STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015228	A. BUILDING _____ B. WING _____	**09/15/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDAR CREST	**4490 VIRGINIA LOOP ROAD MONTGOMERY, AL 36116**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure care plans were developed for pressure ulcer prevention for RI (Resident Identifier) #1, a resident who was assessed as being at risk for developing pressure ulcers. As a result of not having a plan of care with individualized approaches for prevention of pressure ulcers, RI #1 developed a stage three pressure ulcer on 8/31/2016. This failure affected one of four sampled residents whose care plans were reviewed. Findings Include: Review of a facility policy titled Skin Management with a revision date of 8/2012 revealed the following: . NEWLY admitted RESIDENTS . 3. Appropriate preventive services .will be implemented on all residents identified at risk (score of 18 or less on the Braden Scale - For Predicting Pressure Sore Risk), and the interventions documented on the Care Plan. 6. A Care Plan is developed upon admission, identifying the contributing risks for breakdown, . and the interventions implemented to promote healing and prevent further breakdown. The Care Plan should address, but is not limited to: .Preventive devices . Positioning requirements . Proper body alignment . 1.) RI #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. RI #1's admission Braden Scale assessment form (for predicting pressure sore risk) dated 4/21/2016, on the day of admission, was incomplete and did not have a score totaled. The back side of the Braden Scale assessment form had further guidance for additional risk factors that were checked for RI #1 that revealed, End Stage [MEDICAL CONDITION] and Diabetes Mellitus were co-morbid conditions. RI #1's admission MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 4/27/2016, revealed a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The MDS also revealed RI #1 required extensive assistance of two or more persons for bed mobility, had limitations in both lower extremities, was at risk for pressure ulcer development, and had two stage one pressure ulcers at the time of admission. RI #1's Braden Scale assessments dated 4/27/2016, 5/3/2016, and 5/10/2016 revealed a score of 15, a mild risk for pressure ulcer development. RI #1's Braden Scale assessment dated [DATE], revealed a score of 14, a moderate risk for pressure ulcer development. RI #1's Braden Scale assessments dated 6/6/2016 and 7/27/2016 both revealed a score of 13, a moderate risk for pressure ulcer development. On 08/31/2016 at 8:38 p.m., the Division of Health Care Facilities Complaint Unit received a call from RI #1's spouse which revealed the following: . (spouse) received a call from the facility notifying . (of) the areas on (RI #1's) legs . (spouse stated RI #1 was) not being turned . is unable to position (self) . and is at risk for pressure ulcers . A review of RI #1's care plans revealed the facility failed to develop an individualized plan of care that included interventions for pressure ulcer prevention. RI #1's care plans did not include approaches to address RI #1's risk for pressure ulcer development or actual ulcers present at the time of admission. A review of RI #1's Progress Notes revealed the following: . 8/31/2016 17:20 (5:20 p.m.) . Resident has . wounds on . left ankle. A review of RI #1's WEEKLY PRESSURE ULCER RECORD dated 9/1/2016, with Initial Evaluation checked and Plan of Care Updated checked yes, revealed a stage three wound that contained necrotic tissue on the left lateral leg measuring three by 0.9 centimeters. On 9/13/2016 at 2:10 p.m., RI #1 was observed in bed on his/her back with the head of the bed elevated. RI #1's left outer ankle was turned to the left, lying on the bed, and covered with a bandage. On 9/13/2016 at 6:00 p.m., EI (Employee Identifier) #2, RN (Registered Nurse) Treatment Nurse, was asked when the area was first noticed. EI #2 said, one night last week and she assessed it the next day. EI #2 further said, RI #1's left leg just flops that way. When asked what was done to position RI #1 to keep the ankle from lying on the bed, EI #2 said, RI #1 was provided with a bigger bed. When asked when the bed was provided, EI #2 said, 9/2/2016 (after the wound on the ankle had already been identified). When asked why RI #1 received the bed at that time, EI #2 said, RI #1's spouse was asking constantly for RI #1 to be turned every two hours or more. When asked how often RI #1 was being turned, EI #2 said, RI #1 did not have a turn schedule, and the staff turned and repositioned RI #1 as often as they could. On 9/14/2016 at 11:15 a.m., EI #9 MDS Coordinator, was asked who was responsible for developing care plans for pressure ulcer prevention. EI #9 said, MDS. When asked why RI #1 did not have a care plan to address pressure ulcer prevention, EI #9 said, RI #1 should have had one, and she would have to check the chart. When asked what the harm was in not having a care plan for pressure ulcer prevention, EI #9 said, developing a pressure ulcer. On 9/14/2016 at 3:25 p.m., EI #4 CNA (Certified Nursing Assistant) was asked how she knew what to do for RI #1. EI #4 said, the Kardex. When asked what RI #1's cardex documented for prevention of pressure ulcers, EI #4 said, to turn every two hours with two person assist. When asked what other information the cardex documented about pressure ulcer prevention, EI #4 said, preventive care was checked. EI #4 was asked what that included. EI #4 said, It doesn't tell me. When asked what her observation was of why RI #1's left leg leaned to the left side, EI #4 said, Because, (RI #1) doesn't have the wedge up under (him/her) to support it. When the pillow is used it (left leg) flops to the side. EI #4 was asked how she usually found RI #1 positioned. EI #4 replied, Mostly on (RI #1's) back with (RI #1's) left leg flopped over and the pillow is being used under (RI #1's) foot and (RI #1's) ankle and the left leg/foot is turned out to the left. When asked what she used to position RI #1. EI #4 said, two pillows or a wedge. When asked how well the pillows held up, EI #4 said, not good. When asked what happened to the pillows, EI #4 replied, When you put them behind (RI #1), (because of RI #1's) weight, they will be flat when you go back to position (RI #1). When asked if she had asked anybody about something stronger to use for a positioning device, EI #4 said, no, because she sometimes used a wedge when she could find one, but if not, she just used the pillows. On 9/14/2016 at 4:00 p.m. EI #2, RN Treatment Nurse was again interviewed and was asked why RI #1 did not have a care plan developed for the prevention of pressure ulcers. EI #9 said, she did not know why and MDS should know. When asked why RI #1 should have a care plan for being at risk for developing pressure ulcers, EI #9 said, Because we want to prevent (RI #1) from getting any breakdown. When asked what harm RI #1 suffered in not having a care plan for pressure ulcer risk, EI #9 said, RI #1 had an ulcer to develop. When asked how staff knew how to position RI #1 to best prevent wounds without a care plan, EI #9 said, they would not know. On 9/15/2016 at 9:35 a.m. EI #1 DON (Director of Nursing), was asked why individualized care plans were not developed for

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

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F 0279 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) prevention of pressure ulcers for RI #1. EI #1 said she could not say why care plans were not there, but they should have been. When asked what harm RI #1 suffered because there were no care plans for pressure ulcer prevention and there were not any measures in place for the staff to follow, EI #9 said, RI #1 developed a wound without a care plan in place. This deficiency was cited as a result of the investigation of complaint/report number AL 641.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure RI (Resident Identifier) #1, a resident assessed to be at risk for pressure ulcer development, was turned and repositioned in bed to prevent pressure ulcer development. There was no plan of care in place to address RI #1's risk for pressure ulcer development. As a result, RI #1 developed a stage three pressure ulcer on the left lower leg. This affected one of three residents sampled for pressure ulcers. Findings included: Review of a facility policy titled Skin Management, with a revision date of 8/2012, revealed the following: . NEWLY admitted RESIDENTS . 3. Appropriate preventive surfaces of beds, . will be implemented on all residents identified at risk (score of 18 or less on the Braden Scale - For Predicting Pressure Sore Risk), and the interventions documented on the Care Plan. 6. A Care Plan is developed upon admission, identifying the contributing risks for breakdown, . and the interventions implemented to promote healing and prevent further breakdown. RI #1 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. RI #1's admission Braden Scale assessment form (for predicting pressure sore risk) dated 4/21/2016, on the day of admission, was incomplete and did not have a score totaled. The back side of the Braden Scale assessment form had further guidance for additional risk factors that were checked for RI #1 that revealed End Stage [MEDICAL CONDITION] and Diabetes Mellitus were co-morbid conditions. RI #1's admission MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 4/27/2016, revealed a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The MDS also revealed RI #1 required extensive assistance of two or more persons for bed mobility, had limitations in both lower extremities, was at risk for pressure ulcer development, and had two stage ones present on admission. RI #1's Braden Scale assessments dated 4/27/2016, 5/3/2016, and 5/10/2016 revealed scores of 15, a mild risk for pressure ulcer development. RI #1's Braden Scale assessment dated [DATE], revealed a score of 14, a moderate risk for pressure ulcer development. RI #1's Braden Scale assessments dated 6/6/2016 and 7/27/2016, revealed scores of 13, a moderate risk for pressure ulcer development. RI #1's quarterly MDS assessment, with an Assessment Reference Date of 7/28/2016, revealed a BIMS score of 15, which indicated intact cognition. The MDS also revealed RI #1 required extensive assistance of two or more