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	255110	A. BUILDING _____ B. WING _____	06/20/2019

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MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 6/17/19 to 6/20/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F656, F758, F686 and F880. At the time of the survey the census was 106, and the facility held a license for 125 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 recommendations. If a facility disagrees with the	F 656		7/31/19

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

Electronically Signed | 08/01/2019

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 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 observation, staff interview, and facility policy review, the facility failed to develop a care for the use of a bed cradle to help prevent pressure ulcers, for one (1) of 23 care plans reviewed, Resident #51. Findings include: Review of a document on facility letterhead, signed by the Administrator, dated 6/20/19, revealed the facility used the Resident Assessment Instrument (RAI) manual instructions as it pertains to care plans. The RAI manual (October 2017) revealed: The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review for Resident #51 revealed a physician's	F 656	" A comprehensive care plan for the use of a bed cradle to assist in the prevention of pressure ulcers was developed and documented on 06/10/2019 for Resident #51 by the MDS Coordinator. " All residents in this facility having orders for the use of a bed cradle to assist in prevention of pressure ulcers could be affected by this deficient practice. " An inservice was conducted on 07/31/2019 by Nurse Trainer and ADON to facility nurses on developing a comprehensive care plan on the use of a bed cradle ordered by resident physician. Nurse receiving order from physician will document on the facility JOT sheet the order and care plan for its use. Each Unit Supervisor (Nurse, 7p to 7a) will audit JOT sheet each night for order of, and	

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F 656	Continued From page 2 order for a foot cradle to foot of the the bed with an order date of 4/25/19. Review of Resident #51's current care plan revealed there was no care plan for the use of the bed cradle ordered on 4/25/19. On 06/19/19 at 10:45 AM, an observation of pressure ulcer care to Resident #51's left great toe was performed by Registered Nurse (RN) #1. She stated they were doing preventative care and the resident should have a metal bed cradle on her bed to keep the weight of her covers off her toe. RN #1 confirmed there was no bed cradle on Resident #51's bed. RN #1 stated she felt Resident #51 got the pressure area on her left great toe due to pressure from heavy covers over her feet. An interview, on 6/20/19 at 8:26 AM, with Licensed Practical Nurse (LPN) #1, confirmed there was no care plan generated on Resident #51's chart for the order dated 4/25/19, for a bed cradle to her bed. She stated there was order for the bed cradle so there should have been a care plan. LPN #1 confirmed the order had not been placed on the handwritten care plan "jot sheet". An interview on 6/20/19 at 8:30 AM, with RN #2, revealed when a new order is written, the nurses are responsible for doing a handwritten care plan or they review new orders and add them to the "jot sheet", which is used as a handwritten care plan. She stated the Minimum Data Set (MDS) Nurses update the care plan from the "jot sheet" at the next assessment date. RN #2 stated the nurses in the MDS office do not always review the new orders.	F 656	care plan for the use of Bed cradle. MDS Coordinator will audit the JOT sheet from previous 24hours for orders and care plan for use of bed cradle by resident at a minimum of five times weekly. The Results of these audits will be documented on facility worksheet and presented to DON/ADON for review. " DON/ADON will provide the QA committee with results of these audits and actions taken for review and recommendations if warranted.	

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F 656	Continued From page 3 An interview, on 6/20/19 at 8:33 AM, with RN #3, revealed it was the responsibility of the floor nurses to up date the hand written care plan. She confirmed there was no handwritten or typed care plan for Resident #51's April 25,2019 order for a foot cradle. An interview on 6/20/19 at 8:41 AM, with the Director of Nursing (DON), revealed whoever took the order off was responsible for putting the information on the "jot sheet", which is like a handwritten care plan, and the MDS Nurse gets her information from the "jot sheet", or the orders to update the care plan in the computer. She stated the MDS nurses are supposed to be checking the orders too, so there is a double check. The DON confirmed Resident #51 should have had the bed cradle care planned for use to help prevent any further breakdown to her toe.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		7/31/19

