STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366104	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALEM NORTH HEALTHCARE CENTER	250 CONTINENTAL DRIVE SALEM, OH 44460

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure a resident received restorative nursing programs in accordance with therapy recommendations. This affected one (Resident #45) of three residents reviewed for activities of daily living. Findings include: Review of Resident #45's medical record revealed [DIAGNOSES REDACTED]. A Physical Therapy (PT) evaluation dated 10/11/19 indicated Resident #45 was referred to therapy due to a recent surgery of the left hip for a femur fracture. Resident #45's ambulation, strength, transfers and balance were all impaired. An Occupational Therapy (OT) evaluation dated 10/11/19 indicated Resident #45 was referred to OT due to a hospitalized from [DATE] to 10/10/19 with a left femur fracture after a fall. Resident #45 had a decrease in strength, functional mobility, transfers, range of motion, ability to safely ambulate, balance, functional activity tolerance and coordination. An OT discharge summary dated 11/08/19 indicated Resident #45 made substantial functional gains in response to skilled interventions. Discharge recommendations were made for a restorative nursing program (RNP) for strength and activities of daily living. A PT discharge summary dated 11/08/19 indicated Resident #45's functional abilities had progressed and Resident #45 responded positively to passive techniques to stimulate functional performance and enhance safety to prevent further decline. To facilitate Resident #45 maintaining her current level of performance and in order to prevent decline, development of and instruction in restorative nursing programs for ambulation, active range of motion (ROM) and transfers were completed with the interdisciplinary team (IDT). No records of restorative programs were located in the medical record. On 03/05/20 at 12:18 P.M., Registered Nurse (RN) #300 verified a restorative program was never started for Resident #45 after therapy was discontinued because a written referral was never received. On 03/05/20 at 1:06 P.M., Physical Therapy Assistant (PTA)/Therapy Manager #400 stated when residents were discharged from therapy the therapist (OTR or PT) discussed residents with the COTA (certified occupational therapy assistant) or PTA and determined what services residents needed upon discharge from therapy. PTA #400 stated she had not personally been involved in Resident #45's therapy. The therapists who wrote the discharge summaries were not available for interview. PTA #400 verified the person doing the discharges indicated RNP were recommended with PT documenting a program was completed with the IDT for ambulation, active ROM and transfers and OT documenting a referral for RNP for strength and activities of daily living.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review and interview, the facility failed to ensure physician's orders and recommendations for pressure ulcer interventions were implemented. This affected one (Resident #45) of five residents reviewed for pressure ulcers. The facility identified 11 residents with pressure ulcers, excluding stage I ulcers (nonblanchable redness of a localized area, usually over a bony prominence). Findings include: Review of Resident #45's medical record revealed [DIAGNOSES REDACTED]. A nursing note dated 01/04/2020 at 4:30 P.M. indicated Resident #45 complained of left heel pain. A black area was noted on the left heel. A Braden scale assessment dated [DATE] indicated Resident #45 was at moderate risk for pressure ulcers with risk factors including slightly limited sensory perception, occasionally moist skin, chairfast, slightly limited mobility, very poor nutrition, and potential problem with friction and shear. A wound consult documentation dated 01/22/20 indicated Resident #45 had an unstageable pressure ulcer (obscured full-thickness skin and tissue loss in which the tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) on the left heel. Pressure Relief Ankle Foot Orthosis (PRAFO) offloading boots were ordered but had not yet arrived. Treatment orders were changed, and the wound doctor documented under offloading: continue regular perimeter mattress (a mattress with raised side edges to prevent falls) in the low position, elevate heels when in bed, PRAFO boot pending and to be worn at all times, order bilateral lower extremity soft offloading boots, turn in bed every two hours, and wheelchair cushion. A significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated Resident #45 was severely cognitively impaired. Resident #45 required extensive assistance for bed mobility, transfers, and dressing. The MDS indicated Resident #45 had an unstageable pressure ulcer which was not present on admission. Skin and ulcer treatments did not include a pressure reducing device for the chair. On 02/20/20, an order was written for an offload boot to the left foot for pressure relief of the heel to be on while in bed. the boot could be on while out of bed. A skin grid pressure assessment dated [DATE] indicated the pressure ulcer on the left heel presented as a stage III (full thickness