>Initial Comments</b></p> <p>On March 9, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL24424042C. The following correction order is/are issued for tag identification 1252.</p> <p>At the time of the investigation, there were #20 clients receiving services under the comprehensive license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).</p>	
01252 SS=F	<p>144A.4798, Subd. 3 Infection Control Program</p> <p>Subd. 3. Infection control program. A home care</p>	01252		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>H24424</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN DIAMOND OPERATOR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 LONDON ROAD DULUTH, MN 55805</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01252	<p>Continued From page 1</p> <p>provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19.</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients).</p> <p>The findings include:</p> <p>The licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards, for infection control that included compliance to COVID-19 practices to include symptom screening of employees, symptom screening of all essential healthcare worker; and ensuring staff received training for proper usage of cleaning products.</p> <p><b>EMPLOYEE/ ESSENTIAL HEALTH CARE WORKERS COVID-19 SCREENING</b></p>	01252		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>H24424</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN DIAMOND OPERATOR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 LONDON ROAD DULUTH, MN 55805</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01252	<p>Continued From page 2</p> <p>The licensee failed to ensure employees were appropriately screened prior to entry into the facility.</p> <p>The MDH guidance titled, "COVID-19 Toolkit", dated August 14, 2020, noted all staff should have active health screening for fever and illness conducted before starting each shift. This would include assessment for a fever (measured temperature of &gt; 100 degrees F) or subjective fever (chill, feeling feverish) and asking about new symptoms of illness (cough, shortness of breath, shills, headache, muscle pain, sore throat, and new loss of taste or smell).</p> <p>The Center for Disease Control (CDC) webpage titled, "Recommendation for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" dated July 15, 2020, noted screening of all individuals entering a facility to include obtaining a temperature and for symptoms consistent with COVID-19.</p> <p>On March 9, 2021, at approximately 8:30 a.m., when entering the facility, the staff member, housing manager (HM)-A, did not complete a symptom screening for COVID-19.</p> <p>During interview on March 9, 2021, at 9:45 a.m., HM-A stated when they employees enter the building they complete the symptom screening for themselves. The employee symptom screening documents were locked in the office which employees didn't have access to.</p> <p>A random review of five employee symptom screenings from February 22, 2021, through March 9, 2021, were reviewed based on staff recently scheduled. There was 44 opportunities of staff to complete a self-symptom screening when</p>	01252		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>H24424</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN DIAMOND OPERATOR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 LONDON ROAD DULUTH, MN 55805</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01252	<p>Continued From page 3</p> <p>entering the building; however, there were only documentation of 11 times staff had completed a screening when entering the facility.</p> <p>During interview on March 9, 2021, at 10:40 a.m., registered nurse (RN)-F stated the employee symptom screening logs were to be completed on every employee, every time they are entering the facility. RN-F stated essential healthcare workers should also complete a symptom screening when entering the facility. RN-F was unable to provide any documentation regarding symptom screenings completed on essential health care workers.</p> <p>The licensee did not provide a policy about symptom screening staff, or essential visitors.</p> <p><b>CLEANING SUPPLIES AND USAGE TRAINING:</b></p> <p>During observation on March 9, 2021, at 10:10 a.m., a cleaning solution cabinet located in the "gitchi" house contained a spray bottle tabled, "bleach water." The bottle lacked a date when mixed, and had no written instructions on where or how to use the cleaner.</p> <p>During interview on March 9, 2021, at 10:20 a.m., HM-G stated the night shift staff do the public area cleaning in the facility, such as floors and high touch areas. HM- G stated staff received no specific training on proper usage of cleaning solution, which specific cleaning products should be used, and what high touch areas need to be cleaned.</p> <p>During interview on March 9, 2021, at 10:50 a.m., RN-F stated staff were not trained regarding cleaning products and how they should be mixed; and the facility completed no audits related to infection control practices and COVID-19. RN-A</p>	01252		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>H24424</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>TWIN DIAMOND OPERATOR LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1411 LONDON ROAD DULUTH, MN 55805</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01252	<p>Continued From page 4</p> <p>stated the facility does not audit the compliance to regulatory requirements and was not able to provide infection control compliance audits.</p> <p>The licensee's "Disinfecting environmental surfaces" dated October 29, 2020, noted to use cleaning products according to manufacturer's recommendation. When mixing bleach solution, the solution must be changed every 24 hours.</p> <p>The licensee's, undated, "Covid Precautions" dated March 30, 2020, policy noted staff must clean equipment according to the manufacturer recommendations.</p> <p>The licensee's undated "Diamond Willow Staff Training for Cleaning and Disinfecting" policy lacked direction for staff on usage of all facility cleaning products except; it did direct staff to clean according to manufacturer's recommendations. The policy also indicated to leave bleach wipes dry for one minute and destroy diluted bleach solution after 24 hours.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01252		