STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG HEALTH CARE	1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 5, 6, 7, 10, and 11, 2015 Facility number: 000162 Provider number: 155261 AIM number: 100284300 Census bed type: SNF/NF: 50 Total: 50 Census payor source: Medicare: 1 Medicaid: 41 Other: 8 Total: 50 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1	F 0000	Submission of this plan of correction shall notconstitute or be construed as an admission by Williamsburg Health Care that theallegations contained in this survey report are accurate or reflect accuratelythe provision of service to the residents of Williamsburg Health Care.	
F 0156 SS=D Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an			

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	assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review and interview, the facility failed to give timely notice for Medicare services ending for 1 of 3 residents reviewed for liability notices	F 0156	**F156 – Notices of Rights, Rules, Services, Charges** I. Please note that resident #72 was not negatively affected as a result of the failure to provide a Notice	09/01/2015

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	(Resident #72). Finding includes: Liability and appeal notices were reviewed on 08/10/15 at 10:30 a.m. Resident #72's notice indicated the last date of service was 6/19/15. The date of receipt of the notice was 6/19/15. The notice indicated the Social Service Director spoke with the resident ' s daughter and indicated, " She is in agreement and will not appeal. " During an interview on 08/10/15 at 10:18 a.m., the Administrator indicated she was unable to locate documentation indicating the resident ' s representative received notice prior to 6/19/15. Documentation on the "Notice of Medicare Non-Coverage" Form CMS 10123-NOMNC (approved 12/31/2011) indicated, " ...How to Ask For an Immediate Appeal You must make your request to your Quality Improvement Organization (also known as QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services. Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above..."		of Medicare Non-Coverage. II. As all residents whose stays are covered by Medicare could be affected, the following corrective action was taken: III. As a means to ensure ongoing compliance with notifying residents of their Medicare non-coverage, the Administrator will conduct weekly checks with therapy and/or the Director of Nursing to ensure timely completion of notices. Observations of the issuance of Notices of Medicare Non-Coverage shall also be completed weekly to ensure continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the monitoring is provided in Attachment A. Due to the evidence provided, Williamsburg Health Care requests papercompliance on tag F156.	

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	3.1-4(f)(1)(B)			
F 0170 SS=D Bldg. 00	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on interview and record review, the facility failed to ensure Saturday delivery of mail for 50 of 50 residents. Finding includes: During an interview on 8/6/15 at 10:00 a.m., the Resident Council President indicated the facility did not receive mail on Saturdays. During an interview on 8/11/15 at 1:57 p.m, the Administrator indicated the facility's mail was sent to a street address at another location. The mail was sorted by a facility representative Monday through Friday and delivered to the facility's business office. During an interview on 8/11/15 at 3:25 p.m., the Activity Director indicated the mail was not delivered to the facility on Saturdays. She indicated the mail was delivered to the business office Monday through Friday. She indicated she was responsible for delivery of mail to the	F 0170	**F170 – Right toPrivacy – Send/Receive Unopened Mail** I. Please note that no residents were harmed as a result of no Saturday mail delivery. The facilitydoes provide PO Box 625 for weekend delivery but residents and/or families failto utilize it. II. As all residents who reside in the facility could be affected, the following corrective action was taken: III. In an effort to ensure residents receive mail onweekends, the facility started having mail for all facility addresses deliveredon Saturdays to the facility. Observations of the delivery of mail to residents shall be completedweekly by the Administrator to ensure continued compliance. Should concerns be noted, re-education and/ordisciplinary action shall be taken as warranted. Monitoring for compliance will be conductedby the Administrator or her designee. IV. As a means of quality assurance, results of the aforementioned monitoring and subsequentactions taken shall be reported to the Quality Assurance Committee duringquarterly	09/01/2015

