

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Momentous Health at Vandalia		STREET ADDRESS, CITY, STATE, ZIP CODE 208 North Cassel Road Vandalia, OH 45377	

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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review, staff interview, and review of the facility policy review, the facility failed to ensure there was a Registered Nurse (RN) scheduled at least eight consecutive hours per day, seven days per week. This had the potential to affect all of the residents residing in the facility. The facility census was 108 residents. Findings include: Findings Include: Review of policy titled Staffing and dated 05/01/22 reveals that the facility should maintain adequate staffing on each shift to ensure resident's needs and services are met. Interview on 03/13/26 at 1:52 P.M. with Chief Operating Officer (COO) #400 confirmed the facility di not have a Registered Nurse(RN) on duty in the facility on 02/28/26. Review of the Minimum Direct Care Daily Average of 2.50 - Survey Tool dated from 02/27/26 through 03/05/26 revealed there was no RN coverage on 02/28/26.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policies the facility failed to implement interventions and provide sufficient supervision to prevent residents from ingesting foreign objects. This affected one (Resident #8) of three residents reviewed for supervision. The facility also failed to ensure fall prevention interventions were in place. This affected one (Resident #7) of three residents reviewed for supervision. The facility also failed to ensure hazardous chemicals were secured. This had the potential to affect the following facility-identified cognitively impaired and independently mobile (Residents (#27, #44, #55, #59, and #80) on the 100 hall. The facility census was 108 residents. Findings include:1. Review of the medical record for Resident #8 revealed an admission date of 11/22/25 with diagnoses including pica, borderline personality disorder, bipolar, morbid obesity, and conversion disorder.</p> <p>Review of a nurse progress note for Resident #8 dated 12/17/25 at 7:04 A.M. revealed while nurse was on the phone the resident put a thumb tack in her mouth. Another nurse tried to get Resident #8 to spit the thumb tack out, but the resident swallowed it. Staff called emergency medical services (EMS) and transported the resident to the hospital.</p> <p>Review of the hospital note for Resident #8 dated 12/17/25 revealed the resident presented to emergency department after swallowing a thumb tack. Resident #8 passed the thumb tack through her digestive tract spontaneously and sustained no injuries.</p> <p>Review of the nurse progress note for Resident #8 dated 01/10/26 revealed the resident told staff she had gotten a battery from a blood pressure cuff at the nurses' station and swallowed it and then called 911. Resident #8 said she had gotten into an argument with her mom, and she swallowed the batter because she was mad. EMS transported Resident #8 to the hospital.</p> <p>Review of the hospital note for Resident #8 dated 01/10/26 revealed the resident was admitted to the hospital for ingestion of two triple A sized batteries. Resident #8 passed the batteries through her digestive tract spontaneously and sustained no injuries.</p> <p>Review of a nurse progress note for Resident #8 dated 01/31/26 revealed the resident told the nurse she ate the battery out of the thermostat. Th nurse called EMS and the resident was transported to the hospital.</p> <p>Review of the hospital note for Resident #8 dated 01/31/26 revealed the resident was admitted to the hospital following ingestion of two double A batteries. The hospital staff successfully removed the batteries from Resident's stomach using a Roth net (a device used to retrieve items from the digestive tract), and the resident sustained no injuries.</p> <p>Review of the care plan for Resident #8 dated 02/03/26 revealed the resident had a behavior problem which included swallowing batteries and other foreign objects.