STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366041	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addison Heights Health and Rehabilitation Center	3600 Butz Rd Maumee, OH 43537

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review and interview, the facility failed to ensure bed rails were in place to assist with bed mobility. This affected one (#58) resident of three reviewed for bed rail use. The facility census was 68. Findings Include:Review of the medical record for Resident #58 revealed an admission date of 05/02/25 with diagnoses of morbid obesity, muscle weakness, and Type II Diabetes Mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/25, revealed Resident #58 had intact cognition and was able to roll to the left and right with supervision and/or touching assistance.Review of the current care plan, initiated 05/02/25 and updated 06/24/25 revealed Resident #58 had impaired functional abilities, self-care and mobility deficits. Interventions included bilateral half side rails to promote independence with bed mobility, self-positioning and transfers.Review of the Side Rail/Grab Bar Review assessments, completed 05/02/25 and 11/06/25 revealed bilateral side rails/grab bars were indicated and served as an enabler to promote independence.Review of the current physician order dated 06/04/25 revealed Resident #58 had half side rails to right and left side of bed to promote independence with bed mobility, transfers, and positioning.Observation and interview on 12/01/25 at 1:50 P.M. with Resident #58 revealed a grab bar was on the left side of his bed, but no grab bar was on the right side of his bed, which was against the wall. Resident #58 stated he was supposed to have a grab bar on both sides of the bed to assist with mobility as he received personal cares in bed and the grab bars allowed him to assist in rolling himself from side to side. Observation and interview on 12/01/25 at 1:56 P.M. with Maintenance Director (MD) #351 confirmed Resident #58's bed did not have a grab bar on the right side because of the way the mattress fit the bedframe.Interview on 12/08/25 at 12:23 P.M. with MD #351 revealed he began working in the facility in July 2025 and since that time he had not changed Resident #58's mattress or bedframe, and had not assessed Resident #58's mattress or bedframe to assure they fit appropriately.This deficiency represents non-compliance investigated under Complaint Number 2636738.

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of the facility's investigation, review of Self-Reported Incident (SRI) #267064, staff interview, police report review, and facility policy review, the facility failed to provide adequate supervision which resulted in an incident of sexual abuse. This affected one (#36) of five residents reviewed for abuse. The facility census was 68.1. Review of the medical record for Resident #36 revealed an admission date of 06/27/25 with diagnoses of Alzheimer's disease, cerebral infarction, depression, anxiety, and cerebrovascular disease.Review of the comprehensive, significant change Minimum Data Set (MDS) assessment, dated 12/10/25, revealed Resident #36 had severely impaired cognition, used a wheelchair for mobility and was dependent on staff for all activities of daily life.Review of a nursing progress note dated 11/01/25 at 10:57 P.M., and written by the Director of Nursing, revealed Resident #36 was in her wheelchair in the lounge and another resident (Resident #73) had his hand in her brief. The residents were immediately separated and placed on 15-minute checks. 2. Review of the medical record for Resident #73 revealed an admission date of 10/06/25 with diagnoses of Alzheimer's disease, depression, and anxiety.Review of the modification of the comprehensive MDS assessment, dated 10/13/25, revealed Resident #73 had impaired cognition and was independently able to stand from a sitting position, transfer himself from a bed to chair, and able to walk up to 50 feet. Review of a nursing progress note dated 11/02/25 revealed Resident #73 was seen by a Certified Nursing Assistant (CNA) kneeling in front of another resident with his hand in the side of her brief. The residents were immediately separated and placed on 15 minute checks.Review of a Interdisciplinary Team (IDT) progress note dated 11/04/25 revealed team met to discuss residents incident with another Resident. Residents were immediately separated and kept separated. Physician and family notified . New intervention in place for staff to monitor resident lounge at all times. Care plan updated. IDT agrees to interventionReview of the police report dated 11/02/25 at 1:19 A.M. revealed on November 01, 2025 at approximately 11:07 P.M. the officer was dispatched to assist fire at the facility on a sexual assault call. The report went on to document on 11/05/25 contact with the prosecutor was made regarding the