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	residents on those days. A policy, identified as current, titled, "Resident's Rights", (no date) provided by the Administrator on 8/11/15 at 11:20 a.m., included but not limited to, "...(i) Mail: the resident has the right to privacy in written communications, including ... (1) Send and promptly receive mail that is unopened...." 3.1-3(s)(1)		meetings. V. Evidence of the monitoring is provided in Attachment B. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F170.	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure the assessment of a dialysis fistula (dialysis access site) for 1 of 1 resident reviewed for dialysis. (Resident #32) Finding includes: During an interview on 8/11/15 at 10:21 a.m., Resident #32 indicated her dialysis fistula was assessed by staff when she	F 0309	**F309 – Provide Care/Services for Highest Well Being** I. Please note that resident #32 was not harmed as a results of failure to assess her dialysis fistula on non-dialysis days. II. In an effort to ensure the continued accuracy of assessing a dialysis fistula, each resident currently receiving dialysis services or with the presence of an arteriovenousshunt were identified and necessary actions taken as warranted, including	09/01/2015

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	retured from dialysis on Monday, Wednesday, and Friday. She indicated her fistula was not assessed on non-dialysis days. During an interview on 8/11/15 at 10:32 a.m., RN #10 indicated Resident # 32's dialysis fistula was assessed on dialysis days. Resident #32's clinical record was reviewed on 8/7/15 at 10:43 a.m. Diagnosis included but was not limited to, end stage renal disease. A quarterly Minimum Data Set (MDS) assessment dated 6/6/15, indicated the resident had no cognitive impairment. The Care Plan, initiated 9/12/14, indicated a Problem, "...I am in end stage renal failure and receive dialysis three times per week. I am on a renal diet as well as a fluid restriction. I have a fistula [arteriovenous access utilized for hemodialysis] placed in my right arm....Interventions included but were not limited to,...Assess fistula at least daily, listen for bruit [audible blood flow] or feel thrill [pulsation] over fistula...." A policy, identified as current, titled, "Atreriovenous Shunt/Access: Assessment and Care of", dated July, 1996, provided by the Administrator on		daily assessment of the dialysis fistula. III. As a means to ensure ongoing compliance with accurately assessing a resident's dialysis fistula, a form has been created for the nurses to complete each shift. Monitoring for compliance will be conducted by administrative nursing daily on their scheduled days of work. Continued completion of the arteriovenous shunt assessments and subsequent action(s) taken will be reported to the Administrator. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the form for arteriovenous shunt assessment is provided in Attachment C. Evidence of the monitoring is provided in Attachment D. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F309.	

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	8/6/15, included but was not limited to, "Purpose: The Resident who is to receive hemodialysis will have an artificially created arteriovenous shunt properly maintained/assesses by the facility." "...Policy: The ateriovenous shunt of a hemodialysis Resident will be assessed on initial admission or readmission, and every shift thereafter...." 3.1-37 (a)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received services to increase and or prevent further decrease in range of motion for 2 of 3 residents reviewed for range of motion services. (Residents #61 and #71). Findings include: 1. On 8/5/15 at 2:19 p.m., Resident #61 was observed in her room sitting in a	F 0318	**F318 –Increase/Prevent Decrease in Range of Motion** I. 1. Resident #61 no longer liked the timing of the splint applications and it was adjusted to her current wishes and implemented. 2. Resident #71 has been placed on the restorative nursing program list and receives services. II. 1-2. In an effort to ensure the continued delivery and accuracy of range of motion services or restorative nursing services for residents, a list of all residents Occupational and Physical Therapy wish to be	09/01/2015