</p> <p>Interview on 03/11/26 at 11:24 A.M. with Licensed Practical Nurse (LPN) #331 confirmed Resident #8 had a behavior of swallowing batteries and/or other foreign objects after she had an argument with her parents or she was told that she couldn't have or do something she wanted to do. (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 03/12/26 1:30 P.M. with the Chief Operating Officer (COO) confirmed Resident #8 was admitted to the facility from a sister facility and had exhibited the behavior of swallowing foreign objects in the sister facility. The COO confirmed they transferred Resident #8 to the facility because she would be able to be in a smaller secured unit where they could provide a higher level of supervision. The COO stated the facility knew upon admission that Resident #8 had the behavior problem of ingesting foreign objects, but the facility did not put a care plan in place regarding the behavior until 02/03/26. The COO confirmed Resident #8 had three incidents of ingesting foreign objects followed by transport to the hospital on [DATE], 01/10/26, and 01/31/26.</p> <p>Interview on 03/19/26 at 2:00 P.M. with the Administrator and the Director of Nursing (DON) confirmed the facility had not completed follow-up investigations to determine root cause and interventions to prevent recurrence for the incidents for Resident #8 on 12/17/25, 01/10/26, and 01/31/26</p> <p>Review of the facility policy titled Safety and Supervision of Residents dated 05/01/22 revealed the facility tried to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The care team should implement targeted interventions to reduce individual risks to hazards in the environment, including adequate supervision (such as 15-minute checks or closer observation) and assistive devices. Other interventions could include specific activities for the residents or taking them for a walk outside the facility.</p> <p>Review of the facility policy titled Falls and Incident Investigations dated 07/22/22 confirmed would investigate all resident occurrences whether falls or incidents to ascertain root cause and have a plan developed to prevent recurrence.</p> <p>2. Review of the medical record for Resident #7 revealed an admission date of 01/05/21 with diagnoses including alcohol abuse, anxiety disorder, and major depressive disorder.</p> <p>Review of the physician's orders for Resident #7 revealed an order dated 04/28/25 for Dycem (a rubberized mat to prevent slipping) to wheelchair every shift.</p> <p>Review of the MDS assessment for Resident #7 dated 12/19/25 revealed the resident had impaired cognition and required staff assistance with activities of daily living (ADLs.)</p> <p>Review of the fall care plan for Resident #7 dated 01/13/26 revealed the resident was at risk for falls related to impaired cognition, impaired mobility, resistance to care, and use of psychotropic drugs. Interventions included the following: bed against wall for environmental enhancement, bed in lowest position at all times unless providing care, bring resident to the common area when restless, Dycem above and below wheelchair cushion, Dycem to wheelchair seat, encourage to remind to ask for assistance, floor mat next to the bed when the resident was in bed.</p> <p>Observation on 03/11/26 at 1:45 P.M. of Resident #7 revealed the resident was lying in bed with no fall mats beside the bed. Next to the bed was Resident #7's wheelchair with no Dycem above or below the wheelchair cushion.</p> <p>Interview on 03/11/26 at 1:45 P.M. with Certified Nurse Aide (CNA) #240 confirmed Resident #7 was lying in bed and did not have a fall mat beside the bed. CNA #240 confirmed the wheelchair parked next to Resident #7 belonged to the resident and did not have Dycem above or below the wheelchair (continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on record review, staff interview, and review of the facility policy, the facility failed to ensure current and accurate documentation of resident advanced directives were included in the medical record. This affected four (Residents #6, #24, # 27, # 65) of 32 residents reviewed for advanced directives. The facility census was 108 residents. Findings include:1.Review of the medical record for Resident #24 revealed an admission date of 08/29/24 with diagnoses including chronic pain syndrome, major depressive disorder, and bipolar disorder.</p> <p>Review of the physician's orders for Resident #24 revealed an order dated 03/12/25 for a code status of Do Not Resuscitate Comfort Care (DNRCC.)</p> <p>Review of the care plan for Resident dated 12/05/25 revealed the resident had a code status of DNRCC.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #24 dated 12/09/25 revealed the resident was cognitively intact.</p> <p>Review of the hard (physical) chart for Resident #24 revealed there was a sticker undated on the outside of the chart indicating the resident was a full code status.