STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 05/20/19 to 05/23/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatory deficiencies at F656, F690, and F880. The census at the time of the survey entrance was 169, and the facility was certified for 180 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		6/21/19

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

Electronically Signed | 06/20/2019

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 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to follow Resident #173's comprehensive care plan related to catheter care for one (1) of three (3) care plans reviewed for catheter care. Findings include: A review of the facility's "Comprehensive Person Centered Care Plans" policy, with a latest revision date of 03/18, revealed each resident will have a person centered plan of care to identify how the interdisciplinary team will provide care. Assigned disciplines will be identified to carry out the intervention. A review of the comprehensive care plan, with an onset date of 02/9/16, revealed the Problem/Need for the potential for Urinary Tract Infection (UTI) related to the presence of an	F 656	- Resident # 173's Comprehensive Care Plan (CCP) and the Pocket Care Guide (PCG) were reviewed on 5/24/19 by the Director of Nursing Services (DNS) and no changes were made. On 5/21/19 the Certified Nursing Assistant(CNA) #1 was counseled 1:1 by the DNS on proper indwelling urinary catheter care with a return demonstration and following the pocket care guide(PCG). - All residents who have an indwelling urinary catheter have the potential to be affected. The Comprehensive Care Plans/Pocket Care Cuides for seven(7) residents with indwelling urinary catheters were reviewed by the DNS on 5/28/19. No negative findings were identified. - Beginning 5/28/19 to 6/10/19 the	

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F 656	Continued From page 2 indwelling Foley catheter and history of urinary retention. The Goal & Target Date stated the resident would not have any signs and symptoms of a UTI thru 07/20/19. On 05/21/19 at 10:10 AM, an observation revealed Resident #173 was lying in bed with an indwelling urinary catheter to gravity drainage. Further observation revealed Certified Nursing Assistant (CNA) #1 and CNA #2 performed catheter care on Resident #173. Both CNAs washed their hands and applied clean gloves. CNA #1 wiped in a downward motion on each side of the resident's groin areas, and down the middle of the resident's vaginal area. While holding the catheter tubing at the distal end, farthest away from the meatus CNA #1 wiped the catheter tubing towards the meatus two times, and after CNA #2 told her "not that way," CNA #1 then wiped the catheter tubing away from the resident's meatus area twice. CNA #1 then held the end of the catheter tubing with her left hand at the distal end from the meatus, while using her right hand to wipe towards the distal end away from the meatus. After completion of the catheter care both CNAs applied the resident's brief, positioned her up in bed onto her left side, and covered her up. CNA #1 disposed of the soiled linens and other items. On 05/22/19 at 12:05 PM, an interview with CNA #1 revealed she stated when she started to wipe the catheter tubing, she wiped in the wrong direction. She stated she wiped towards the vagina area and should have wiped away from the vagina. She stated the resident could have gotten an infection. CNA #1 stated, she held the catheter away from her body (referring to Resident #173), and should have held it closer to	F 656	Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse in-serviced all Nurses and Certified Nursing Assistants (CNAs) on following each assigned residents' Comprehensive Care Plan/Pocket Care Guide for daily care to include indwelling urinary catheter. The Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse completed Nurse and CNA competency check-offs for indwelling urinary catheter care 6/14/19 to ensure the CCP/PCGs are followed. - Beginning 6/3/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse performed daily observations of one (1) CNA over three shifts performing indwelling urinary catheter care and following each resident's CCP/PCG for three (3) weeks, Monday through Friday. Any problems identified will be reported to the Quality Assurance Committee (QAC) by the DNS. The QAC will make recommendations for continued observations.	