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F 686	Continued From page 4 Based on observation, staff interview, and record review, the facility failed to ensure a bed cradle was used as a preventive measure for a resident at risk for recurrent skin breakdown for one (1) of six (6) residents reviewed for pressure ulcer/injury, Resident #51. Findings include: Record review revealed a physician's order for a foot cradle to foot of the the bed with an order date of 4/25/19, for Resident #51. An observation, on 06/19/19 at 10:45 AM, revealed pressure ulcer care to the Resident #51's left great toe was performed by Registered Nurse (RN) #1. No concerns noted with the wound care. The ulcer was healed. The skin at the site was dark pinkish in color and fragile. The RN applied skin prep to the area. She stated they were doing this as a preventative measure and the resident should have a metal bed cradle on her bed to keep the weight of her covers off her toe. RN #1 confirmed there was no bed cradle on Resident #51's bed. RN #1 stated she felt Resident #51 got the pressure area on her left great toe due to pressure from heavy covers over her feet. RN #1 located Resident #51's bed cradle underneath the sink counter in the Resident's room. RN #1 cleaned the dust and lint from the cradle with a wipe and placed it on the resident's bed. An interview, on 6/20/19 at 8:20 AM, with Certified Nurses Assistant CNA #1, revealed care to be given by CNA's is documented in their computers. She stated the bed cradle for Resident #51 should be listed under the equipment section. Review of the computer	F 686	" The bed cradle ordered for resident #51 was installed to help prevent the development of pressure ulcers by nursing staff on 06/19/2019. " All residents with orders for the use of a bed cradle to assist in the prevention of pressure ulcers could be adversely affected by this deficient practice. " QAPI nurse will conduct daily audits to verify the use of bed cradles 5 days a week for 90 days, document the results on facility worksheet and provide copies to the DON/ADON upon completion. All nursing staff inserviced on the of use bed cradles ordered for residents to assist in the prevention of pressure ulcers on residents as ordered by physician on the 07/31/2019 by facility nurse trainer. Audit will include the proper use of, orders issued for the use of, and care plan documentation related to implementation and use of bed cradle to assist in the prevention of pressure ulcers. " Results of QAPI nurse audits of bed cradle orders, care plan and use of, will be provided to the facility Quality Assurance Committee by the DON/ADON for review and further action if necessary.	

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F 686	Continued From page 5 screen indicated Resident #51 was to have a bed cradle to the foot of her bed. CNA #1 stated she was not sure why the bed cradle was not on the bed. She stated she just didn't notice it. CNA #1 confirmed the bed cradle intervention was documented in the computer. An interview, on 6/20/19 at 8:26 AM, with Licensed Practical Nurse (LPN) #1, confirmed Resident #51 had an order dated 4/25/19, for a bed cradle to her bed. LPN #1 stated the bed cradle should be on the bed. An interview, on 6/20/19 at 8:41 AM, with the Director of Nursing (DON), confirmed Resident #51 should have had the bed cradle on her bed to help prevent any further breakdown to her toe.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		7/31/19

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F 758	Continued From page 6 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide a stop date for as needed (PRN) psychotropic medications ordered for two (2) of six (6) residents reviewed. Resident #31 and Resident #51. Findings include:	F 758	" Physician contacted via telephone and advised of the requirements of CFR(s) 483.45(e)(3)(e)(1 - 5), specifically the requirement for a stop date on PRN Anti-psychotics, anti-depressants, anti-anxiety, and hypnotic medications ordered for facility residents. Physician issued orders for a stop date for psychotropic medications ordered for	

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F 758	Continued From page 7 Review of the facility's "Free From Unnecessary Psychotropic Concerns" policy, not dated, revealed as needed (PRN) orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Resident #31 Record review revealed Resident #31 had an order dated 3/14/19 for Ativan 0.5 milligram (mg) by mouth (PO) twice daily (BID) prn, for anxiety. The order did not have a stop date. Review of Resident #31's Medication Administration Record (MAR) revealed the resident continued to receive Ativan 0.5 mg PO BID prn through 6/16/19. Resident #51 Record review revealed Resident #51 had an order dated 1/10/19, for Ativan 1 mg PO BID prn with no stop date. Review of the MAR revealed Resident #51 continued to receive Ativan 1 mg PO BID as needed through June 18, 2019. An interview , on 6/19/19 at 3:14 PM, with the Consultant Pharmacist revealed she informs facilities a test trial should be done for these medications (psychotropic) and then the resident should be reassessed. She confirmed she knew about the initial 14 day stop date. The Consultant Pharmacist confirmed the order for the PRN Ativan should have a stop date. She stated she	F 758	resident #31 and resident #51. " All residents with PRN orders for anti-psychotic, anti-depressant, anti-anxiety and Hypnotic medications could be affected for this deficient practice. " Facility nursing staff were re-inserviced on the requirements of CFR(s) 483.45(e)(3)(e)(1-5)on 07/31/2019 by facility nurse trainer. An Audit has been performed on all residents having PRN orders for anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications, by QAPI nurse to ensure stop dates or physicians reason for continuing the medication beyond 14 days is present. This audit was performed on 06/19/2019, and no further violations identified. Audit will be performed by a QAPI Nurse five times per week for 90 days, and then monthly to verify compliance. The results will be documented on facility worksheet and provided to the ADON/DON. The facility pharmacy consultant will perform monthly audits of stop dates as it pertains to CFR(s): 483.45(e)(3)(e)(1-5). This audit will be documented on the "Consultant Pharmasist's Medication Regime Review" and presented to the QA committee via the Director of Nursing. The Consultant Pharmasist's Medication Regime will include a paragraph reviewing the requirements of CFR(s) 483.45(e)(3)(e)(1-5) as a reminder of these requirements to staff nursing personnel. " The QAPI/DON will review audit	

