

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345449</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSAL HEALTH CARE/KING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 WHITE ROAD</b> <b>KING, NC 27021</b>	
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E 000	Initial Comments	E 000		
F 000	INITIAL COMMENTS	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)  §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were left at bedside for 1 of 1 sampled resident (Resident #45) reviewed for self-administration of medications.  The findings included:  Resident #45 was admitted to the facility on 3/23/21 with diagnoses that included diabetes mellitus type 2, cerebrovascular accident and hypertension.	F 554	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.  How corrective action will be accomplished for those residents found to	5/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/20/2021

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 554	<p>Continued From page 1</p> <p>An admission Minimum Data Set (MDS) assessment dated 3/30/21 revealed Resident #45 had moderately impaired cognition.</p> <p>An observation on 4/26/21 at 10:47 AM revealed Resident #45 had a 1-ounce clear plastic cup approximately half full of various medications on her bedside table that was in front of her.</p> <p>An interview conducted with Resident #45 on 4/26/21 at 10:47 AM revealed she didn't feel well when Nurse #2 brought the medications, so Nurse #2 left them there.</p> <p>A comprehensive medical record review conducted on 4/26/21 did not reveal an assessment was completed for the resident to self-administer medications.</p> <p>On 4/26/21 at 12:21 PM, Nurse #2 was interviewed. She stated she knew medications were not to be left at the bedside. She added Resident #45 was coughing when she brought the medications and she then got called to assist another staff member so left the medications in Resident #45's room.</p> <p>On 4/29/21 at 4:00 PM, the interim Director of Nursing was interviewed. She stated medications should not be left at the bedside.</p>	F 554	<p>have been affected by the deficient practice;</p> <p>Resident #45 is no longer at Universal Healthcare of King.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>100% of current resident rooms were rounded on to ensure medications were not left at the bedside by Director of Nursing, ADON, and unit managers. Completed on 5/21/2021.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>All license nurses and medication aides will be educated on not leaving medications unattended at the bedside of the resident. Medications are to be given then, if resident does not want to take medications at the appropriate time, staff is to discard of the medication appropriately and document. In person or via telephone by the Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by 5/24/2021.</p> <p>Any Licensed Nurse and/or medication aide that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by midnight</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 554	Continued From page 2	F 554	5/25/2021.  All Licensed nurses, including Agency staff before their first assignment, will be educated in orientation in person by Staff Development Nurse or Director of Nursing or Assistant Director of Nursing on not leaving medications unattended at the bedside of the resident. Medications are to be given then, if resident does not want to take medications at the appropriate time, staff is to discard of the medication appropriately and document.  Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will audit 10% of each hall to ensure no medications are left at the bedside 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 2.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is May 24, 2021  Director of Nursing is responsible for ensuring continued compliance.		
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	F 686		5/24/21	

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F 686	<p>Continued From page 3</p> <p>resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff and nurse practitioner interviews, the facility failed to document the correct area of pressure ulcer and failed to transcribe a treatment order and a pressure reducing device to the Treatment Administration Record (TAR) for 1 of 3 residents (Resident #45) reviewed for pressure ulcers.</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility on 3/23/21 with diagnoses of, in part, deep tissue injury to right heel and osteomyelitis of coccyx.</p> <p>An admission Minimum Data Set assessment dated 3/30/21 revealed Resident #45 had moderately impaired cognition and required extensive assistance to total dependence on staff for completion of her activities of daily living. Resident #45 was non-ambulatory, able to feed herself after set up, continent of bowel and had an indwelling urinary catheter. Resident #45 was identified as being at risk for pressure ulcer development and presence of 1 or more unhealed pressure ulcers, 1 stage 4 and 1 unstageable pressure ulcer. The resident utilized</p>	F 686	<p>This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #45 is no longer at Universal Healthcare of King.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>100% skin assessment was completed on 5/13/2021. 100% of Treatment</p>		