</p> <p>Interview on 03/10/26 at 10:47 A.M. with Registered Nurse (RN) #223 confirmed the code status sticker on the outside of Resident #24's chart did not match the order in the resident's record.</p> <p>2. Review of the medical record for Resident #65 revealed an admission date of 03/01/18 with diagnoses including cerebral infarction, fracture of left femur, and vascular dementia.</p> <p>Review of the physician's orders for Resident #65 revealed an order dated 05/19/25 for the resident to be a full code status.</p> <p>Review of the care plan for Resident #65 dated 11/24/25 revealed the resident's code status was DNRCC.</p> <p>Review of the Resident #65's hard (physical) chart revealed it contained a signed and completed state of Ohio DNRCC form.</p> <p>Interview on 03/10/26 at 10:48 A.M. with RN #223 confirmed orders in hard chart did not match orders in the EHR.</p> <p>3. Review of medical record for Resident #6 revealed an admission date of 03/14/24 with diagnoses including generalized muscle weakness, chronic obstructive pulmonary disease, and chronic pain syndrome.</p> <p>Review of the care plan for Resident #6 dated 11/25/25 revealed the resident's code status was full code.</p> <p>Review of the physician's orders for Resident #6 revealed an order dated 01/14/26 for the resident to (continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>have a code status of DNRCC.</p> <p>Review of the MDS assessment for Resident #6 dated 02/25/26 revealed the resident was cognitively intact.</p> <p>Review of the care plan for Resident #6 dated 11/25/25 revealed the resident's code status was full code.</p> <p>Review of the face sheet for Resident #6 undated revealed the resident's code status was full code.</p> <p>Interview on 3/10/26 at 10:46 A.M. with Licensed Practical Nurse (LPN #320) confirmed the face sheet and the care plan indicated Resident #6's was a full code, but the resident's order was for DNRCC.</p> <p>4. Review of medical record for Resident #27 revealed an admission date of 3/05/20 with diagnoses including traumatic brain injury, dementia, and bipolar disorder.</p> <p>Review of the MDS assessment for Resident #27 completed on 12/10/25 revealed the resident had severe cognitive impairment.</p> <p>Review of the physician's orders for Resident #27 undated revealed an order dated 02/05/24 for the resident to have a code status of DNRCC.</p> <p>Review of the face sheet for Resident #27 undated revealed the resident's code status was full code.</p> <p>Interview on 3/10/26 at 10:47 A.M. with RN #216 confirmed Resident #27's face sheet indicated the resident's code status was full Code which did not match the physician's order in the resident's chart.</p> <p>Review of facility policy titled Advance Directives dated 05/01/22 revealed the resident's advanced directives would be reviewed upon admission, readmission from the hospital, quarterly, and annually by the social worker. Documentation of the review should be noted on the advance directive care plan, quarterly social work assessment, and/or admission/annual advance directive information form.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on review of the medical record, observation, resident interview, staff interview, and review of the facility policy, the facility failed to maintain resident rooms in good repair. This affected two (Residents #69 and #80) of 32 residents reviewed The facility census was 108 residents. Findings include: 1. Review of the medical record for Resident #80 revealed an admission date on 12/11/25 with diagnoses including paranoid schizophrenia, presbyopia, and diabetes mellitus two. Review of the Minimum Data Set (MDS) assessment for Resident #80 dated 12/26/25 revealed resident had moderate cognitive impairment. Observation on 03/09/26/26 at 5:02 P.M. of Resident #80's room revealed there were multiple small holes on the bedroom wall and the outside of the bathroom door had scratches and chipped paint. Interview on 03/09/26 at 5:02 P.M. with Resident #80 confirmed she did not like the holes on the bedroom wall and she felt the bathroom door with the scratches and chipped paint should be repaired. Interview on 03/16/26/26 at 9:18 A.M. with Maintenance Assistant (MA) #313 confirmed there were multiple small holes in Resident #80's wall made by screws which should have been filled in with plaster and repaired. MA #313 confirmed Resident #80's bathroom door was scratched and needed to be repainted. 