matter and the officer explained the circumstances of the case and medical diagnoses of both parties involved. The Prosecutor replied based upon those diagnoses his office would not be able to prosecute for any criminal charges. The police case was closed with no criminal charges being filed based on the conversation with the prosecutor. Review of Self-Reported Incident 267064 completed by the facility a allegation of Sexual abuse when Resident #73 had his hand in the side of the brief of Resident#36. The SRI indicated both residents had a diagnosis of dementia. Further review of the report revealed the incident occurred on 11/01/25 at 11:00P.M. in the dining area of the dementia unit. Staff reported Resident #36 did not object to this behavior and when staff attempted to separate the two, Resident #36 became agitated and did not want staff to intervene. Resident #73 was redirected without issue. 15-minute checks were initiated for Resident #73 with no further issues. Responsible parties were notified and physician was notified. Psychiatric services were notified for Resident #73 and Tagamet (medication used in dementia patients to decrease inappropriate sexual behaviors) was adjusted. The facility documented staff was educated regarding sexual behavior among dementia residents/resident rights. Neither resident had any recollection of the event. The SRI documented a police report was filed.Review of the facility's investigation into SRI #267064 revealed one staff witnessed the incident between Resident #36 and Resident #73. Review of the witness statement, dated 11/01/25, written by Certified Nursing Assistant (CNA) #399 revealed she saw Resident #73 with his hand in the side of Resident #36's brief, and CNA #399 redirected the patient.Review of the statement provided by Licensed Practical Nurse (LPN) #400, dated 11/01/25, revealed he was notified Resident #73 was trying to touch Resident #36. LPN #400 wrote he could see the side of Resident #36's brief was pulled out.Interview on 12/22/25 at 9:20 A.M. with the Administrator revealed he was familiar with SRI #267064 and recalled the findings of the investigation were Resident #73's hand was inside Resident #36's brief, along the hip.Telephone interview on 12/22/25 at 11:37 A.M. with CNA #399 revealed she had been providing resident care to another facility resident when she came out to witness an incident between Resident #36 and Resident #73. CAN #399 stated the other staff working on the hall were the nurse who was passing medication and the other CNA who was in another resident room. CAN #399 stated she came out of the room she had been providing care in she saw Resident #36 in her wheelchair and Resident #73 kneeling beside her in the common area near the nurse's station. CNA #399 approached the two residents and saw Resident #36, seated in her wheelchair, wearing two facility-provided gowns, one open to the front

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, staff interview, review of Self-Reported Incident #267064, and review of the facility policy, the facility failed to ensure an allegation of sexual abuse was reported timely to the State Agency. This affected one (Resident #36) of five residents reviewed for abuse. The facility census was 68.Review of the medical record for Resident #36 revealed an admission date of 06/27/25 with diagnoses of Alzheimer's disease, cerebral infarction, depression, anxiety, and cerebrovascular disease.Review of the comprehensive, significant change Minimum Data Set (MDS) assessment, dated 12/10/25, revealed Resident #36 had severely impaired cognition, used a wheelchair for mobility and was dependent on staff for all activities of daily life.Review of a nursing progress note dated 11/01/25 at 10:57 P.M., and written by the Director of Nursing, revealed Resident #36 was in her wheelchair in the lounge and another resident (Resident #73) had his hand in her brief. The residents were immediately separated and placed on 15-minute checks.Review of the facility's Self-Reported Incident (SRI) #267064 revealed it was initiated 11/02/25 at 10:11 A.M. by the Administrator. SRI #267064's Category of Allegation/Suspicion was sexual abuse.Interview on 12/22/25 at 10:56 A.M. with the Administrator confirmed he did not report the incident within two hours because he felt no abuse had occurred. Review of the policy Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, copyright 2025, revealed in response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall ensure that all alleged violations involving abuse . are reported in the proper time frame pursuant to this policy. Further review revealed the guidance: When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: . reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. This deficiency is a recite to the complaint survey completed 10/14/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and