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F 686	<p>Continued From page 4</p> <p>pressure reducing devices for bed and chair and received pressure ulcer care.</p> <p>A care plan dated 3/30/21 revealed a focus on pressure ulcers to sacrum and right heel. Interventions included treatments as ordered, assess and record measurements, observe for signs and symptoms of infection, diet as ordered, pressure reducing device to bed and wheelchair, turn and position as needed, provide incontinent care, wound vacuum, ankle foot orthosis (AFO) to bilateral lower extremities.</p> <p>A wound assessment dated 3/23/21 completed by the treatment nurse revealed a deep tissue injury to Resident #45 ' s right heel and a Stage 4 pressure ulcer to sacral area.</p> <p>A physician ' s order dated 3/23/21 read, in part, "initiate skin prep to right heel daily, continue (AFO) boot (a pressure reducing device). The order did not include a discontinuation date.</p> <p>A review of Resident #45 ' s TAR for March 23 2021 to March 30, 2021 did not include the orders for skin prep to right heel daily or the AFO boot.</p> <p>A wound assessment dated 3/30/21 completed by the treatment nurse revealed a deep tissue injury to right heel.</p> <p>A physician ' s order dated 3/30/21 read, "skin prep to left heel deep tissue injury daily until resolved", which was the incorrect area.</p> <p>A review of Resident #45 ' s TAR beginning March 23, 2021 to April 19, 2021, when the order was changed, revealed documentation of skin prep to the left heel deep tissue daily until</p>	F 686	<p>Administration Record was reviewed for accuracy of treatments to the appropriate site and pressure relieving device completed on 5/21/2021.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Treatment nurse was educated on transcribing the orders to Treatment Administration Record accurately on 4/30/2021. Treatment nurse received correct action on 4/28/2021.</p> <p>All Licensed nurses will be educated on "Transcribing the orders to Treatment Administration Record accurately. In person or via telephone by the Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by 5/24/2021.</p> <p>Any Licensed Nurse that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by midnight 5/25/2021.</p> <p>All Licensed nurses, including Agency staff before their first assignment, will be educated in orientation in person by Staff Development Nurse or Director of Nursing or Assistant Director of Nursing on "Transcribing the orders to Treatment Administration Record accurately.</p>		

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F 686	Continued From page 5 resolved, which indicated the incorrect area.  Wound assessments for the sacral area and right heel were reviewed with improvements noted.  On 4/28/21 at 11:30 AM, an observation of Resident #45 ' s wounds to her sacral area and left heel were conducted. Resident #45 ' s right heel was also observed. There was a golf ball sized area to Resident #45 ' s outer right heel that appeared dark purple in color. The wound was not open. The right heel had no open areas and no areas of redness observed. Resident #45 ' s sacral area had a large, open area. The wound bed was bright red and the tissue surrounding the wound was pink. There were no obvious signs of infection. The treatment nurse cleaned the area with normal saline and applied the new wound vacuum dressing. Treatment was also completed to the right and left heels. There were no concerns related to the treatment completed. Resident #45 had bilateral AFO boots in place.  On 4/29/21 at approximately 8:15 AM, the treatment nurse was interviewed. He stated the orders should be transcribed to the TAR as they are written, and he must have mixed up his right and left. He stated he applied the skin prep to the correct heel and applied the AFO boot after completing the treatments.	F 686	Director of Nursing, Assistant Director of Nursing, Wound Nurse, and/or Unit Managers will audit 10% of Treatment Administration Record and resident on each hall, 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 2.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is May 24, 2021  Director of Nursing is responsible for implementing the acceptable plan of correction.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		5/24/21	