tissue loss) pressure ulcer measuring 0.6 centimeters (cm) x 0.5 cm x 0.3 cm. On 03/03/20 at 1:47 P.M. and 3:21 P.M. and on 03/04/20 at 8:28 A.M. and 11:55 A.M. revealed Resident #45 was sitting in a wheelchair with no cushion. On 03/04/20 at 11:40 A.M., Resident #45 was observed lying in bed. There was no offload boot on the left foot. The boot was on the wheelchair seat. State tested Nursing Assistant (STNA) #388 stated the boot was removed when Resident #45 went to bed. On 03/04/20 at 11:43 A.M., Registered Nurse (RN) #300 stated Resident #45 could wear the offload boot in the bed but sometimes Resident #45 wanted the boot removed. On 03/04/20 at 11:58 A.M., STNA #388 stated she removed Resident #45's offload boot whenever she put Resident #45 to bed. Resident #45 did not refuse to wear the boot and never requested it be removed. On 03/04/20 at 3:20 P.M., Resident #45 was observed lying in bed. The offload boot was on the floor. On 03/05/20 at 12:30 P.M., RN #300 stated she spoke to the wound doctor who stated he believed he saw a cushion in Resident #45's wheelchair. RN #300 stated the wound doctor told her it was standard to use cushions in wheelchairs to prevent pressure ulcers and if he realized she did not have one he would have ordered one.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident #37 had interventions in place for significant weight loss. This affected one of one residents reviewed for weight loss. Findings include: Resident #37 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission physician orders [REDACTED]. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was severely cognitively impaired and needed assistance with set-up of his meals for eating. Review of the admission nutrition assessment dated [DATE] revealed the resident was started on protstat (a high protein liquid supplement) 30 cubic centimeters (cc) twice a day and a health shake high calorie liquid supplement twice a day due to a pressure ulcer. The resident's admission weight was 204.4 pounds. The assessment did not indicate how many calories or protein the supplements provided. There was no evidence of obtaining food preferences or implementing snacks. Review of the weight change note dated 09/26/19 revealed Resident #37 had a significant weight loss in a one month from previous sister facility. There was no further documentation. Review of the physicians order dated 01/08/19 revealed to decrease the [MEDICATION NAME] to 20 mg a day. Review of Resident #37's weight on 11/04/19 revealed he weighed 199.2 pounds. Review of the 12/02/19 nutrition review note

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

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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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) revealed the weight loss and indicated the [MEDICATION NAME] (which indicates visceral protein stores) was low at 2.7 (normal was above 3.4) and Resident #37's average intake was zero to 75 percent with some refusals. There were no interventions put into place. Review of Resident #37's weight on 01/16/20 revealed he weighed 181.8 pounds. Review of the weight warning note dated 01/20/20 revealed Resident #37 triggered for significant weight loss for one and three months and the resident had poor intake of meals. The prostat (which provided 202 calories and 30 grams of protein) was discontinued and medication pass 2.0 was started to provide 360 calories and 15 grams of protein in an effort to increase intakes and stabilize weights. Medication pass 2.0 provided half of the protein as prostat and only 158 calories more a day. Review of Resident #37' weight on 01/27/20 revealed he weighted 177 pounds. Review of the 02/05/20 weight warning note revealed Resident #37 had a significant weight loss for three and six months and consumed less than 50 percent of meals. There were no interventions put into place. Review of the 03/02/20 nutrition assessment revealed revealed Resident #37 had weight loss but continued to be over weight. Resident #37 consumed 25 to 50 percent of his meals and no interventions were put into place. There was no evidence the dietitian talked to the resident or staff to obtain preferences or see how to get the resident to eat more. Review of Resident #37's weight on 03/05/20 revealed he weighted 175 pounds. Review of the current nutrition care plan revealed to educate and reinforce the importance of maintaining the diet order, monitor significant weight loss and appropriate laboratory values. On 03/03/20 at 5:10 P.M., Resident #37 was observed in the dining room at a table by himself with no staff intervention. The resident did not eat any of his meal. On 03/03/20 at 5:12 P.M., interview with Resident #37 revealed he was not hungry. On 03/04/20 at 12:50 P.M., interview with State tested Nurse Aide (STNA) #377 revealed Resident #37 does not usually eat much of his meals but he likes junk food and would eat that including finger foods if offered. On 03/04/20 at 12:54 P.M., Resident #37 was observed in the dining room at a table by himself without any staff intervention, and he only ate half of his green beans and bites of his sweet potato. On 03/04/20 at 12:55 P.M., interview with