2. Review of the medical record for Resident #69 revealed an admission date of 03/04/26 with diagnoses including, cerebral infarction, major depressive disorder, and diabetes mellitus. Review of the MDS assessment for Resident #69 dated 02/26/26 revealed resident was cognitively intact. Observation on 3/09/26 at 9:14 A.M. of Resident #69's room revealed the bedroom door was difficult to shut as the door was cracked and got caught on the door frame. Interview on 03/09/26 at 10:13 A.M. with Resident #69 confirmed she was concerned about her bedroom door being in poor repair and that the door was unable to be fully closed. Interview on 3/16/26 at 9:14 A.M. with MA #313 confirmed Resident #69's bedroom door needed the hinges adjusted so it would not catch on the door frame and there were cracks on the side of the door. Review of facility policy titled Homelike Environment dated 05/01/22 revealed that facility would provide a homelike and orderly environment for the residents.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to develop comprehensive care plans to address residents' identified needs. This affected three (Residents #42, #9, and #8) of four residents reviewed for care plans. The facility census was 108 residents. Findings include: 1. Review of the medical record for Resident #42 revealed an admission date of 12/03/25 with diagnoses including osteoarthritis, obstructive sleep apnea, and congestive heart failure.</p> <p>Review of the care plan for Resident #42 initiated 12/03/25 revised 12/31/25 revealed the resident was at risk for potential pain or discomfort. Further review of the care plan revealed it did not include interventions related to pain management.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 01/07/26 revealed the resident was cognitively intact.</p> <p>Review of the physician's orders for Resident #42 revealed an order dated 01/19/26 for Voltaren gel to be applied to the right shoulder topically every six hours as needed for pain.</p> <p>Interview on 03/09/26 at 1:12 P.M. with Resident #42 confirmed he frequently requested his as needed Voltaren gel for his right shoulder pain.</p> <p>Interview on 03/11/26 at 11:59 A.M. with Licensed Practical Nurse (LPN) #231 verified Resident #42 had a pain care plan which did not include pain management interventions.</p> <p>2. Review of the medical record for Resident #9 revealed an admission date of 03/11/24 with diagnoses including anxiety disorder, hypertension, Alzheimer's disease, and schizoaffective disorder.</p> <p>Review of the MDS assessment for Resident #9 dated 01/01/26 revealed the resident had mild cognitive impairment.</p> <p>Review of the care plan for Resident #9 dated 03/11/24 revealed there was no activities care plan for the resident.</p> <p>Interview on 03/09/26 at 3:19 P.M. with Resident #9 confirmed she did not like to go to the facility activities because they were infantile.</p> <p>Interview on 03/11/26 at 1:25 P.M. with the Chief Operating Officer (COO) confirmed the facility had not developed an activities care plan for Resident #9.</p> <p>3. Review of the medical record for Resident #8 revealed an admission date of 11/22/25 with diagnoses including pica, borderline personality disorder, bipolar, morbid obesity, and conversion disorder.</p> <p>Review of the nurse progress notes for Resident #8 dated 12/17/25, 01/10/26, and 01/31/26 revealed the resident had ingested foreign objects including a thumb tack on one occasion and batteries on two other occasions. (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan for Resident #8 dated 02/03/26 revealed the resident had a diagnosis of pica and had a behavior of ingesting foreign objects.</p> <p>Review of the MDS assessment for Resident #8 dated 02/08/26 revealed the resident was cognitively impaired.</p> <p>Interview on 03/11/26 at approximately 1:25 P.M. with the COO#400 confirmed the facility did not develop and implement a behavioral care plan for Resident #8 until 02/03/26 which was after the resident had ingested foreign objects on three occasions.</p> <p>Review of the facility policy titled Resident Care Plans dated 05/01/22 revealed the facility would develop a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the residents' physical, psychosocial, and functional needs and would implement the care plan for each resident.