facility policy review, the facility failed to ensure medications were given per physician order. This affected two (#85 and #55) of seven residents reviewed for medication administration. The facility census was 68. Findings Include:1. Review of the medical record for Former Resident, Resident #85 revealed an admission date of 10/10/25. Resident #85 discharged home on [DATE]. Diagnoses included a fractured neck of right femur, osteoarthritis, anxiety, schizoaffective disorder, and venous thrombosis. Review of the 5-day Minimum Data Set (MDS) assessment, dated 10/17/25, revealed Resident #85 had impaired cognition.Review of the physician orders initiated 10/10/25 revealed Resident #85 should have received Senna (laxative) oral tablet, 8.6 milligrams (mg), two tablets by mouth once daily for constipation, Cefuroxime Axetil (an antibiotic) oral tablet 500 mg, one tablet twice daily for infection for five days; Eliquis (anticoagulant) oral tablet 5 mg, one tablet twice daily for anticoagulant; Risperidone (antipsychotic) oral tablet 2 mg, one tablet by mouth two times daily for antipsychotic; and Methocarbamol (muscle relaxer) oral tablet 500 mg, one tablet by mouth four times daily for muscle relaxer.Review of the Medication Administration Record (MAR), dated October 2025, revealed on 10/10/25 a 9 was placed in the administration box for each of the above listed medications. Review of the chart codes on the final page of the MAR revealed 9 indicated other/see nurse notes.Review of the nurses ' progress notes dated 10/11/25 at 6:15 A.M. revealed Methocarbamol was not given due to awaiting medications, Senna was not given due to awaiting medications, and Risperidone was not given due to awaiting medications. Review of a nurse ' s progress note dated 10/11/25 at 11:14 AM. revealed Methocarbamol was not given due to awaiting delivery of medication.Review of a nurse ' s progress note dated 10/13/25 revealed the provider was notified of the missed doses of medications from admission due to medications not being available. Further review revealed no new orders were received. Interview on 12/08/25 at 1:15 P.M. with the Director of Nursing (DON) and concurrent review of Resident #85 ' s MAR dated October 2025 confirmed the charting indicated Resident #85 did not receive his medications upon admission to the facility. Additionally, the DON confirmed the MAR showed Resident #85 received only nine doses of the antibiotic Cefuroxime Axetil instead of the ten doses ordered by the physician. 2. Review of the medical record for Resident #55 revealed an admission date of 01/23/23 with diagnoses of spondylolisthesis (a vertebra out of alignment and pressing on another vertebra), cervical region, chronic pain, cervicalgia (neck pain), and cervical disc disorder.Review of the quarterly MDS assessment, dated 11/08/25, revealed Resident #55 had intact cognition and received scheduled pain medications. Further review revealed Resident #55 had frequent pain that frequently affected his sleep and day-to-day activities.Review of a discontinued physician order dated 07/18/25 through 10/15/25 revealed Resident #55 received Lyrica oral capsule 150 mg (pregabalin) by mouth three times daily for nerve pain.Review of Resident #55 ' s MAR, dated October 2025, revealed a 9 for all three doses on 10/04/25 of Lyrica and for the morning dose on 10/05/25. Review of the chart codes on the final page of the MAR revealed 9 indicated other/see nurse notes.Review of the nursing medication administration progress notes dated 10/04/25 and 10/05/25 revealed Lyrica was on order from the pharmacy.Review of the current physician order dated 11/03/25 revealed Resident #55 received pregabalin oral capsule 150 mg by mouth three times daily for nerve pain. Review of Resident #55 ' s MAR, dated November 2025, revealed a 9 for three doses on 11/28/25 and three doses on 11/29/25.Review of the nursing medication administration progress notes dated 11/28/25 and 11/29/25 regarding pregabalin revealed the medication was not available, a new prescription was needed, and the facility was waiting to receive the medication.Interview on 12/03/25 at 1:25 P.M. with Resident #55 revealed he recently had spinal neck surgery and had neck pain and the facility ran out of his Lyrica (pregabalin) for six doses the previous week.Interview on 12/08/25 at 1:15 P.M. with the Director of Nursing (DON) and concurrent review of Resident #55 ' s MARs dated October 2025 and November 2025 confirmed the charting indicated Resident #55 did not receive three doses of Lyrica (pregabalin) on 10/04/25, did not receive one dose on 10/05/25, did not receive three scheduled doses on 11/28/25 and did not receive three doses on 11/29/25. Review of the policy, Administering Oral Medications, dated 10/2010, revealed staff should verify there was a physician order for the procedure of administering medications. Additionally, staff should allow the resident to swallow tablets or capsules at his or her comfortable pace.This deficiency represents non-compliance investigated under Complaint Number 2660262 and Complaint Number 2656086.