IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 24, 2018

Lari Storro, Administrator
Liberty Dialysis Sandpoint
1210 Washington Ave
Sandpoint, ID 83864

RE: Liberty Dialysis Sandpoint, Provider #132522

Dear Ms. Storro:

This is to advise you of the findings of the Medicare survey of Liberty Dialysis Sandpoint, which was conducted on August 17, 2018.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the ESRD into compliance, and that the ESRD remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **September 6, 2018,** and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

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

PRINTED: 08/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	132522	A. BUILDING _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY DIALYSIS - SANDPOINT	1210 WASHINGTON AVE SANDPOINT, ID 83864

(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
V 000	INITIAL COMMENTS [CORE] The following deficiency was cited during the recertification survey at your facility from 6/25/18 - 6/29/18. The surveyor conducting the survey was: Trish O'Hara, RN, HFS Acronyms used in this report include: d/c - discontinue d/t - due to EMR - Electronic Medical Record ER - Emergency Room ICHD - Incenter Hemodialysis mg - milligram PCT - Patient Care Technician PD - Peritoneal Dialysis QAI - Quality Assurance and Improvement RN - Registered Nurse	V 000		
V 634	QAPI-INDICATOR-MEDICAL INJURIES/ERRORS CFR(s): 494.110(a)(2)(vi) The program must include, but not be limited to, the following: (vi) Medical injuries and medical errors identification. This STANDARD is not met as evidenced by: Based on review of records, incident reports, and staff interview, it was determined the facility failed to ensure accurate patient incident data was gathered and analyzed. This failure directly impacted 3 of 5 ICHD patients (Patients #1, #2, and #5) whose records were reviewed, and had	V 634		

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

Director of Operations 9-5-18

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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V 634	Continued From page 1	V 634		

the potential to impact all patients in the facility. Failure to gather and analyze accurate incident report information significantly impeded the facility's ability to develop and implement appropriate corrective action plans necessary to minimize the potential for incidents to reoccur. The findings include:

Adverse occurrences were not reported, as follows:

- Patient #2 was an 81 year old male. His physician ordered dialysis prescription, dated 5/31/18, included Heparin (an anticoagulation medication) to be administered per machine pump at a rate of 1000 units/hour for his 4 hour treatment, for a total of 4000 units.

Patient #2's 7/12/18 treatment sheet documented a total Heparin pump dose given as 3600 units.

His 7/19/18 treatment sheet documented a total Heparin pump dose given as 2000 units.

His 8/02/18 treatment sheet documented a total Heparin pump dose given as 3000 units.

No medication error reports could be found for these events.

In an interview on 8/17/18 at 9:00 AM, the clinical manager said the dose documented was manually entered into the record and the discrepancies could be due to incorrect entry or incorrect manual calculation.

- Patient #5 was a 60 year old female. Her physician ordered dialysis prescription included Heparin to be administered per machine pump at

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V 634	Continued From page 2 a rate of 1000 units/hour, for 2.75 hours of her 3.75 hour treatments, for a total of 2750 units. Patient #5's 6/29/18 treatment sheet documented a total Heparin pump dose given as 3700 units. Her 7/02/18 treatment sheet documented a total Heparin pump dose given as 3100 units. Her 7/17/18 treatment sheet documented a total Heparin pump dose given as 3200 units. No medication error reports could be found for these events. In an interview on 8/17/18 at 9:00 AM, the clinical manager said the dose documented was manually entered into the record and the discrepancies could be due to incorrect entry or incorrect manual calculation. - Patient #1 was a 66 year old male who dialyzed incenter from 6/29/18 - 7/27/18. He was prescribed a 4 hour treatment three times a week. On 6/29/18, the physician ordered Heparin to be administered as 1000 units/hour per machine pump for his 4 hour treatment, for a total of 4000 units. On 7/13/18 Patient #1's treatment sheet documented no bolus or intermittent Heparin had been administered. On 7/20/18 Patient #1's treatment sheet documented a total Heparin pump dose of 3000 units. No medication error reports could be found for these events.	V 634		