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure resident care plans were revised to reflect changes in toileting needs. This affected one (Resident #4) of four residents reviewed for care plans. The facility census was 108 residents. Findings include: Review of the medical record for Resident #4 revealed an admission date of 11/02/24 with diagnoses including chronic obstructive pulmonary disease, diabetes mellitus type two, and acquired absence of right and left leg below knee. Review of the Minimum Data Set (MDS) assessment for Resident #4 dated 12/16/25 revealed the resident did not have an indwelling catheter and was occasionally incontinent of urine. Review of care plan for Resident #4 dated 1/09/26 revealed the resident had indwelling foley catheter and requires catheter care per facility policy. Observation on 03/09/26 at 10:35 A.M. revealed Resident #4 was in bed and did not have a foley catheter. Interview on 3/16/26 at 10:59 A.M. with Registered Nurse (RN) #307 confirmed the resident no longer had a foley catheter, and the facility had not updated the resident's care plan. Review of facility policy titled Resident Care Plans dated 5/1/22 revealed resident care plans should be revised and updated with changes in resident condition and status.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on review of the medical record, observation, and staff interview, the facility failed to ensure oxygen therapy was administered as ordered by the physician. This affected one (Resident #2) of three residents reviewed for oxygen therapy. The facility census was 108 residents. Findings include: Review of the medical record for Resident #2 revealed an admission date of 08/11/25 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease (COPD) and respiratory failure. Review of the care plan for Resident #2 dated 08/11/25 revealed the resident was at risk for altered respiratory status, difficulty breathing, or potential for an alteration in respiratory status related to COPD. Interventions included provide oxygen per physician's order. Review of the physician's orders for Resident #2 dated March 2026 revealed there was no order for oxygen therapy. Observation on 03/10/26 at 1:48 PM revealed Resident #2 was receiving continuous oxygen therapy via nasal cannula per concentrator set at three liters per minute (LPM). Interview on 03/11/26 at 12:02 PM with Licensed Practical Nurse (LPN) #231 confirmed Resident #2 utilized continuous oxygen therapy. LPN #231 stated she did not know what level of oxygen had been ordered by Resident #2's physician. LPN #231 confirmed they typically set all the residents' oxygen at three LPM unless otherwise ordered.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Momentous Health at Vandalia		STREET ADDRESS, CITY, STATE, ZIP CODE 208 North Cassel Road Vandalia, OH 45377	
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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on medical record review, resident interview, and staff interview, the facility staff failed to provide pain management interventions as ordered by the physician and per resident request. This affected one (Resident #42) of six residents reviewed for pain management. The facility census was 108 residents. Findings include: Review of the medical record for Resident #42 revealed an admission date of 12/03/25 with diagnoses including osteoarthritis, obstructive sleep apnea, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment for Resident #42 dated 01/07/26 revealed the resident was cognitively intact. Review of the physician's orders for Resident #42 revealed an order dated 01/19/26 for Voltaren gel to be applied to the resident's right shoulder topically every six hours as needed for pain. Review of the Medication Administration Record (MAR) for Resident #42 dated March 2026 revealed there was no record of administration of Voltaren gel on 03/07/26, 03/08/26, 03/09/26, and 03/10/26. Interview on 03/09/26 at 1:12 P.M. with Resident #42 confirmed he requested his as needed Voltaren gel on 03/07/26 and 03/08/26, but the nurses told him it was not available. Interview on 03/11/26 at 11:09 A.M. with Resident #42 confirmed he requested his as needed Voltaren gel on 03/09/26 and 03/10/26, but the nurses told him it was not available. Interview on 03/11/26 at 11:59 A.M. with Licensed Practical Nurse (LPN) #231 confirmed Resident #42 had a physician's order for Voltaren gel and had asked for the medication to be applied to his right shoulder, but the medication was out of stock. This deficiency represents noncompliance investigated under Complaint Number 1360651.</p>		