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, record review, and policy review, the facility failed to ensure food items were labeled with open dates and failed to ensure staff were knowledgeable regarding identifying expiration dates of packaged foods. This affected one (#16) resident identified to be on thickened liquids. The facility census was 68.Findings Include: Review of the medical record for Resident #16 revealed an admission date of 03/01/21 with diagnoses of hemiplegia/hemiparesis, cerebral infarction, and chronic obstructive pulmonary disease. Review of the 5-day Minimum Data Set (MDS) assessment, dated 11/23/25, revealed Resident #16 had impaired cognition. Review of a physician order dated 11/19/25 and discontinued 12/02/25 revealed Resident #16 was on nectar thick liquids.Review of a current physician order dated 12/02/25 revealed Resident #16 was on nectar thickened liquids.Observations of food storage on 12/01/25 beginning at 3:20 P. M. and concurrent interview with Dietary Manager (DM) #395, revealed a reach-in cooler with four 46-ounce cartons of nectar thickened beverages, opened, and approximately halfway consumed. DM #395 confirmed a carton of thickened water with pomegranate flavoring had the date 11/06/25 handwritten on the carton, a carton of thickened orange juice with the date 10/30/25 handwritten on the carton, a carton of thickened cranberry juice with a date 10/30/25 handwritten on the carton, and a carton of thickened milk with the date 10/09/25 handwritten on the carton. DM #395 stated the handwritten dates were the dates the product was received into inventory. DM #395 confirmed no other date was written on the carton to identify when the product was opened. DM #395 stated only one resident in the facility, Resident #16, was on thickened liquids and the facility did not go through the liquids very quickly. Further interview with DM #395 revealed she believed the product was safe to consume through the date stamped on the carton from the manufacturer. Continued observation of the back of each of the cartons revealed the product was to be refrigerated upon opening, and was good for seven days if refrigerated. DM #395 confirmed she did not realize the product was only good for seven days after opening.Review of the facility ' s training records, dated 10/08/25 revealed DM #395, along with all dietary staff, was educated on expired food disposal, and labeling and dating foods by the Administrator. Review of the undated policy, Food Storage, revealed all food not in original containers will be labeled, dated and stored in appropriate containers. The policy provided no guidance regarding dating of food items with multiple servings in the original containers. This deficiency is a recite to the annual survey completed 09/15/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure proper infection control practices were implemented regarding the use of personal protective equipment (PPE) during a SARS CoV-2 (COVID-19) outbreak. This had the potential to affect 54 residents not diagnosed with COVID-19 during the outbreak. The facility identified 14 residents with a COVID-19 infection (#17, #20, #34, #36, #37, #39, #41, #43, #46, #50, #56, #62, #67, and #73). The facility census was 68. Findings Include:Observation on 12/01/25 at 1:10 P.M., upon entrance to the facility, revealed staff and residents were wearing surgical masks.Interview on 12/01/25 at approximately 1:11 P.M. with Medical Records (MR) #362 revealed the facility was in a COVID-19 outbreak. Observations on 12/01/25 between 1:48 P.M. and 2:59 P. M. revealed personal protective equipment (PPE) carts and signs for droplet precautions were posted appropriately throughout the facility.Observation on 12/01/25 at 2:49 P.M. revealed Resident #36 sitting in a Broda chair in the memory care unit (MCU) in front of the nurse's station, within approximately six feet of the entrance door to the unit. Interview on 12/01/25 at 2:51 P.M. with Unit Manager (UM) #348 confirmed Resident #36 tested positive for COVID-19 but was kept within eyesight of staff because Resident #36 was a high fall risk. UM #348 stated staff attempted to place a mask on Resident #36's face but Resident #36 would remove it. Concurrent observation at 2:52 P.M. revealed Human Resources Supervisor #384 placed a surgical mask on Resident #36's face and Resident #36 immediately pulled at it until the strings across her ears were tight, then turned her head to remove the mask.Observation on 12/01/25 at 2:54 P.M. in the MCU revealed Certified Nursing Assistance (CNA) #329 wearing a mask and entering a room with COVID-19 isolation precautions posted on the