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F 656	Continued From page 3 her body (referring to Resident #173) so the tension would not have been there. On 05/22/19 at 12:15 PM, an interview with CNA #2 revealed CNA #1 was wiping in the wrong direction and that could cause a bacterial infection. She also stated when CNA #1 was holding the catheter tubing closer to her (referring to Resident #173) and wiping the tubing (referring to the catheter tubing), that could have caused the catheter to be pulled out. Review of the May 2019 physician's orders revealed an order, dated 03/10/19, for a 16 FR (French) Foley catheter with a 5cc (five cubic centimeter) balloon to gravity drainage. May change as needed for occlusion, leakage or dislodgement. Record Foley output every shift. On 05/22/19 1:45 PM, an interview with the Director of Nursing (DON), revealed, she would expect the staff to follow the comprehensive care plan. Review of the Face Sheet revealed Resident #173 was admitted by the facility, on 02/09/16, with the included diagnoses: Pressure Ulcer of Sacral Region, Stage 4, Overactive Bladder, Pressure Ulcer Right Buttock Stage 3. A record review of the most recent Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/04/19, revealed Resident #173's Urinary Bowel and Bladder Continence was checked "not rated", resident had a catheter (indwelling, condom, urinary ostomy, or not urine output for the entire 7 (seven) days of observation. it was resident had a catheter.	F 656		

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 690	- Resident #173 had no complications	6/21/19

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F 690	Continued From page 5 review, and facility policy review, the facility failed to provide catheter care in a manner to prevent possible cross contamination/Urinary Tract Infection (UTI), for one (1) of three (3) residents reviewed with catheters. Resident #173. Findings include: On 5/21/19 at 10:10 AM, an observation revealed Certified Nursing Assistant (CNA), assisted by CNA #2, provided Resident #173's catheter care#173 was lying in bed with an indwelling urinary catheter to gravity drainage. Both CNAs washed their hands and applied clean gloves. CNA #1 wiped the resident's perineal area in a downward motion on each side of the resident's groin areas, and down the middle of the resident's vaginal area. While CNA #1 held the catheter tubing at the distal end farthest away from the meatus, she wiped the catheter tubing towards the meatus two times, and after CNA #2 told her "not that way", CNA #1 then wiped the catheter tubing away from the meatus area twice. CNA #1 held the catheter tubing with her left hand at the distal end from the meatus, while using her right hand to wipe towards the distal end away from the meatus. After completion of the catheter care, both CNAs applied the resident's clean brief, positioned her up in bed onto her left side, and covered her up. CNA #1 disposed of the soiled linens and other items. On 5/22/19 at 12:05 PM, an interview with CNA #1, revealed when she started to wipe the catheter tubing she wiped in the wrong direction. She stated she wiped towards the vagina area, and should have wiped away from the vagina. She stated the resident could have gotten an infection. CNA #1 stated she held the catheter	F 690	related to the indwelling urinary catheter care on 5/21/19 during survey. The DNS assessed resident #173 on 5/21/19. There were no negative effects from the care rendered on 5/21/19. CNA #1 was counseled 1:1 on 5/21/19 by the DNS on proper indwelling urinary catheter care with a return demonstration and following the PCG. - All residents who have an indwelling urinary catheter have the potential to be affected. The CCPs/PCGs for seven (7) residents with indwelling urinary catheters were reviewed by the DNS on 5/28/19. No negative findings were identified. - Beginning 5/25/19 to 6/10/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse in-serviced all Nurses and Certified Nursing Assistants (CNAs) on proper indwelling urinary catheter care to prevent possible urinary tract infection (UTI). The Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse completed Nurse and CNA competency check-offs for indwelling urinary catheter care 6/14/19. - Beginning 6/3/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse performed daily observations of one (1) CNA over three shifts performing proper indwelling urinary catheter care, for three (3) weeks, Monday through Friday. Any problems identified will be reported to the	