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V 634	Continued From page 3 In an interview on 8/17/18 at 9:00 AM, the clinical manager said she did not know why incorrect Heparin doses had been given on 7/13/18 and 7/20/18. Additionally, on 7/11/18 the physician ordered Venofer (an iron medication) for Patient #1. This was to be given as 100 mg/treatment for 5 consecutive treatments starting 7/11/18. The first dose was given on that date. However, no Venofer dose was documented as having been given on the next consecutive treatment date of 7/13/18. No medication error report could be found for this event. In an interview on 8/17/18 at 9:00 AM, the clinical manager said the EMR tracked medication orders and printed labels for appropriate administration dates. She said the EMR sometimes did not print the correct labels and medications were missed. Patient #1 dialyzed using PD from 7/28/18 - 8/5/18. He returned to ICHD on 8/06/18. His Heparin was ordered as 7600 units/hour per machine pump for his 4 hour treatment, for a total of 30,400 units. On 8/06/18 Patient #1's treatment sheet documented a total Heparin pump dose of 2000 units. No medication error report could be found for this event. In an interview on 8/17/18 at 9:00 AM, the clinical manager said Patient #1 had returned to ICHD	V 634		

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V 634	Continued From page 4 from the PD program on 8/06/18 and his Heparin pump dose order had been incorrectly entered into the EMR. She said the order should have been entered as 1000 units/hour rather than 7600 units/hour. Further, Patient #1 had a PD catheter surgically repositioned on 8/08/18 prior to his incenter treatment. A PCT note on Patient #1's 8/08/18 treatment sheet stated "Patient alert; Treatment discontinued without problem; Per pt and wife, he wants to be d/c from tx d/t bleeding. He wants to go to ER. RN aware." The RN documented "tx d/ced pt sent to bgh er per dr order. d/ced v/s stable." There was no further documentation. In an interview on 8/17/18 at 11:00 AM, the PCT said Patient #1 had experienced profuse bleeding from his PD catheter surgical site that staff could not stop. She said the patient had been transported to the local hospital via ambulance. The RN was not available for interview. No adverse occurrence report could be found for this event. Adverse occurrences were not recognized and reported to the QAI committee for review.	V 634		

Fresenius Medical Care
Dba
Plan of Correction for Sandpoint
Medicare ESRD Recertification Survey
Date of Survey: 8/17/2018

E006

The Director of Operations reviewed the Guidelines for Emergency Preparedness, with the Facility Administrator on 8/28/2018. On 08/30/18 the Facility Administrator held a staff meeting with all In-Center and Home staff on the following policies:

- FMS-CS-IC-II-130-014A Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D1 Facility Specific Disaster Safety Plan form

Educational emphasis was placed on:

- The Interdisciplinary Team (including the Medical Director) led by the Director of Operations or Area Manager will annually complete the Hazard Vulnerability Assessment (HVA) spreadsheet identifying hazardous events that may affect clinic operations.
- On 8/28/2018 the HVA was updated to include the local logging company as a fire hazard. This was placed in the Emergency Preparedness binder.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 08/29/18.

Effective 9/1/2018 the Facility Administrator will audit quarterly the emergency plan, ensuring that all paperwork is not outdated, utilizing the Clinical practice audits for emergency preparedness. The Governing Body has determined this will be an ongoing audit of the emergency plan, to be reported in the Quality Assessment and Improvement meeting on a quarterly basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The Facility Administrator is responsible for overall compliance.

The deficiency was corrected on 9/16/2018

Fresenius Medical Care
Dba
Plan of Correction for Sandpoint
Medicare ESRD Recertification Survey
Date of Survey: 8/17/2018

E031

The Director of Operations reviewed the Guidelines for Emergency Preparedness, with the Facility Administrator on 8/28/2018. On 08/30/18 the Facility Administrator held a staff meeting with all In-Center and Home staff on the following policies:

•FMS-CS-IC-II-130-014A Emergency Preparedness Plan Policy
•FMS-CS-IC-II-130-013 D3 Patient Emergency Contact List
•FMS-CS-IC-II-130-013- D3 Staff Emergency Contact Information
•FMS-CS-IC-II-130-013D2 Facility Emergency Information Directory

Educational Emphasis was placed on:

•Create and maintain staff, patient and facility emergency information contact lists
•Quarterly, the Facility Administrator or designee will review and update: The FKC Facility Emergency Information Directory
•Quarterly, the Facility Administrator will review and update: Patient Emergency Contact List, and Staff Emergency Contact Information, update the patient roster.

- On 8/28/2018 the county emergency numbers were added to the information numbers list.
- All direct patient care and non-direct patient care staff are given this information during orientation and reminded during annual staff meetings.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 08/29/18.

Effective 9/1/2018 the Facility Administrator will perform an audit quarterly of the emergency plan, ensuring that all contact information for staff and patients are not outdated. The Governing Body has determined this will be an ongoing audit of the emergency plan, to be reported in the Quality Assessment and Improvement meeting on a quarterly basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The Facility Administrator is responsible for overall compliance.