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F 758	Continued From page 8 should have caught this with her monthly medication review. An interview, on 6/19/19 at 11:34 AM, with the Administrator, revealed they had eliminated a lot of PRN psychotropic medications. He stated that he, the Director of Nursing (DON), and the Consultant Pharmacist are responsible for monitoring this. The Administrator stated he was not aware there was not a stop date on these orders, but he did know this issue had been addressed. An interview, on 6/19/19 at 12:00 PM, with the DON, confirmed the Ativan should have a stop date. She stated they are continuing to working on this and educate personnel.	F 758	findings and provide results to the QA committee for review and recommendations. Any problems related to compliance with CFR(s) 483.45(e)(3)(e)(1-5) encountered with resident physicians or physician extenders with compliance will be referred to the facility Medical Director for guidance and assistance in obtaining compliance.	
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	F 880		7/31/19

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F 880	Continued From page 9 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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.	F 880		

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F 880	Continued From page 10 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, and facility policy review, the facility failed to prevent the likelihood of the spread of infection during catheter and incontinent care for one (1) of eight (8) residents observed for care, Resident #91. Findings include: Review of the facility's "Gloves" policy, not dated, revealed gloves prevent the spread of infection and disease to other residents, personal, and visitors, and keep hands free from potentially infectious material and to wash your hands after removing gloves. Review of the facility's "Catheter Care Policy/Procedure", not dated, revealed in Procedure step #15: remove gloves and wash hands. Procedure #16 revealed if you need to replace a clean dry brief, you must put on a new pair of clean gloves before touching the clean brief and resident. On 06/19/19 at 10:00 AM, an observation of catheter care, performed by Certified Nurses Assistant (CNA) #1, revealed Resident #91 had a bowel movement prior to the catheter care procedure. CNA #1 performed catheter care on the resident. CNA #1 secured the catheter in one	F 880	" CNA #1 received a one-on-one re-inservice on 06/21/2019 by facility Nurse Trainer and ADON with return demonstration successfully provided when engaged in resident care with residents utilizing a bed cradle and cushions or wedges. Special emphasis was placed on hand washing, when to change gloves and how to handle contaminated supplies. Resident #91 was placed on acute charting and monitoring for signs and symtoms of infection for 72 hours. Negative signs and symtoms were noted during this observation period. " All residents residing in this facility receiving catheter and incontinent care could be affected by this deficient practice. " Certified Nursing Assistants employed by this facility were re-inserviced by nurse trainer 07/31/2019 on facility policy and procedures while engaged in catheter and incontinent care. ADON was present and emphasized importantance of facility policy and procedure as it related to hand washing, when to change gloves, and procedure for handling contaminated supplies while providing catheter and	

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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 (1) hand near the urinary meatus while cleaning and wiping in a direction away from the resident, using one (1) stroke with each wipe used. Resident #91 was then repositioned to her right side and incontinent care was performed. CNA #1 did not wash her hands and change gloves prior to beginning incontinent care. CNA #1 picked up the pack of wipes, while wearing gloves that had been contaminated during the incontinent care, and placed the wipes on the over bed table. During the procedure, a garbage bag on the bed containing soiled wipes and a brief fell onto the floor. CNA #1 picked the bag up off the floor and placed it back on the bed. CNA #1 then took a roll of clear garbage bags out of her back pocket and retrieved a bag and placed it on the bed and then returned the roll of garbage bags to her back pocket, while wearing the same contaminated gloves. CNA #1 then removed her gloves and washed her hands. She brought a clean pair of gloves back to the bedside with her and placed them on the garbage bag that had been on the floor. CNA #1 donned those gloves that were laying on the garbage bag, then applied a clean brief and replaced the resident's covers and call light. During an interview, on 6/19/19 at 2:55 PM, CNA #1 confirmed she contaminated things because she did not change her gloves after doing incontinent care. CNA #1 confirmed she should not have picked the garbage up from the floor and put it on the bed and should not have picked up the wipes with dirty gloves. She stated contamination can cause infections. An interview, on 6/20/19 at 10:45 AM, with the Director of Nursing, revealed she had the CNA's do a catheter care and incontinent care check off	F 880	incontinent care. Return demonstration was successfully provided by attending CNA's. CNA#1 is to be mentored with CNA supervisor while providing catheter care and or incontinent care for a period of 30days and then resume semi-annual testing and facility recertification in these areas if performance is deemed satisfactory by the DON. CNA#1 and CNA staff were instructed not to place care items, i.e. garbage bags, in pockets to prevent the possible spread of infection per facility policy and procedure. " CNA Supervisor will report weekly to the ADON/DON the progress/performance of CNA#1 skills while providing catheter and incontinent care to residents. ADON/DON will provide the QA committee CNA#1,s progress reports with recommendation for additional guidance if warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. BUILDING _____ B. WING _____	06/20/2019

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MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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F 880	Continued From page 12 using a mannequin. She stated the procedure used by CNA #1 was an infection control issue and using contaminated gloves could spread infection. Record review revealed CNA #1 had attended the in-service/check off on 5/20/19.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/21/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	**3701 JOANNE DRIVE** **CORINTH, MS 38834**

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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 | 07/29/2019

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
	255110	A. BUILDING _____ B. WING _____	06/21/2019

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 6/21/19 revealed 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 | 07/29/2019

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.