Resident #37 revealed he was not hungry. On 03/04/20 at 5:55 P.M., Resident #37 was lying in bed with his dinner tray cover at his side. The resident did not eat any of his meal. The resident's mighty shake was open with a straw in it, but the resident had not drank any of it. On 03/04/20 at 5:56 P.M., interview with Resident #37 revealed he was not hungry and did not eat any of his meal or supplement. On 03/05/20 at 10:00 A.M., interview with Licensed Practical Nurse (LPN) #364 revealed Resident #37 usually slept a lot, did not eat much during meals and did not have any type of snacks planned between meals. On 03/05/20 at 10:10 A.M., interview with STNA #348 revealed Resident #37 liked sweets like cookies and ice cream and does not eat much of his meals. On 03/05/20 at 10:45 A.M., interview with Registered Dietitian (RD) #400 verified the admission assessment did not document the calories or protein the supplements provided but stated they provided a total of 602 calories and 42 grams of protein. RD #400 verified she had not talked to Resident #37 or staff to obtain preferences or find alternative ways to increase his intake. RD #400 verified Resident #37 had significant weight loss at one, three and six months, but there were no interventions to address the continued significant weight loss. RD #400 verified the only change was on 01/20/20 when she changed the prostat to medication pass 2.0. This resulted in a an increase of 158 calories but a decrease of 15 grams of protein a day despite the resident having a low [MEDICATION NAME] level. RD #400 verified the resident was not receiving any scheduled snacks. On 03/05/20 at 11:30 A.M., interview with the Director of Nursing (DON) verified the above concerns. The DON was going to have the pharmacist review the resident's medications and see what else could be done in an attempt to increase Resident #37's intake. On 03/05/20 at 12:44 P.M., the resident did not eat any of his meal except for a bowl of fruit and his juice.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to monitor therapeutic levels for [MEDICAL CONDITION] medication. This affected one (Resident #31) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #31's medical record revealed the resident was admitted to the facility 09/05/19 with [DIAGNOSES REDACTED]. Review of a 10/10/19 laboratory report included [MEDICAL CONDITION] levels. The [MEDICAL CONDITION] Stimulating Hormone (TSH) was 6.467, a high level with the normal 0.340-5.60 milliunits per liter (mU/L) and a T3 total low at 0.41 with normal 0.60-1.80 nanograms per deciliter (ng/dl). Physician orders [REDACTED]. Laboratory testing for Serum Triiodothyronine (T3), Free [MEDICATION NAME] (FT4), and TSH in eight weeks. Review of the Medication Administration Record [REDACTED]. A pharmacy review 11/29/19 included the resident was on [MEDICATION NAME] with no supporting diagnosis. The [DIAGNOSES REDACTED]. A plan of care was included for [MEDICAL CONDITION] with an intervention to obtain and monitor lab/ diagnostic work as ordered. Report results to physician and follow-up as indicated. There was no evidence of the T3, FT4, or TSH laboratory test being drawn or reported on 12/06/19 as ordered. The draw date was changed to 12/12/19. There was no evidence of the T3, FT4, or TSH laboratory test being drawn or reported. Review of the 01/08/20 quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident was moderately impaired for daily decision making, felt tired and had trouble falling asleep. Pharmacy reviews 12/30/19, 01/26/20, and 02/25/20 did not capture the lack of results from the ordered laboratory testing. Interview 03/04/20 at 5:31 P.M. with the Director of Nursing (DON) verified the T3, FT4 and TSH were not obtained as ordered. The DON included the order was put in the electronic system; however, you have to go to a separate website and put the order in for the laboratory and that was not completed. The DON stated the nurse who took the order realized later in the week the [MEDICATION NAME] was not on the MAR indicated [REDACTED]. At that time she changed the laboratory test to be completed 12/12/19 instead of 12/06/19 to make the draw eight weeks from the time the medication was started. The DON verified the resident was started on a new medication for low [MEDICAL CONDITION] levels, and the baseline level to determine how the resident was responding to the medication was not completed. The missing laboratory test went undetected on the subsequent pharmacy reviews.