The deficiency was corrected by 9/16/2018.

Fresenius Medical Care
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Plan of Correction for Sandpoint
Medicare ESRD Recertification Survey
Date of Survey: 8/17/2018

E033

The Director of Operations reviewed the Guidelines for Emergency Preparedness, with the Facility Administrator on 8/28/2018. On 08/30/18 the Facility Administrator held a staff meeting with all In-Center and Home staff on the following policies:

•FMS-CS-IC-II-130-014A Emergency Preparedness Plan Policy
•FMS-CS-IC-II-130-013 D3 Patient Emergency Contact List
•FMS-CS-IC-II-130-013- D3 Staff Emergency Contact Information
•FMS-CS-IC-II-130-013D2 Facility Emergency Information Directory

Educational Emphasis was placed on:

•The facility developed a communication plan for all patients (in-center and home) for sharing of patient information. This has been placed into the emergency plan binder.
    •All dialysis patient's demographics, orders, and transfer sheets will be located in the emergency binder located in the Crash Cart. These will be updated quarterly with new information, and monthly with new admissions.
•Create and maintain staff, patient and facility emergency information contact lists
•Quarterly, the Facility Administrator or designee will review and update: The FKC Facility Emergency Information Directory
•Quarterly, the Facility Administrator will review and update: Patient Emergency Contact List, and Staff Emergency Contact Information, update the patient roster.

- On 8/31/2018 all information was updated with new orders, and current patient information, for both in-center and home patients.
- All direct patient care and non-direct patient care staff are given this information during orientation and reminded during annual staff meetings.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 08/29/18.

Effective 9/1/2018 the Facility Administrator will perform an audit quarterly of the emergency plan, ensuring that all contact information for staff and patients are not outdated. The Governing Body has determined this will be an ongoing audit of the emergency plan, to be reported in the Quality Assessment and Improvement meeting on a quarterly basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The Facility Administrator is responsible for overall compliance.

The deficiency was corrected by 9/16/2018.

Fresenius Medical Care
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Plan of Correction for Sandpoint
Medicare ESRD Recertification Survey
Date of Survey: 8/17/2018

E034

The Director of Operations reviewed the Guidelines for Emergency Preparedness, with the Facility Administrator on 8/28/2018. On 08/29/18 the Facility Administrator held a staff meeting with all In-Center and Home staff on the following policies:

- FMS-CS-IC-II-130-001A FMS Annual Facility Local Disaster Management Agency Contact Information Plan Policy
- FMS-CS-IC-II-130-001C FKC Annual Facility Local Disaster Management Agency Contact Information Plan
- FMS-CS-IC-II-130-001D1 Annual Notification Requirement Letter
- FMS-CS-IC-II-130-001D2 Local Emergency Operations Center Annual Contact Confirmation Form

Education emphasis was placed on:

- The facility developed a communication plan for all patients (in-center and home) for sharing of patient information. This has been placed into the emergency plan binder.
- All dialysis patient's demographics, orders, and transfer sheets will be located in the emergency binder located in the Crash Cart. These will be updated quarterly with new information, and monthly with new admissions.
- 8/31/18 Facility Administrator will re contact Local contact with the EOC to include what elements in the facility we have in cooperation with the county emergency team.
- Ensure Facility Administrators, Director of Operations, Clinic Manager perform the annual contact to Local Disaster Management.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 08/29/18.

Effective 9/1/2018 the Facility Administrator will audit quarterly the emergency plan, ensuring that all paperwork is not outdated, utilizing the Clinical practice audits for emergency preparedness. The Governing Body has determined this will be an ongoing audit of the emergency plan, to be reported in the Quality Assessment and Improvement meeting on a quarterly basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The Facility Administrator is responsible for overall compliance.

The deficiency was corrected by 9/16/2018.

Fresenius Medical Care
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Plan of Correction for Sandpoint
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Date of Survey: 8/17/2018

E039

The Director of Operations reviewed the Guidelines for Emergency Preparedness, with the Facility Administrator on 8/28/2018. On 08/30/18 the Facility Administrator held a staff meeting with all In-Center and Home staff on the following policies:

- FMS-CS-IC-II-130-014A Guidelines for Emergency Preparedness Policy
- FMS-CS-IC-II-130-014D1 Facility Specific Disaster Safety Plan Form

Education emphasis was placed on:

- On 9/27/2018 Facility will re hold the Table Top Drill on Loss of water, all staff will participate in active drill.
- Facility has scheduled 2nd Table Top Drill on Bomb threat for 10/25/2018.
- Facility Administrator is working with the Local Police Department to finalize a date for a Community wide disaster drill on an Active Shooter this fall.
- Ensure Facility participates in 2 Table top drills a year Documented in eQuip for the Quality Assessment Improvement Meeting.
- Ensure Facility participates in 1 Community Drill a year, Documented in eQuip for the Quality Assessment Improvement Meeting.