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	recliner. The resident was not wearing any type of splint or device to improve/prevent further contractures. A "Carrot" splint (devices that positions fingers away from the palm of the hand) was observed on her bed side table. During observations on 8/7/15 at 3:10 p.m. and 8/10/15 at 9:37 a.m., Resident #61 was in a recliner in her room. She was not wearing a splint device and the carrot was observed on her bed side table. During an interview with Resident #61 on 8/10/15 at 10:22 a.m., she indicated she was suppose to wear a splint device on her right hand and hold a carrot in her left hand. She indicated she had never refused to utilize the devices. On 8/10/15 at 10:30 a.m., RN #6 indicated the resident was in the Restorative Nursing Program. She indicated the resident's splint device should have been placed on her right hand and the carrot placed in her left hand for 2 hours after breakfast. She indicated the devices were removed for lunch and replaced for 2 hours after lunch. RN #6 indicated she was not aware the resident's devices had not been placed. During an interview on 8/10/15 at 1:38		on a functional maintenance program was obtained and necessary actions taken as warranted, including addition to the restorative nursing program or range of motion services. III. 1-2. As a means to ensure ongoing compliance with correctly delivering range of motion services or a restorative nursing program for residents with a functional maintenance program, residents with such services have been indicated on the aides' daily assignment sheets and the functional maintenance program included with documentation logs in the aide rehabilitation book. Nursing staff were in-serviced on the new procedure. Monitoring for compliance will be conducted by administrative nursing daily on their scheduled days of work. Continued completion of range of motion services or restorative nursing programs and subsequent action(s)taken will be reported to the Administrator. IV. 1-2. As a means of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. 1-2.Evidence of the audit of functional maintenance programs is included in Attachment E. Evidence of the in-servicing is provided in Attachment F. Due to the evidence provided, Williamsburg Health Care requests paper	

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	p.m., Restorative Aide #9, indicated when she was not working the CNA assigned to the hall was responsible for placing the splint device on the resident. She indicated the splint device was to be placed for 2 hours in the morning and 2 hours after lunch. On 8/10/15 at 1:45 p.m., CNA #12 indicated she would place the splint device on the resident when Restorative Aide #9 was not available. The CNA indicated she would document the splint device placement on the Rehab Treatment Record. Resident #61's record was reviewed on 8/7/15 at 3:04 p.m. The resident's Admission Minimum Data Set (MDS) Assessment, dated 5/11/15, indicated the resident had no cognitive deficit and had functional limitation in range of motion to both of her upper extremities. A care plan, dated 6/22/15, indicated the resident had contractures of both hands. The care plan indicated the Occupational Therapist (OT) recommended the resident wear a splint device with digit separators on her right hand and have a carrot in her left hand. The care plan indicated the resident participated in the Restorative Nursing Program for Range of Motion (ROM) and splint device		compliance on tag F318.	

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	placement. Interventions included, but were not limited to, restorative staff to perform Passive Range of Motion (PROM) exercises to her digits prior to applying splint device each day. The splint device would be placed each day at 9:00 a.m., removed at 11:00 a.m., and then placed on again at 2:00 p.m., and removed at 4:00 p.m. A carrot would be placed in her left hand per the same schedule. The Functional Maintenance Program (FMP) plan, dated 6/19/15, indicated the resident was to wear the splint device with digit separators on right hand and carrot in left hand. The device would be placed on the resident from 9:00 to 11:00 a.m., removed for lunch and placed on the resident from 2:00 to 4:00 p.m., and then removed for dinner. The resident was to have PROM to her digits prior to splint device placement. A hand written notation at the bottom of the form indicated, "To be done daily! Even when therapy is not here!" A physician's order dated 6/24/15, indicated to discontinue the resident from skilled OT services secondary to goals met. The resident was to wear right hand splint device per FMP (Functional Maintenance Program) schedule.			

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	A document titled, "Occupational Therapy (OT) Discharge Summary," dated 6/25/15 at 5:42 p.m., indicated the OT had recommended the resident was to wear the progressive orthotic splint device to her right hand and carrot to her left hand 2 hours on after breakfast and 2 hours on after lunch. A review of a document titled "Rehab Log," dated July 2015, did not include documentation to indicate splint application on July 4, 5, 7, 8, 9, 11, 12, 13, 18, 19, 20, 22, 25, 26, and 28, 2015. The August 2015 log did not include documentation to indicate splint application August 1, 2, 8, 9, and 10, 2015 A document titled "Rehabilitation Treatment Record," dated August 2015, reviewed on 8/10/15 at 2:21 p.m., did not include documentation to indicate splint devices were placed on August 1, 3, 4, 5, 6, 7, 8, and 9, 2015. 2. During an interview on 8/10/15 at 1:41 p.m., Restorative Aide #9 indicated, Resident #71 did not receive range of motion services and was not on a restorative nursing program. During an interview on 8/10/15 at 2:18 p.m., Physical Therapist (PT) #11 indicated, Resident # 71 was discharged			