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F 689	<p>Continued From page 6</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement a physician ordered fall prevention intervention (floor mats) for 1 of 3 (Resident #1) reviewed for falls.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/5/19 with diagnoses of Parkinson ' s disease, dementia and spinal stenosis.</p> <p>A review of a quarterly Minimum Data Set (MDS) assessment dated 4/16/21 revealed Resident #1 had severely impaired cognition, did not ambulate and was dependent on staff for bed mobility and transfers. Resident #1 utilized a wheelchair and was incontinent of bowel and bladder. One fall with injury since admission was documented.</p> <p>A Resident Incident Report dated 2/9/21 at 3:15 AM revealed a nursing assistant found Resident #1 lying on the floor beside the bed. The incident report revealed Resident #1 attempted to get out of bed unassisted and sustained a hematoma to his forehead. No other injury was observed, vital signs were within normal limits, neurological checks were initiated, and a floor mat was added.</p> <p>A review of Resident #1 ' s care plan updated on 4/16/21 with a focus on falls. An intervention for a fall mat to floor was marked out and not dated and added back on 2/9/21.</p>	F 689	<p>Plan of Correction This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Resident #1 was observed with no fall mat implemented as ordered by physician. Fall mat was added to care plan and placed on the floor of the resident on 4/30/2021</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>100% of current resident orders and care plans were reviewed and residents' rooms to ensure accuracy in fall mats and corrected as needed by Director of Nursing, ADON, and unit managers. Completed on May 21, 2021.</p>		

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F 689	<p>Continued From page 7</p> <p>A review of Resident #1 ' physician ' s orders revealed an order dated 11/12/19 for floor mat at bedside and check placement every shift.</p> <p>A review of the Medication Administration Record for April 2021 revealed nurses signed off the order as completed for floor mat at bedside and check placement every shift.</p> <p>On 4/26/21 at 4:22 PM, Resident #1 was observed out of bed to his wheelchair. No fall mat was observed to the floor beside the bed. There was no floor mat observed in the resident ' s room or bathroom area.</p> <p>On 4/27/21 at 8:30 AM, Resident #1 was observed out of bed to his wheelchair. No fall mat was observed to the floor beside the bed. There was no floor mat observed in the resident ' s room or bathroom area.</p> <p>On 4/29/21 at 5:30 AM, an observation was made of Resident #1 lying in bed. There was no fall mat observed to the floor beside the bed and no fall mat was found in the room or in bathroom.</p> <p>On 4/29/21 at 5:35 AM, an interview was conducted with Nursing Assistant #2. She stated when she arrived on her shift, she gets report from the off-going shift. She stated the nurses also tell her what the resident needs. She stated she did not know Resident #1 needed a fall mat.</p> <p>On 4/29/21 at 5:40 AM, an interview was conducted with Nurse #3. She stated fall mats were interventions put into place when a resident fell. She stated Resident #1 had not had a fall in a while, so she didn ' t think he had a fall mat. She stated it may be information that is on the</p>	F 689	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Unit managers, unit coordinators, and ADON were in-serviced on updating the care plan and ensuring that the fall mats are in use per care plan by Director of Nursing on May 19, 2021.</p> <p>CNA□s will be in-serviced on following the Kardex starting May 20, 2021 and completed by midnight of May 25, 2021 by SDC. Any CNA□s there did not receive education by midnight of May 25, 2021 will not be allowed to work until in-service completed.</p> <p>All new hired nurse management will be in-serviced on updating care plan and ensuring fall mats are in use per care plan during orientation by SDC. CNA□s will be educated in orientation by SDC on following the Kardex.</p> <p>DON, ADON, RN unit manager, or unit coordinator, will conduct an audit of all fall mats in place per care plan weekly X 4 weeks, biweekly X 2 weeks, and monthly X 1.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 1</p>		

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F 689	Continued From page 8 Medication Administration to sign off or as a "for your information". She stated she did not know why Resident #1 did not have a fall mat and added several residents have moved from room to room and sometimes their things didn ' t get moved with them.	F 689	for further problem resolution if needed. Date of compliance is May 24, 2021  Director of Nursing is responsible for ensuring continued 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 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	F 880		5/24/21	