For those direct patient care staff that were not in attendance at the staff meeting, a 1:1 educational in-service was delivered on 08/29/18.

On 09/04/18, Facility administrator held a Governing Body meeting with the schedule of the proposed dates for the 2 Table Top Drills and Community Drill. The Facility Administrator will conduct semi-annual audits utilizing the emergency preparedness checklist in the Clinical Practice Audits. The Governing Body has determined the facility will continue on-going frequency of the 2 Table Top Drills and the 1 Community Based Drill. This will be discussed in the Quality Assessment Improvement meetings. Further discussion will follow the Quality Assessment Improvement meeting calendar on a semi-annual basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review finders, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

The in-service sheets are available in the clinic for review.

The Facility Administrator is responsible for overall compliance.

The deficiency was corrected by 9/16/2018.

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V634

On 8/30/2018, the Facility Administrator, held a staff meeting with all In-center and Home staff and reinforced the expectations and responsibilities of the facility staff on Policies:

- FMS-CS-IC-I-101-001A Quality Assessment and Performance Improvement Program (QAPI) Policy
- FMS-CS-IC-II-165-001A Patient Adverse Event Policy

Educational Emphasis was placed on staff practice:

- Learning Modules System: Adverse Event Training, has been assigned to all staff, to ensure the knowledge of what is an adverse event. Completion of module will be completed by 9/16/2018.
- Ensure complete documentation in accordance with Quality Assessment Improvement and Adverse Event Policies are followed.
- Ensure adverse event is documented in patient health record.
- Ensure event has been entered into the Adverse Event Summary for Hemodialysis or Peritoneal Dialysis.
- Ensure Facility Administrator is notified of Adverse Event.
- Ensure the Quality Assessment and Performance Improvement Program held monthly, Reviews and evaluates each individual Adverse Event.
- Ensure Trending patient safety, outcome, and ways to prevent said event if applicable in Quality Assessment and Improvement.
- If trend is found, Root Cause Analysis is completed, and documented in Quality Assessment Improvement.
- Action plans will be created to work and update the process of the analysis and the progress of initiations.

For those Direct Patient Care staff that were not in attendance at the staff meeting, were given a 1:1 educational in-service by 08/29/18.

Effective 9/1/2018, Facility Administrator or designee will conduct Bi-weekly preparation for Quality Assessment Improvement using equip adverse event entry log tool with documentation of checking Adverse Events from Staff. Quality Assessment Improvement minutes to include a greater focus on adverse events and their outcomes for the next 6 Months. This will be completed utilizing the Audit Tool for QAI prep Adverse Events.
Effective 9/1/2018 , Facility Administrator or designee will conduct treatment sheet audits on 1 shift of treatment sheets 3 times a week for 4 weeks. These audits will be over multiple days, and shifts to ensure that each patient and staff member are audited on documentation and reporting of Adverse Events. This will be completed utilizing the Audit Tool for Treatment Sheets.
Effective 9/1/2018, Facility Administrator or designee will conduct review of 50% of PD treatment sheets a month, for 3 months, to ensure that documentation and reporting of Adverse Events. This will be completed utilizing the Audit Tool for Treatment Sheets. The Governing Body will determine on-going frequency of the audits based on compliance. Once 100% compliance is sustained monitoring will be done through the equip Adverse Event entry log Audit per the Quality Assessment Improvement Calendar, 3 times a month basis.

Any ongoing non-compliance by staff, per the Conditions for Coverage and the Fresenius Kidney Care policy, will be addressed with corrective action as appropriate.

The Facility Administrator is responsible to review, analyze, and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the Quality Assessment Improvement Committee monthly.

The Director of Operations is responsible to present the status of the Pan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.

The Quality Assessment Improvement Committee is responsible to provide oversight, review findings, and take actions as appropriate.

The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

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The in-service sheets are available in the clinic for review.

Facility Administrator is responsible for overall compliance.

The deficiency will be corrected by 9/16/2018.