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

Electronically delivered

November 3, 2023

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

Re: Reinspection Results
Event ID: HS1H12

Dear Administrator:

On September 20, 2023 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 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

Electronically delivered
November 3, 2023

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: CCN: 245384
Cycle Start Date: August 17, 2023

Dear Administrator:

On October 24, 2023, we notified you a remedy was imposed. On September 20, 2023 the Minnesota Department(s) of Health and Public Safety 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 October 15, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 17, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 24, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 17, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 15, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

Electronically delivered
September 6, 2023

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: CCN: 245384
Cycle Start Date: August 17, 2023

Dear Administrator:

On August 17, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, 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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: alex.warren@state.mn.us
Mobile: (218) 302-6186

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 approved 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 17, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 17, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245384 | A. BUILDING ______ B. WING ______ | C 08/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604** |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 8/14/23 through 8/17/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 8/14/23 through 8/17/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: H53844452C (MN87553) and H53844453C (MN93379).<br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | | 9/13/23 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/13/2023 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 812 | Continued From page 1<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure the facility's dishwasher temperatures were reaching the minimum temperature for the wash and rinse cycles. This deficient practice had the potential to affect all 27 residents who received meals from the facility's kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen with cook (C)-A on 8/14/23 at 6:35 p.m., C-A stated the dishes were all washed for the day. C-A said the dishwasher was hot water sanitization. The dishwasher temperatures were filled in sporadically for August. The dishwasher had a label on the side of the machine "Hobart" with | F 812 | F812<br><br>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance.<br><br>After the temperature reading was found to be low, the use of the main kitchen dish machine was immediately stopped. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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F 812

Continued From page 2

wash temperature of 160 degrees Fahrenheit (F) and rinse temperature of 180 degrees F.

The manufacturers' instructions for use dated 2/16, and the stamped label on the side of the dishwashing machine identified the temperatures needed to reach a wash temperature of 160 degrees F and a final rinse temperature of 180 degrees F, to ensure sanitation.

On 8/17/23 at 9:22 a.m., in the main kitchen C-B ran a bin for dish collection through the dishwasher. The wash temperature on the Ecolab display was; wash 111 degrees F and rinse 183 degrees F. C-B ran a rack of cups through the dishwasher, the wash temperature on the Ecolab display was; wash 110 degrees F, rinse 170 degrees F. The Ecolab display with the temperature readings turned red. C-B stated they were not sure what to do about the dishwasher temperatures and the red warning display. C-B determined they should call the dietary manager. At approximately 9:36 a.m., the dietary manager (DM)-A entered and determined the dishwasher should not be used and staff would need to wash dishes in the kitchenettes on the Woods or Waves units.

During an interview on 8/17/23 at 9:41 a.m., maintenance (M)-A stated they were having trouble with the dishwasher in the kitchen and parts were on order.

During an interview on 8/17/23 at 9:52 a.m., the DM-A verified the dishwasher temperatures for the wash cycle needed to be at least 150 degrees F and the rinse cycle needed to be at least 180 degrees F. Staff were not recording temperatures in August and stated they really did not know if

F 812

Maintenance was notified of the issue and they called the manufacturer. Maintenance was able to make adjustments on the machine for the temperature to be above 160 degrees Fahrenheit for the wash cycle and above 180 degrees for the rinse cycle per manufacturer specifications. There are parts that have also been ordered for the machine for a long-term solution. Individual staff training was provided to each dietary employee by the Dietary Manager regarding the following:

All Dietary Staff are required to record temperatures on Temperature Log Sheet three times per day to ensure the temperatures for the wash temperature are at or above 160 degrees Fahrenheit and the rinse temperature are at or above 180 degrees Fahrenheit.

Staff was also re-educated on:

1. Sanitation protocols, i.e. need for wash/rinse temperatures to be at 160/180 degrees Fahrenheit respectively to ensure sanitation of dishes.

2. Potential for resident to get sick when sanitation protocols are not followed and ensured.

Staff was reminded to not use the machine if the temperatures were not correct and to notify maintenance immediately. If the machine cannot be repaired in the moment, dishes are to be brought to one of the Care Center dish

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| NORTH SHORE HEALTH | 515 - 5TH AVENUE WEST<br>GRAND MARAIS, MN 55604 |