persons for bed mobility, had limitations in both lower extremities, was at risk for pressure ulcer development, and had no pressure ulcers present at the time of the assessment. On 08/31/2016 at 8:38 p.m., the Division of Health Care Facilities Complaint Unit received a call from RI #1's spouse which revealed the following: . (spouse) received a call from the facility notifying . (of) the areas on (RI #1's) legs . (spouse stated RI #1 was) not being turned . is unable to position (self) . and is at risk for pressure ulcers . (spouse) said they are located . above (RI #1's) ankle . A review of RI #1's care plans revealed the facility failed to develop an individualized plan of care that included interventions for pressure ulcer prevention. There were no approaches to address RI #1's risk for pressure ulcer development. A review of RI #1's Progress Notes revealed the following: . 8/31/2016 17:20 (5:20 p.m.) . Resident has . wounds on . left ankle. A review of RI #1's WEEKLY PRESSURE ULCER RECORD dated 9/1/2016, with Initial Evaluation checked and Plan of Care Updated checked yes, revealed a stage three wound that contained necrotic tissue that covered 40 percent of the wound bed, on the left lateral leg measuring three by 0.9 centimeters. On 9/12/2016 at 4:35 p.m., during the initial observations of the facility, RI #1 was laying on his/her back on a specialty air mattress with the head of the bed elevated. On 9/12/2016 at 5:25 p.m., during a phone interview, RI #1's spouse stated RI #1 did not receive a new bed (the current specialty air mattress) until last week even though she had been requesting one since April. On 9/13/2016 at 2:10 p.m., RI #1 was observed lying on his/her back in bed with the head of the bed elevated. RI #1's left lateral ankle was turned to the left, lying on the bed, and covered with a bandage. On 9/13/2016 at 2:50 p.m., EI (Employee Identifier) #2, RN (Registered Nurse) Treatment Nurse, changed RI #1's dressing on the left ankle. As EI #2 observed the wound with the surveyor, she described the wound as a stage three that contained white/yellow necrotic tissue that covered more than half of the wound (60 percent). On 9/13/2016 at 6:00 p.m., EI #2 was asked when the area was first noticed. EI #2 said, one night last week and she assessed it the next day. EI #2 further stated, RI #1's left leg just flops to the left side. When asked what was done to position RI #1 to keep the ankle from lying on the bed, EI #2 said, RI #1 was provided with a bigger bed. When asked when the bed was provided, EI #2 said, 9/2/2016 (after the wound on the ankle had already been identified). When asked why RI #1 received the bed at that time, EI #2 said, RI #1's spouse was asking constantly for RI #1 to be turned every two hours or more. When asked how often RI #1 was being turned, EI #2 said, RI #1 did not have a turn schedule, and the staff turned and repositioned RI #1 as often as they could. EI #2 further stated, even when the facility tried to position RI #1 with a pillow, turned to the right side, RI #1's left leg favors turning to the left onto the ankle. On 9/14/2016 at 8:00 a.m. RI #1 was asked how often he/she was turned. RI #1 said, Only when they would bathe me. RI #1 was asked if staff provided repositioning during incontinent care. RI #1 repeated that repositioning only occurred during bathing. RI #1 was asked what kind of pillows or wedges were used for repositioning. RI #1 stated, They didn't use any. I've been on my back since I've been here since April. RI #1's head of the bed was observed elevated, with RI #1 lying on his/her back, with the left leg turned to the side with a pillow under the left ankle and the foot/ankle resting directly on the pillow. RI #1's left heel was not floated (positioned with the heel elevated to eliminate pressure and prevent pressure ulcers). On 9/14/2016 at 8:05 a.m., EI #3 CNA (Certified Nursing Assistant), was asked how she knew what to do for RI #1 for prevention of pressure ulcers. EI #3 said, inservices were provided, some cream was provided to apply to the resident's back and leg, and to make sure the foot was elevated at all times. When asked what kind of care she provided for RI #1 to prevent pressure ulcers, EI #3 said, reposition, keep foot on a pillow with heel protector. When asked how often RI #1 was repositioned, EI #3 said, every two hours, and if the resident did not want to be turned, she would tell RI #1 to use the call light when ready to turn. When asked how often RI #1 would refuse to be turned, EI #1 said, not often, RI #1 cooperates pretty well. On 9/14/2016 at 8:15 a.m. EI #3 was asked to observe RI #1 and describe what she saw. EI #3 said the left foot was floated on a pillow. When asked if the left leg was floated or lying on the pillow, EI #3 said, It's lying on the pillow. When asked what area was to be floated, EI #3 said, the heel. When asked if she actually knew where RI #1's wound area was, EI #3 said, she had not seen the area. When asked about the wound on the side of the leg/ankle and how pressure was being prevented with that area lying on the pillow, EI #3 said, It's not. EI #3 was asked if she thought RI #1's wound was on the heel. EI #3 replied, yes. When asked what she would do differently knowing the wound was on the side of the leg/ankle, EI #3 stated, I would use a wedge. EI #3 pointed to a wedge on the other side of RI #1's room. On 9/14/2016 at 2:10 p.m. EI #3 was again questioned about RI #1. EI #3 was asked what she had observed as to why RI #1's left leg leaned to the left side. EI #3 said, I guess (RI #1) has no control over the left leg and that is why it leans to the left side. When asked how she usually found RI #1's left leg positioned, EI #3 stated, I don't look at the left leg