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F 690	Continued From page 6 away from her body (referring to Resident #173) and should have held it closer to her body (referring to Resident #173) so the tension would not have been there. On 5/22/19 at 12:15 PM, an interview with CNA #2, revealed the CNA was wiped in the wrong direction and that could cause a bacterial infection. She also stated when CNA #1 was holding the catheter tubing closer to her (referring to Resident #173) and wiping the tubing (referring to the catheter tubing), that could have caused the catheter to be pulled out. 05/22/19 1:45 PM, an interview with the Director of Nurses (DON), revealed CNA #1 wiped the catheter tubing in the wrong direction, she got nervous, and yes, that's definitely a problem, and can cause infection. The DON also stated she has to hold it (referring to the catheter tubing) closer to the catheter insertion site when wiping it. On 5/22/19 at 3:28 PM, an interview with the Staff Development Nurse, revealed she (referring to CNA #1) should have held the catheter tubing close to the meatus area and wiped away from the meatus area. She also stated CNA #1 should have anchored the catheter tubing close to the meatus end so there would be no pulling on the tubing. Review of the May 2019 Physician's Orders, revealed an order, dated 03/10/19, for a 16 FR (French) Foley catheter with a 5 cc (five cubic centimeter) balloon to gravity drainage. May change as needed for occlusion, leakage or dislodgement. Record Foley output every shift. Review of the Face Sheet revealed Resident	F 690	Quality Assurance Committee (QAC) by the DNS. The QAC will make recommendations for continued observations.	

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F 690	Continued From page 7 #173 was admitted by the facility, on 02/09/16, with the included diagnoses: Pressure Ulcer of Sacral Region, Stage 4, Overactive Bladder, Pressure Ulcer Right Buttock Stage 3. A record review of the most recent Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/04/19, revealed Resident #173's Urinary Bowel and Bladder Continence was checked "not rated", resident had a catheter (indwelling, condom, urinary ostomy, or not urine output for the entire 7 (seven) days of observation. it was resident had a catheter.	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		6/21/19

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F 880	Continued From page 8 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 9 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to prevent the possible spread of infection during med pass for one (1) of six (6) residents observed during the medication pass, Resident #135. Findings include: Review of the facility's "Contact Precautions" policy, revised 10/2009, revealed the staff were to wash their hands after contact with the resident and before leaving the room. The policy also stated to dispose of contaminated items in a proper receptacle after care is completed by placing in a plastic bag, closed prior to leaving the room. An observation and interview, on 05/21/19 at 11:27 AM, with Licensed Practical Nurse (LPN) #1 confirmed Resident #135 was on Contact Precautions. There was signage for Contact Isolation on the resident's room door. LPN #1 entered the room to perform a finger stick glucose test on Resident #135. LPN #1 placed the supplies on a disposable plate, and then placed plate on the overbed table without wiping the table off with a sanitizing wipe or placing the place on a surface barrier. LPN #1 performed a blood glucose test on Resident #135, and after performing the procedure, LPN #1 removed her gloves and washed her hands. LPN #1 put on new gloves,	F 880	- Resident #135 had no negative effects related to the nursing care provided on 5/21/19 during survey. Resident #135's Contact Precautions were discontinued on 5/23/19 after a negative C.Difficile result was obtained. The facility has had no residents on Contact Precautions since 5/23/19. Licensed practical nurse (LPN)#1 was counseled by the DNS on 5/21/19 on contact precautions, proper hand washing, proper handling of syringe needle, disposal of used lancets and hypodermic needle in sharps container; and disposal of contaminated items in a closed plastic bag prior to leaving room. - All residents have the potential to be affected. - Beginning 5/28/19 to 6/10/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse in-serviced all Nurses on the Contact Precautions policy, proper hand washing, proper handling of syringe needle, disposal of used lancets and hypodermic needles in sharps containers and disposal of contaminated items in a closed plastic bag prior to leaving the room. - Beginning 6/3/19 the Director of Nursing Services/Assistant Director of Nursing	