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| F 812 | Continued From page 3<br>the dishwasher was getting to the proper temperatures. Not reaching the appropriate temperature could result in residents becoming ill.<br><br>The dishwasher temperature logs were reviewed and identified the following out of range and missing temperatures:<br><br>August 2023<br><br>8/1/23 a.m., rinse 158 F, p.m., wash 134 F, rinse 140 F<br>8/2/23, a.m., rinse 173 F<br>8/4/23, no recordings for a.m.<br>8/5/23, no recordings for a.m.<br>8/6/23, a.m. rinse 173 F, no recordings for p.m., or (at bedtime) HS<br>8/7/23, no recording for p.m. or HS<br>8/8/23, no recording for p.m. or HS<br>8/10/23, no recordings for a.m.<br>8/12/23, no recordings for a.m. or HS<br>8/13/23, no recordings for a.m. or HS<br>8/14/23, no recordings for a.m.<br>8/15/23, no recording for p.m. or HS<br>8/16/23, no recordings for a.m. or HS<br><br>July 2023<br><br>7/1/23, p.m. wash 134 F, rinse 170<br>7/2/23, a.m. wash 139 F, rinse 171<br>7/4/23, a.m. wash 156 F<br>7/7/23, p.m. wash 152 F<br>7/11/23, p.m. wash 130 F, rinse 173 F<br>7/14/23, a.m. wash 155 F, rinse 178<br>7/16/23, p.m. wash 104 F<br>7/22/23, a.m. wash 153 F rinse 175, p.m. wash 158 F<br>7/25/23, p.m. wash 129 F | F 812 | machine to be washed. Staff are to follow the above protocol re: taking and recording temperatures when using Care Center dish machines.<br><br>There was a staff meeting on 9/12/23 to reinforce previously given education and instruction (as noted above) to dietary staff.<br><br>The Temperature Log Sheet will be monitored for completion at rotating time, daily for 14 days, and followed by 4 random times per week for a month. Upon completion of the above monitoring, the Temperature Log Sheet will be monitored weekly for three months by the Dietary Manager. Results of the monitoring will be reported during the October, November and December 2023 Quality Improvement/Peer Review Committee meetings. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST**<br>**GRAND MARAIS, MN 55604** |

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|---|---|---|---|---|
| F 812 | Continued From page 4<br>During an interview on 8/17/23 at 4:53 p.m., the administrator expected staff to run the dishwasher probe per the policy to ensure the dishwasher was getting to the proper temperatures.<br><br>The Dishmachine-Procedure for Operation dated 8/18/23, identified the dishwasher wash cycle needed to be at a minimum of 160 degrees F and the rinse cycle at a minimum of 180 degrees F. | F 812 | | |

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

Electronically delivered
September 6, 2023

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

Re: State Nursing Home Licensing Orders
Event ID: HS1H11

Dear Administrator:

The above facility was surveyed on August 14, 2023 through August 17, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: alex.warren@state.mn.us
Mobile: (218) 302-6186

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00080 | A. BUILDING: ______ B. WING ______ | C 08/17/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604** |

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|---|---|---|---|---|
| 2 000 | Initial Comments | 2 000 | | |

*****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 8/14/23 through 8/17/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed during the survey:<br>H53844452C (MN87553) and H53844453C (MN93379).<br>Minnesota Department of Health is documenting 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 surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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.<br><br>PLEASE DISREGARD THE HEADING OF THE | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00080 | A. BUILDING: ______ B. WING ______ | C 08/17/2023 |

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| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604** |

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| 2 000 | Continued From page 2<br>FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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.<br>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. | 2 000 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by: | 21015 | | 9/13/23 |

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| 21015 | Continued From page 3<br><br>Based on observation, interview, and document review, the facility failed to ensure the facility's dishwasher temperatures were reaching the minimum temperature for the wash and rinse cycles. This deficient practice had the potential to affect all 27 residents who received meals from the facility's kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen with cook (C)-A on 8/14/23 at 6:35 p.m., C-A stated the dishes were all washed for the day. C-A said the dishwasher was hot water sanitization. The dishwasher temperatures were filled in sporadically for August. The dishwasher had a label on the side of the machine "Hobart" with wash temperature of 160 degrees Fahrenheit (F) and rinse temperature of 180 degrees F.<br><br>The manufacturers' instructions for use dated 2/16, and the stamped label on the side of the dishwashing machine identified the temperatures needed to reach a wash temperature of 160 degrees F and a final rinse temperature of 180 degrees F, to ensure sanitation.<br><br>On 8/17/23 at 9:22 a.m., in the main kitchen C-B ran a bin for dish collection through the dishwasher. The wash temperature on the Ecolab display was; wash 111 degrees F and rinse 183 degrees F. C-B ran a rack of cups through the dishwasher, the wash temperature on the Ecolab display was; wash 110 degrees F, rinse 170 degrees F. The Ecolab display with the temperature readings turned red. C-B stated they were not sure what to do about the dishwasher temperatures and the red warning display. C-B determined they should call the dietary manager. At approximately 9:36 a.m., the dietary manager | 21015 | Corrected | |

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| 21015 | Continued From page 4 | 21015 | | |

Continued From page 4

(DM)-A entered and determined the dishwasher should not be used and staff would need to wash dishes in the kitchenettes on the Woods or Waves units.