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) until I get ready to turn (RI #1) and I find it the way you did this morning, laid over on the pillow. When asked why she thought RI #1 felt like repositioning was not being done, EI #3 replied, Maybe because we use the pillow and it is not really strong enough to turn (RI #1) and it just goes down flat. When asked if she had asked anybody for something stronger to use for a positioning device, EI #3 said, no. When asked why she had not told someone about the pillow not being strong enough, EI #3 stated, I didn't think about it until you said (RI #1) didn't feel (he/she) was being turned. On 9/14/2016 at 3:25 p.m. EI #4, a CNA, was asked how often she cared of RI #1. EI #4 said, frequently. When asked what her observation was of why RI #1's left leg leaned to the left side, EI #4 said, Because, (RI #1) doesn't have the wedge up under (him/her) to support it. When the pillow is used it (left leg) flops to the side. EI #4 was asked how she usually found RI #1 positioned. EI #4 replied, Mostly on (RI #1's) back with (RI #1's) left leg flopped over and the pillow is being used under (RI #1's) foot and (RI #1's) ankle and the left leg/foot is turned out to the left. When asked what she used to position RI #1, EI #4 said, two pillows or a wedge. When asked how the pillows held up, EI #4 said, not good. When asked what happened to the pillows, EI #4 replied, When you put them behind (RI #1), (because of RI #1's) weight, they will be flat when you go back to position (RI #1). When asked if she had asked anybody about something stronger to use for a positioning device, EI #4 said, no, because she sometimes used a wedge when she could find one, but if not, she just used the pillows. On 9/14/2016 at 4:15 p.m. EI #2, Treatment nurse, was again interviewed. EI #2 was asked what she had observed happening with RI #1's left leg/ankle. EI #2 stated, When I go in (RI #1) has a dependent area. It turns and favors the left side and the skin gets moist and with dry flaky areas it is easy to get a wound there with it pressing down. EI #2 was asked what devices she had seen used to turn and position RI #1 from side to side. EI #2 replied, they use pads to turn (RI #1) and use pillows behind his/her back and also to elevate the left leg. When asked what she observed happening to the pillows used for positioning RI #1, EI #2 stated, I see them squashed. EI #2 was asked how the pillows were effective if they were flat behind RI #1. EI #2 said, they were not effective. When asked what harm RI #1 had suffered as a result of pillows being used for turning and repositioning, EI #2 said, RI #1 had skin breakdown from the pillows being used. When asked if she had been asked by anyone about using something else to help position RI #1, EI #2 said, no. On 9/15/2016 at 10:25 a.m. EI #2 was again interviewed. EI #2 was asked if RI #1's left ankle wound was avoidable or unavoidable. EI #2 replied, I think we could have done more. We could have consulted PT (physical therapy). (RI #1) does not move at all (him/her) self. When asked what level of dependence on staff RI #1 was for turning and positioning in bed, EI #2 said, total. This deficiency was cited as a result of the investigation of complaint/report number AL 641.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, record review and interviews the facility failed to ensure RI (Resident Identifier) #3's Foley catheter was connected to a drainage bag below the level of the bladder and the leg bag was emptied prior to reaching full capacity of 900 cc (cubic centimeters) per the facility policy to prevent damage to the bladder wall and urethra. This affected one of two residents sampled with catheters. Findings Include: Review of a facility policy titled, Indwelling urinary catheter (Foley) care and management with a revised dated of October 2, 2015 revealed the following: Introduction .When caring for a patient with an indwelling urinary catheter, follow infection prevention practices, such as .properly securing the catheter; keeping the collection bag below the level of the bladder; maintaining unobstructed urine flow; emptying the collection bag regularly .Implementation .Make sure that the catheter is properly secured. Assess the securement device daily and change it when clinically indicated .Clinical Alert .keep the drainage bag below the level of the patient's bladder and hips to prevent backflow of urine into the bladders, which increases the risk of CAUTI (catheter associated urinary tract infections) .Special Considerations Empty the drainage bag regularly when it becomes one-half to two-thirds full to prevent undue traction on the urethra