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F 880	<p>Continued From page 9</p> <p>persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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, record review, and staff interviews, the facility failed to follow infection control procedures when 1 of 3 staff members</p>	F 880	<p>This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSAL HEALTH CARE/KING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 WHITE ROAD</b> <b>KING, NC 27021</b>		
(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	<p>Continued From page 10</p> <p>(Nurse Aide #1) entered the room of 1 of 1 resident (Resident # 47) who was on contact precautions for Methicillin-resistant Staphylococcus aureus (MRSA) without wearing Personal Protective Equipment (PPE) and did not perform hand hygiene upon exiting the room.</p> <p>The findings Included:</p> <p>A review of the facility's policy entitled Isolation Notices of Transmission-Based Precautions, last revised on 03/2021, revealed the policy references the Center for Disease Control contact precautions policy which states, in part, "Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens."</p> <p>Resident #47 was readmitted to the facility on 3/25/2021 with the following, in part, diagnoses: MRSA right ankle, Acute osteomyelitis right ankle, Bacteremia.</p> <p>An observation was made on 04/26/21 at 12:47 PM of Nurse Aide #1 entering Resident # 47's room and delivering lunch meal tray without putting on a gown or gloves. The resident's door was marked with a contact isolation sign stating you must wear a gown and gloves when entering room and you must perform hand hygiene when entering and exiting rom. Bins on the outside of the door contained gowns and gloves. She entered and exited the room without washing her hands and did not use any type of hand sanitizer. She then proceeded to deliver more trays.</p> <p>An observation was made on 04/27/21 at 08:15</p>	F 880	<p>compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>On 4/26/2021 Nurse Aide #1 was noted not donning PPE before entering resident #47 Contact Precaution room when delivering lunch meal. Nurse Aide #1 was also noted to exit the room without washing her hands or using hand sanitizer, then preceded to delivery more trays. On 4/27/2021 Nurse Aide #1 was noted not donning PPE before entering resident #47 Contact Precaution room when delivering breakfast. Nurse Aide was also noted to exit the room without washing her hands or using hand sanitizer upon exiting into the hallway.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All residents have the potential to be affected by the alleged deficient practice. Staff members that enter and exit Contact Precautions rooms have been observed Doffing and Donning PPE using proper infection control techniques.</p>		

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F 880	<p>Continued From page 11</p> <p>AM of Nurse Assistant #1 was seen in Resident # 47's room delivering his breakfast meal tray and did not have on gown or gloves. She exited the room without washing her hands and did not use any type of hand sanitizer upon exiting into the hallway.</p> <p>An interview on 04/27/21 at 08:20 AM revealed that Nurse Assistant #1 stated she did not think Resident #47 was still on contact precautions because he had been readmitted to the facility from the hospital over a month ago. She thought he should be off precautions by now.</p> <p>An interview with the Infection Prevention Nurse at 11:45 AM on 4/29/2021 revealed education is provided upon hiring, and yearly, to all staff regarding infection control practices, policies and procedures including airborne and contact isolation requirements.</p> <p>An interview with the Administrator at 1:40 PM on 4/29/2021 revealed all staff had been made aware of the facility's contact precaution's policy that was revised and updated on March 2021 and the interim director of nursing and the infection control nurse were in the process of re-educating all staff on the importance of following the policy.</p>	F 880	<p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Nurse Aide #1 was given re-education by Staff Development Coordinator on 4/27/2021 on donning and doffing of PPE, infection control practices, when to don and doff PPE when entering isolation rooms.</p> <p>On 4/27/2021 Nurse Aide #1 received corrective action.</p> <p>All staff will be re-educated on proper donning and doffing of PPE, infection control practices, and when to don and doff PPE when entering a Contact Precaution room on the following days 4/27/2021 □ 5/24/2021 by Staff Development Coordinator or designee. Staff that did not receive the education before midnight of 5/25/2021 will not be able to work until they do so.</p> <p>New hires will not be permitted to start an assignment until they have been educated on donning and doffing PPE, infection control practices, when to don and doff PPE when entering a Contact Precaution room.</p> <p>An audit will be completed on three designated staff members 5 days/week x 2 weeks, three times a week x 2 weeks, weekly x 1 month. Results of the audit will be reported to the Administrator. Any staff</p>		

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

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F 880	Continued From page 12	F 880	<p>found not to be following infection control protocols will have progressive disciplinary action.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Date of compliance is May 24, 2021</p> <p>The Administrator is responsible for implementing the acceptable plan of correction.</p>		