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview, record review and policy review, the facility failed to ensure palatable meals for Residents #53, #67, #43, #30 and #42. This had the potential to affect the 72 residents who received meals from the facility. Findings include: On 03/02/20 at 9:23 A.M., interview with Resident #53 revealed the food was not palatable. On 03/02/20 at 10:18 A.M., interview with Resident #67 revealed the food was not palatable. On 03/02/20 at 10:32 A.M., interview with Resident #43 revealed the food was not palatable. On 03/02/20 at 1:56 P.M., interview with Resident #30's family revealed the food was not palatable. On 03/0/20 at 2:23 P.M., interview with Resident #42 revealed the food was not palatable. On 03/05/20 during the tray line observation between 4:30 P.M. and 5:02 P.M. revealed the temperature of the milk that was held in a tub with a small amount of ice was tested with the facility thermometer by Dietary Manager (DM) #390 which read 42 degrees Fahrenheit (F). Interview with DM #390 revealed he wanted the temperature of the milk to be below 45 degrees F on tray line. Observation of the south dining room cart revealed the trays were not put into an insulated cart nor did the trays had heated pellets in place to keep the food at acceptable palatable temperatures. The south dining room cart left the kitchen at 5:02 P.M. with a test tray and 18 resident trays. All the trays were passed at 5:12 P.M. On 03/05/20 at 5:13 P.M., the test tray revealed the milk was 50 degrees F and warm to taste, the sweet and sour pork and the rice each were 130 degrees F and were luke warm to taste while the peas were 110 degrees F and cool to taste. The temperatures were taken by DM #390 with the facility thermometer. The DM verified the above concerns. DM #390 verified milk was taken out of the cooler about 20 minutes prior to tray line beginning and verified there was not enough ice placed in the bin to ensure the milk remained at the appropriate temperature throughout tray line. On 03/05/20 at 8:40 A.M., interview with the Administrator verified the above concerns. On 03/05/20 at 3:50 P.M., interview with Corporate Dietary Manager #401 verified milk should be kept below 41 degrees F on tray line and not 45 degrees F as indicated by DM #390 and verified the above concern with the test tray. Review of the food preparation policy, revised September 2017, revealed food preparation techniques should minimize the amount of time food items were exposed to temperatures greater that 41 degrees F. All foods would be held at the appropriate temperatures which was less than 41 degrees F for cold items.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, personnel record, medical records, policy review and staff interview, the facility failed to ensure sanitary procedures during a pressure ulcer dressing change, post incontinence care and the handling of laundry/ personals and employee [MEDICATION NAME] testing per protocol. This affected one resident (Resident #11) of the 11 residents the facility identified as having pressure ulcers and had the potential to affected all 74 residents in the facility. Findings include: 1. Observation of the dressing change the pressure ulcer dressing change on Resident #11 took place 03/04/20 at 1:38 P.M. Resident #11 had a Stage IV (the pressure injury is very deep, reaching into muscle and bone and causing

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) extensive damage. Damage to deeper tissues, tendons, and joints may occur) pressure ulcer to the coccyx. While in the hall at the treatment cart, Licensed Practical Nurse (LPN) #343 placed gauze in a cup with Dakins solution (antiseptic solution). Upon entering the resident room she put supplies on a towel on the overbed table, washed her hands and gloved. State tested Nurse Aide (STNA) #348 assisted LPN #343 washed her hands and gloved. The previous pressure ulcer dressing had fallen off during care. STNA #348 turned the resident to his left side for the dressing change. He had a formed stool approximately three inches long protruding from his rectum. The STNA went to the bathroom, got disposable drycloth and wet it. She grabbed the stool with her right hand into the cloth. A second formed stool followed and she removed it holding the same wet cloth and added it to the first. She wiped the rectum with the side of the cloth and threw the stool and cloth over the bed into a trash can. STNA #348 proceeded to hold the resident up on his side for the dressing change without changing her gloves. LPN #343 placed the soaked Dakins gauze into the deep egg size wound at the coccyx. She waited about 30 seconds to take it out. When removing the gauze she used a twisting movement to clean the ulcer, removed it and threw it in the trash. With the same soiled gloves she picked up the fiberco (hyaluric acid) dressing. LPN #343 placed the fiberco in the wound with her gloved hands. She pressed the fiberco more securely into the wound with sterile qtips. She picked up [MED] with Silver (designed to be highly absorbent and form a gel-like covering over the wound, to help maintain a moist environment that promotes healing) with her gloved hands and placed it in the ulcer on top of the fiberco. She used Skin Prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) around the wound on the skin and let it dry. She placed a dated Permafoam Aerated dressing. LPN #343 and STNA #348 pushed the wet under pad to the side and rolled him over removing it. With her gloved hands, the STNA pulled his sheet up over him, took his bed remote and elevated the head of his bed. Interview 03/04/20 01:53 P.M. with LPN #343 verified she cleaned the resident's wound and placed a clean dressing without removing her gloves and washing her hands between clean and dirty. LPN #343 verified she should of removed her gloves and washed her hands before touching the packing material she placed into the pressure ulcer. STNA #348 verified she pulled the resident's covers up to his upper chest and touched his bed remote to adjust the height of his bed with the same gloves that were on when she cleaned the residents bowel movement. Review of the facility's Perineal Care Male and Female policy, last reviewed 05/30/19, did not include to remove gloves post incontinence care for a bowel movement prior to touching bedding that would be pulled up toward the residents face or equipment/items that could transfer the bowel movement to a surface the resident, staff or visitors can touch. Review of the facility's Wound Care policy, last reviewed 05/30/19, did not address hand hygiene. 