door. CNA #329 did not don any personal protective equipment before entering the room. Continued observation at approximately 2:57 P.M. revealed CNA #329 exiting the room wearing the same mask. Concurrent interview with CNA #329 revealed she entered the room to assist Resident #67, who was not diagnosed with COVID-19, but who shared a room with Resident #56 who was diagnosed with COVID-19. CNA #329 stated Resident #56 was in the bed by the window and CNA #329 stayed near the bed by the door to assist Resident #67. CNA #329 stated she did not don PPE before entering the room because she did not provide any assistance with Resident #56 who was diagnosed with COVID-19. Additionally, CNA #329 confirmed she did not change her mask upon exit from the room and was unsure whether she should.Interview on 12/03/25 at 10:56 A.M. with Assistant Director of Nursing/Infection Preventionist (ADON/IP) #306 stated staff on the MCU were expected to encourage residents with COVID-19 to stay in their rooms, or put masks on residents if they would allow it. Further interview revealed the facility began educating staff on 12/01/25 regarding donning and doffing PPE for droplet precautions. ADON/IP #306 stated she continued to educate staff on 12/02/25 and 12/03/25.Interview on 12/03/25 at 5:24 P.M. with Licensed Practical Nurse (LPN) #304, on the MCU, stated she brought her own N 95 masks to the facility when she learned there was a COVID-19 outbreak. LPN #304 stated she could find no N 95 masks on the MCU. LPN #304 identified Resident #36 required one-on-one staff assistance for cares and was diagnosed with COVID-19. LPN #304 confirmed no N 95 masks were available for staff to use when providing care to residents diagnosed with COVID-19.Observation and interview on 12/03/25 at 5:31 P.M. with CNA #336 revealed she was wearing a surgical mask and no additional PPE while assisting residents in the MCU dining room. CNA #336 confirmed Resident #43, Resident #50, and Resident #73 were also in the dining room and were diagnosed with COVID-19. CNA #336 stated all three residents were able to feed themselves and she did not provide those residents with assistance. CNA #336 confirmed she was not wearing an N 95 while in proximity to residents diagnosed with COVID-19.Interview on 12/03/25 at approximately 5:37 P.M. with CNA #302, who was wearing a surgical mask, revealed she provided assistance to Resident #50, who currently had a COVID-19 infection, without wearing an N 95 mask because none were available on the MCU.Interview on 12/03/25 at approximately 5:40 P.M. with ADON/IP #306 stated the facility had adequate stock of N 95 masks; however, she could not find more than two boxes during the interview and concurrent search of supply closets. ADON/IP #306 stated she was attempting to find their most recent supply delivery.Interview on 12/04/25 at 7:53 A.M. with CNA #313 confirmed there were no N 95 masks on the MCU on 12/03/25 and further confirmed she provided care to residents on 12/03/25 without wearing an N 95. Concurrent observation in the MCU revealed N 95 masks were available. Interview on 12/04/25 at 12:45 P.M. with CNA #325 revealed she passed meal trays to three residents (#46

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review and interview, the facility failed to ensure mattresses and bedframes were compatible. This affected one (#58) of three residents reviewed for mattress and bed frame compatibility. The facility census was 68. Findings Include:Review of the medical record for Resident #58 revealed an admission date of 05/02/25 with diagnoses of morbid obesity, muscle weakness, and Type II Diabetes Mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/08/25, revealed Resident #58 had intact cognition and was able to roll to the left and right with supervision and/or touching assistance.Review of the current physician order dated 05/07/25 revealed Resident #58 required a low air loss mattress at all times. Observation and interview on 12/01/25 at 1:50 P.M. with Resident #58 revealed a grab bar was on the left side of his bed, but no grab bar was on the right side of his bed. Resident #58 stated the mattress was too big for the frame. Observation and interview on 12/01/25 at 1:56 P.M. with Maintenance Director (MD) #351 confirmed Resident #58's bed did not have a grab bar on the right side of the bed because of the way the mattress fit the bedframe. Additionally, Resident #58's mattress overhung the frame by approximately five inches. MD #351 confirmed Resident #58's mattress was overhanging the bed frame. MD #351 stated he was aware Resident #58's mattress was too large for the frame and was in the process of ordering and replacing bedframes. Interview on 12/08/25 at 12:23 P.M. with MD #351 confirmed mattresses should be fully supported by the frame. This deficiency represents non-compliance investigated under Complaint Number 2636738.