During an interview on 8/17/23 at 9:41 a.m., maintenance (M)-A stated they were having trouble with the dishwasher in the kitchen and parts were on order.

During an interview on 8/17/23 at 9:52 a.m., the DM-A verified the dishwasher temperatures for the wash cycle needed to be at least 150 degrees F and the rinse cycle needed to be at least 180 degrees F. Staff were not recording temperatures in August and stated they really did not know if the dishwasher was getting to the proper temperatures. Not reaching the appropriate temperature could result in residents becoming ill.

The dishwasher temperature logs were reviewed and identified the following out of range and missing temperatures:

August 2023

8/1/23 a.m., rinse 158 F, p.m., wash 134 F, rinse 140 F
8/2/23, a.m., rinse 173 F
8/4/23, no recordings for a.m.
8/5/23, no recordings for a.m.
8/6/23, a.m. rinse 173 F, no recordings for p.m., or (at bedtime) HS
8/7/23, no recording for p.m. or HS
8/8/23, no recording for p.m. or HS
8/10/23, no recordings for a.m.
8/12/23, no recordings for a.m. or HS
8/13/23, no recordings for a.m. or HS
8/14/23, no recordings for a.m.
8/15/23, no recording for p.m. or HS

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| 21015 | Continued From page 5<br>8/16/23, no recordings for a.m. or HS<br><br>July 2023<br><br>7/1/23, p.m. wash 134 F, rinse 170<br>7/2/23, a.m. wash 139 F, rinse 171<br>7/4/23, a.m. wash 156 F<br>7/7/23, p.m. wash 152 F<br>7/11/23, p.m. wash 130 F, rinse 173 F<br>7/14/23, a.m. wash 155 F, rinse 178<br>7/16/23, p.m. wash 104 F<br>7/22/23, a.m. wash 153 F rinse 175, p.m. wash 158 F<br>7/25/23, p.m. wash 129 F<br><br>During an interview on 8/17/23 at 4:53 p.m., the administrator expected staff to run the dishwasher probe per the policy to ensure the dishwasher was getting to the proper temperatures.<br><br>The Dishmachine-Procedure for Operation dated 8/18/23, identified the dishwasher wash cycle needed to be at a minimum of 160 degrees F and the rinse cycle at a minimum of 180 degrees F.<br><br>SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures were monitored per manufacturer's guidelines; and could educate all appropriate staff on the policies and procedures;<br>and could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21015 | | |

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| 21426 | Continued From page 6 | 21426 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the blood test to detect tuberculosis (TB) was completed for 1 of 5 employees (AA-A) reviewed for tuberculosis screening.<br><br>Finding include:<br><br>Activities Aide (AA)-A's employee record identified a hire date of 7/31/23. AA-A's QuantiFERON-TB Gold Plus, B (a blood test used for tuberculosis detection) test was | 21426 | Corrected | 9/13/23 |

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| 21426 | Continued From page 7<br>canceled on 7/29/23, because the sample was improperly collected. One or more of the collection tubes was over-filled. There was no evidence another test was completed.<br><br>AA-A's time sheet identified AA-A worked on 7/31/23, 8/1/23, 8/2/23, 8/4/23, 8/10/23, 8/11/23, 8/14/23, and 8/16/23.<br><br>During an interview on 8/17/23 at 1:55 p.m., registered nurse (RN)-B stated the lab called a physician to get the sample re-ordered and did not call the facility's infection control staff and they were never notified to re-draw the blood test for AA-A. The facility was made aware of the missing lab test when TB information was requested during the survey. AA-A was re-drawn for the blood test on 8/16/23.<br>During an interview on 8/17/23 at 2:30 p.m., the administrator verified AA-A should have had the test performed prior to working with residents as it was important to ensure someone was not asymptomatic and spreading TB to residents and staff.<br><br>The Facility Tuberculosis (TB) Risk Assessment dated 6/2023, identified the baseline screening included an assessment for current symptoms of active TB, assessing TB history, and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test.<br><br>The facility Tuberculosis Infection Control Plan dated 3/10/23, identified all new hires would be screened for TB prior to their first day of employment and would receive a quantiferon test prior to the first day of employment. | 21426 | | |

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| 21426 | Continued From page 8 | 21426 | | |