2. Observation of the laundry on 03/05/20 at 8:50 A.M. revealed it was located in a compact area. The folding table located in front of the second clothes dryer was three fourths of the surface of the desk. There were personal items and writing materials on the right side of the desk. Laundry #314 was folding linens and placing them on the desk. Residents personal clothes and linens were folded on the desk chair seat. The personal clothes and linens were on a storage rack that was up against the desk. The hanging clothes were hanging off the sides of the racks touching the desk and trash can that was next to it. The personals were taken by hand out of the laundry through a hall with an exit door to the outside, pantry, maintenance room, and break room through a door into a hall where two sets of shelving on wheels were stored uncovered across from the time clock. The personals folded on the shelving and the clothes on hangers were handing off the edges of the shelving. The hall the residents personal clothing was stored in contained an exit door to the outside, the employee time clock, bulletin boards with postings, an exit door from the outdoors into the facility and a door to enter the facility from the hall. The racks were pushed against the wall. The hanging clothes were touching the wall. One hanging item was hitting the floor of the hallway. There were drapes on the top of the rack but not pulled out to cover the sides. Interview on 03/05/20 at 10:02 A.M. of Laundry #337 verified there was not room in the laundry room to hang and store personals by name. They are folded on the desk, stacked and hung on the side of shelving. The clothing is then hand carried through the hall (exit door, pantry, maintenance, kitchen and breakroom doors to the hall where the time clocks are) to hang them on the side and top of the shelves on wheels. There are names and room numbers on tape around the top of the shelving for each resident to hang their clothes in that spot. Laundry #337 verified the personal laundry is carried uncovered through a hall into a second hall and stored on shelves across from the time clock until distributed. Laundry #337 verified there was not room in the laundry to hang the personals, cover and deliver them to the floor. Laundry #337 verified they were using the top of a desk and the desk chair to fold and hold laundry. Review of the facility's Laundry Operations policy, revised 06/2016, included all clean linen must be covered during delivery to prevent potential contamination. Review of the facility's Personal Clothing policy, revised 06/2016, included personal clothing was to have a tracking system using two rings for each resident with their name clearly marked on both rings, one for the hanging clothes and one for folded. When the laundry employee takes an article of clothing from the bin, they simply find the name and if the item is to be hung, they put it on a hanger and then on the rack with the appropriate resident's name ring separating that article from clothing belonging to other residents. If the item is folded, the employee creates a separate pile for each resident with the appropriate name ring on top of the stack to identify the owner. 3. Review of personnel records on 03/03/20 revealed four (Administrator, LPN #372, STNA #389 and STNA #318) of eight employees second step [MEDICATION NAME] testing was not completed seven to 21 days after the first step as follows: Administrator: The first step mantoux was completed on 11/21/19, and the second step was completed on 11/27/19. There were six days, not at least seven days, between the first and second step. LPN #372: The first step mantoux was completed on 10/10/19, and the second step was completed on 10/16/19. There were six days, not at least seven days, between the first and second step. STNA #389: The first step mantoux was completed on 05/24/19, and the second step was completed on 05/30/19. There were six days, not at least seven days, between the first and second step. STNA #318: The first step mantoux was completed on 10/04/19, and the second step was completed on 10/10/19. There were six days, not at least seven days, between the first and second step. Interview on 03/03/20 at 3:31 P.M. with Human Resource #373 verified four of eight employees reviewed for [MEDICATION NAME] testing had the second step a day early. Review of the facility's [MEDICAL CONDITION] (TB) Skin Test Health Care Worker Policy, last reviewed 10/31/18, included step 1 will be administered upon hire and step 2 will be administered within 1-3 weeks.