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F 880	Continued From page 10 and picked up the supplies including the disposable plate with the used lancet, test strip and used gloves that was located on the residents over bed table, and and walked into the hallway without placing the items in the trash in the room or in another bag. LPN #1 disposed of the lancet in the sharps container located on her medication cart, and the garbage in the dirty utility room at the nurses desk with a biohazard sign on the door. LPN #1 then removed her gloves and used alcohol gel located on her cart for hand hygiene. LPN #1 drew up 8 units of Novolog into in an insulin syringe for Resident #135 insulin sliding scale dose, and walked down the hallway from her cart located at the nurses desk to Resident #135's room, about 30 feet away with the needle exposed on the syringe. LPN #1 stated she could not recap the needle is why the needle was exposed. LPN #1 administered the 8 units of Novolog insulin in Resident #135's right arm. LPN #1 carried the used retracted syringe back to her cart at the nurses desk, and disposed of the syringe in the sharps container on her medication cart. LPN #1 then removed her gloves at her cart, and used alcohol gel for hand hygiene. LPN #1 said she was complete as soon as she signed off her Medication Administration Record (MAR). LPN #1 was not observed washing her hands after she left Resident #135's room after administering the insulin injection. Review of Resident #135's May 2019 physician's orders revealed an order for Novolog Insulin 100 units/milliliter (ml) sliding scale before meals dated 9/21/18. Resident #135's physician's orders also revealed an order for contact precautions and Vancomycin (antibiotic) by mouth, dated 05/14/19, for Enterocolitis due to Clostridium Difficile (C-diff).	F 880	Services/Staff Development Nurse made daily observations of two (2) nurses over three (3) shifts for three (3) weeks, Monday through Friday, to ensure nurses follow proper hand washing, proper handling of syringe needle, disposal of used lancets and hypodermic needles in sharps containers. Observations could not be made on contact precautions and contaminated items since no resident has been on contact precautions since 5/23/19. Any problems identified will be reported to the Quality Assurance Committee (QAC) by the DNS. The QAC will make recommendations for continued observations	

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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
F 880	Continued From page 11 Review of the Resident #135's Medication Administration Record (MAR) for May 2019, revealed Licensed Practical Nurse (LPN) #1 documented she administered 8 units of Novolog Insulin to Resident #135 on 05/21/19 at 11:30 AM. An interview on 05/21/19 at 2:47 PM, with LPN #1 revealed she said she could use either alcohol gel or hand washing after leaving the room with contact precautions with a resident with C-diff. She confirmed C-diff was very contagious. LPN #1 could not state the policy of the facility, except that she could not dispose of gloves in the room. LPN #1 also confirmed she did take the trash from the resident's room without using a trash bag, but she stated it was "OK because I didn't sit it on anything". LPN #1 confirmed she did walk down the hall with insulin syringe uncovered before administering the medication. LPN #1 also said she didn't usually move the cart close to the rooms during medication pass, and walked from the desk with her medications. LPN #1 confirmed it was a hazard to not cover the syringe needle, but did not have another type of safety syringe in the facility to use. LPN #1 said the needle goes back in the syringe after use. An interview on 05/22/19 at 1:44 PM, with the Director of Nursing (DON) revealed she said she expected the nurse to pull the cart close to the room, and to not carry the needle down the hall uncovered. The DON also said the nurse should have used a red bag to put her garbage in before leaving a room on contact precautions. The DON said the policy was to wash your hands before leaving the room when a resident has C-diff.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	05/23/2019

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F 880	Continued From page 12 An interview, on 05/22/19 2:15 PM, with Registered Nurse (RN) #2/Infection Control Nurse, revealed she stated the policy was to bag all garbage before leaving the room, and to wash hands with soap and water after any care with a resident with C-diff. RN #2 confirmed the nurse will be receiving more training and education related to transmission precautions. RN #2 also confirmed the distance the nurse walked was about 25 to 30 feet from Resident #135's room to LPN #1's medication cart located at the nurses desk.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 06/24/2019

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
	255115	A. BUILDING _____ B. WING _____	05/21/2019

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/21/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 06/24/2019

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.