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff were tested for tuberculosis prior to working with residents; could educate all appropriate staff on the policies and procedures and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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| | 245384 | A. BUILDING **04 - NORTH SHORE HEALTH**<br>B. WING ______ | **08/15/2023** |

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| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST**<br>**GRAND MARAIS, MN 55604** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/15/2023 At the time of this survey, North Shore Health was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/15/2023 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>The facility was inspected as one building: North Shore Health, is a 1-story building with no basement. The 100 and 400 wings of the facility were constructed in 2016 and was determined to be of Type II(111) construction. In 2017 the 200 and 300 wings were constructed to the building that were determined to be of Type II(111) construction. The 100,200,300, & 400 wings were constructed to replace the original facility and the plans for these wings were approved on 04/30/2015, prior to the 2012 code adoption and | K 000 | | |

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

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| K 000 | Continued From page 2<br>are considered to be of existing construction. The building is attached to a hospital and is properly separated by a 2 hour fire rated separation. The building is separated into 2 smoke compartments by a 1 hour fire rated smoke barrier.<br><br>The building is fully sprinkled throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms.<br><br>The facility has a capacity of 37 beds and had a census of 27 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 372<br>SS=D | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced | K 372 | | 8/15/23 |

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| K 372 | Continued From page 3<br>by:<br>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/15/2023 between 10:00 am and 01:30 pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to the Woods Wing.<br><br>An interview with the Director of Maintenance verified this deficient finding at the time of discovery. | K 372 | K372<br><br>The penetration running from one smoke compartment to another above the doors leading to the Woods Wing have been sealed with an ASTM (UL 1479) Firestop sealant on August 15, 2023. An above grid permit has been implemented to prevent employees and contractors from leaving above ceiling penetrations. The Above Ceiling Grid Policy and Permit have been added to electronic policy manual, PolicyStat, for annual review.<br><br>The Director of Facilities or designee will perform 15 random quarterly inspections of the above ceiling fire and smoke barriers. This information will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year. | |
| K 521<br>SS=F | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation | K 521 | K521 | 10/15/23 |

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| K 521 | Continued From page 4<br>and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/15/2023 between 10:00 am and 01:30 pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. Last available documentation for damper test was 04/26/2018.<br><br>An interview with the Director of Maintenance verified this deficient finding at the time of discovery | K 521 | Fire Dampers, Fire-Smoke Dampers and Smoke Dampers have been located per architectural and mechanical drawings. The Director of Facilities or a qualified designee will complete inspection of the dampers by October 15, 2023. A Fire Dampers, Fire-Smoke Dampers and Smoke Dampers policy has been added to the electronic policy manual, PolicyStat. The inspection of the Fire Dampers, Fire-Smoke Dampers and Smoke Dampers will be completed every five years and has been placed on the Facilities calendar. | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation | K 712 | K712 | 9/15/23 |

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|---|---|---|---|
| | 245384 | A. BUILDING **04 - NORTH SHORE HEALTH**<br>B. WING ______ | **08/15/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NORTH SHORE HEALTH** | **515 - 5TH AVENUE WEST**<br>**GRAND MARAIS, MN 55604** |

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| K 712 | Continued From page 5<br>and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/15/2023 between 10:00 am and 01:30 pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement. Fire Drill documentation must reflect the dates and time of the accusal Fire Drills. Fire Drill documentation could not be provided at the time of survey.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 712 | The Fire Drill Reports have been printed and placed in the Fire Drill Report Book. The reports show that in the last year, fire drills were performed on each shift quarterly. The fire drills were performed at the required vary times. The Director of Facilities or designee will continue to perform all shift drills as required. The summary of fire drills will be forwarded to the Quality Improvement/Peer Review committee quarterly for one year. | |
| K 761<br>SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80) | K 761 | | 9/8/23 |

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| K 761 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/15/2023 between 10:00 am and 01:30 pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 761 | K761<br><br>The Director of Facilities inspected all resident doors on September 7 and 8, 2023. Resident doors have been added to the annual door inspection list on the Facilities calendar for annual inspection. | |
| K 914<br>SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For | K 914 | | 9/15/23 |

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| | 245384 | A. BUILDING **04 - NORTH SHORE HEALTH**<br>B. WING ______ | **08/15/2023** |

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| K 914 | Continued From page 7<br>LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 08/15/2023 between 10:00 am and 01:30 pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey.<br><br>An interview with the Director of Maintenance verified these deficient findings at the time of discovery. | K 914 | K914<br><br>The Director of Facilities has printed the digital copy of the completed electrical receptacle testing. An Electrical Testing binder has been created and includes the test result. The Director of Facilities has updated the annual Electrical testing work order to include printing the results and then placing in Electrical Testing binder. | |