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	from physical therapy on 6/16/15 and the facility was to begin a restorative nursing program based on his recommendations to maintain the resident's current level of functioning. PT #11 indicated the recommendations were given to the restorative aide. The therapist indicated he was not aware of the resident refusing restorative services. Resident #71's clinical record was reviewed on 8/10/15 at 10:55 a.m. Diagnoses included but were not limited to: weakness, dementia with behavioral disturbances, and a urinary tract infection. A significant change Minimum Data Set (MDS) dated 6/24/15, indicated the resident was moderately impaired in cognitive decision making skills. The assessment indicated the resident had declined in activities of daily living. A document, titled, "Functional Maintenance Program", was provided by PT #11 on 8/10/15 at 2:13 p.m., The therapist indicated the document was provided to the facility on 6/17/15, and was the current restorative program plan for Resident #71. The resident also was to be ambulated 150 feet with rolling walker (RW) and contact guard assist (CGA). Resident was to receive "...lower extremity range of motion (ROM) for: leg kick (3#), knees to chest (3#), ankle			

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(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
	circles (each direction), and lower extremity bike for minutes. [sic] 3 sets of 10 reps. [repetitions]" On 8/11/15 at 11:53 a.m., the Administrator indicated they had no current policy for a restorative nursing program. 3.1-42(a)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5) TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test	F 9999	**F9999 Personnel** I. Employee #13 has received a Mantoux testing and the results were negative. II. As all residents could be affected, the following corrective actions were taken: III. As a means to ensure ongoing compliance with ensuring employees receive tuberculosis testing upon hire, all employees were audited for the presence of a current Mantoux or chest x-ray (in the event of an employeehaving a previous positive result), and necessary actions taken as warranted. The facility will not accept any IGRA tests such as the QuantiFERON TB Gold test for employees. The Administrator will monitor monthly for completion of a tuberculin skin test for new employees. Should	09/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/11/2015
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933	

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	must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. for health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 recently hired employees had tuberculosis screening upon hire. This deficiency had the potential to affect 50 of 50 residents residing in the facility. Finding includes: On 8/11/15 at 10:00 a.m., five employee records were reviewed for proof of tuberculosis (TB) screening upon hire.		non-compliance be observed, re-education and/or disciplinary action shall be taken as warranted. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings. V. Evidence of the audit is provided in Attachment G. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F9999.	

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	The records did not indiclude an approved TB screening for Certified Nurse Aide (CNA) #13 upon hire. State form 5440, "Employee Records," provided by the Administrator on 8/10/15, indicated CNA #13 began employment on 6/5/15. On 8/11/15 at 3:00 p.m., the nursing assignment schedules from 8/3/15 to 8/11/15, indicated the CNA worked six days of the time frame. During an interview of the Director of Nursing, (DON) on 8/10/15 at 2:28 p.m., the DON indicated the Human Resource (HR) Director was responsible for maintaining the Mantoux testing results for the employees. The DON indicated HR and been informed that CNA #13 had received the lab test "QuantiFERON TB Gold" in nursing school on 3/19/15. HR accepted the lab report in place of a Mantoux testing result. On 8/11/15 at 11:34 a.m., the Administrator provided a facility policy titled "EMPLOYMENT HEALTH CERTIFICATION' dated 4/12/07. The policy included, but was not limited to, "State and Federal Law requires that every employee of a health care facility undergo a Pre-employment physical and			

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	155261		08/11/2015

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	be tested for tuberculosis (TB) prior to starting work and re-tested for TB once per year."... 3.1-14(t)(1)			