from the weight of the urine in the bag .Teaching About Leg Bags .Leg bags are usually worn during the day and are replaced at night with a standard drainage bag .a leg bag is smaller than a standard drainage bag and may have to be emptied more frequently .Avoiding complications .to keep the drainage bag lower than bladder or hip at all times because the urine in the bag is a growth medium for bacteria. Caution .not to go to bed or to take long naps while wearing the leg bag. To prevent a full leg bag from damaging the bladder wall or urethra, .empty the bag when it's one-half full or every 3 to 6 hours . RI #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of RI #3's physician's orders [REDACTED]. Review of RI #3's admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 08/08/16 revealed RI #3 had an indwelling catheter. Review of RI #3's care plans revealed a care plan for use of an indwelling catheter had not been developed. On 9/13/16 at 9:40 a.m. RI #3's ADL (Activities of Daily Living)/catheter care was observed with RI #3 in bed. RI #3's leg bag was attached to RI #3's leg. EI (Employee Identifier) #1, Director of Nursing, who was in RI #3's room during the care, was asked how much urine did the leg bag hold, to which she replied, 900 cc's. She was then asked how much urine was in the leg bag to which she replied, 900 cc's. During the ADL care, the CNA Certified Nursing Assistant) laid the leg bag on the bed between RI #3's legs. There was not any extra tubing attached from the catheter to the leg bag. On 09/14/16 at 10:40 a.m. EI #7, RN (Registered Nurse)/Unit Manager, was interviewed. She was asked how long RI #3 had the catheter. She stated RI #3 was admitted with it. EI #7 was asked where the catheter was supposed to be positioned when the resident was in bed and out of bed. She stated the catheter should be positioned below the bladder. EI #7 was asked when leg bags were supposed to be used and when were regular drainage bags to be used. EI #7 stated, the leg bags were to be used anytime a resident was up and out of bed and the regular drainage bags were to be used when a resident was in bed. EI #7 was asked how often the catheter bags were supposed to be emptied to which she replied, every shift. EI #7 was then asked what the potential harm was if the catheter bags were not emptied as they should be, she stated if they got too full it could back up into the bladder, cause infections or spasms. When asked what was the potential harm if the catheter bag was not applied/positioned as it was intended, EI #7 stated it could pull the catheter and it could back-fill into the bladder causing infection. On 09/14/16 at 2:18 p.m., EI #5, CNA (Certified Nursing Assistant) was interviewed. EI #5 was asked where the catheter bag was supposed to be positioned when the resident was in the bed. She stated they were supposed to use a regular Foley catheter bag that hangs from the side of the bed when a resident was in the bed and she further stated they are supposed to use a leg bag only when the resident is up and out of the bed. When asked how often a catheter bag was supposed to be emptied she stated it was just like toileting so it should be done every two hours or as needed. When asked what could be the potential harm if the correct bag was not used and positioned where it was supposed to be, EI #5 stated the urine could back up where it should not and cause infections. She stated the same when asked what the potential harm could be if the catheter bags were not emptied as often as they should be. On 09/14/16 at 4:10 p.m., EI #8, MD (Medical Director/Doctor) was asked how often a catheter bag should be emptied and what could be the potential harm if it was not emptied as often as it should be. EI #8 stated it should be emptied every shift depending upon the level of output and size of the bag and if not, it could cause chronic infections, flow could back up if it got extremely full. On 09/15/16 at 9:02 a.m., EI #1, DON was interviewed. She was asked what type of catheter bag was supposed to be used when a resident was in the bed and what type should be used when a resident was out of the bed. She stated when a resident was in the bed they should use the bedside drainage bag and when a resident was out of the bed they should use the leg bag. When asked how often catheter bags should be emptied, EI #1 stated, every shift. EI #1 was asked where catheter bags were supposed to be positioned, to which she replied, below the bladder in the bedside drainage bag or the leg bag. EI #1 was

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F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) asked what type of catheter bag RI #3 had when she observed the ADL care on 09/13/16. EI #1 stated, RI #3 had a leg bag and she did not know why. When asked how full it was, she stated the bag was full with 900 cc's and not positioned below the bladder. When asked what could the potential harm be if the catheter was not emptied as it should be, she replied it could cause skin irritation and could prevent correct flow of the urine which could back up and cause problems. This deficiency was cited as a result of the investigation of complaint/report number AL 641.