STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056348	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay View Rehabilitation Hospital, LLC	516 Willow Street Alameda, CA 94501

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect two of ten sampled residents (Resident 2 and Resident 3), and one visitor (Visitor 1, family member of Resident 7), from abuse when:Resident 1 fondled the genitals of Resident 2 on 5/24/26.Resident 1 hit the arm of Resident 3 on 6/4/26.The facility relocated Resident 1 to the same unit as Resident 2 after an alleged sexual assault by Resident 1 to Resident 2 on 6/5/26.The facility placed Resident 1 in a room with two vulnerable residents (Resident 9 and Resident 10) on 6/10/26.Additionally, R1 displayed physical aggression towards an unrelated Visitor on 6/4/26. This failure resulted in emotional harm to Resident 2, Resident 3 after Resident 1 abused them and had the potential to render physical and/or emotional harm to Resident 9 and Resident 10 and other vulnerable residents in the facility.An Immediate Jeopardy situation (Immediate Jeopardy (IJ) represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death), was identified and called due to the failure of the facility to protect Resident 2, Resident 3, Visitor 1 and all other vulnerable residents from physical, emotional and sexual abuse beginning on 5/24/26.The Administrator (ADM) was notified verbally and in writing of the IJ situation on 6/10/26 at 6:40 p.m.During a visit to the facility on 6/11/26 the facility provided an acceptable plan of action and the IJ was removed at 5:10 p.m.Non-compliance of F0600 remained at the scope and severity of D no actual harm with potential for more than minimal harm that is not immediate jeopardy. During a review of the admission Record (AR) for Resident 1 printed on 6/10/26, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease of the brain caused by a buildup of certain proteins resulting in the brain shrinking affecting memory, thinking and behavior), diabetes (long term disease in which the body cannot regulate the amount of sugar in the blood), anxiety disorder (a long term mental health condition involving persistent excessive and uncontrolled worry that interferes with daily activities), restlessness (being unable to rest, relax or remain still, due to many different forms of discomfort), and agitation (state of extreme restlessness, excitement or disturbance).During a review of the Minimum Data Set Assessment: Section C: Cognitive Patterns (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 4/15/26, the record indicated the Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information) score for Resident 1 was six out of fifteen indicating severe cognitive impairment (significant, irreversible, loss of intellectual capacity that prevents an individual from living independently).During a review of Change of Condition Evaluation dated 4/12/26, the record stated Resident 1 became extremely agitated and aggressive towards staff when being redirected toward Resident 1?s room. The record stated Resident 1 was threatening staff and ramming them with a wheelchair and was also throwing food and ice at others in the hallway. The record stated since being admitted , Resident 1 has frequently shown hostility toward staff and other residents. This includes arguing and physical aggression, such as grabbing at others. As a result, staff must (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	continuously monitor the resident's location and mood.Record review of Change of Condition Evaluation dated 5/2/26, the record indicated Resident 1 had baseline confusion and was observed to be agitated, restless and wandering around the facility going in and out of other resident rooms. The record stated Resident 1 was combative towards staff when being redirected. During a review of SNF [Skilled Nursing Facility] Visit Note (physician note) dated 4/27/26, the record indicated Resident 1 was noted to hallucinate (sensory perception of something that is not actually present), responding to internal stimuli (any physical or psychological signals originating inside an organism that trigger a response or conscious awareness), exhibiting unsafe and intrusive behaviors. The record indicated Resident 1 .lacks capacity to understand choices and make healthcare decisions.During a review of Attentive Cognitive Mental Health: Psychology Initial Evaluation Note dated 5/19/26, the record indicated Resident 1 had diagnoses of unspecified mood [affective] disorder (a mental health condition that primarily affects your emotional state, causing persistent and intense feelings of sadness, elation, or anger), psychotic disorder due to another medical condition with delusions (severe mental illnesses that disrupt a person's thoughts and perceptions, causing them to lose touch with reality), unspecified depressive disorder (a diagnosis used when a person exhibits symptoms of depression that cause significant distress but does not meet the full, exact criteria for other recognized categories, such as Major Depressive Disorder), and unspecified anxiety disorder (when a person experiences prominent symptoms of anxiety or panic that cause clinically significant distress, but the clinical picture does not fully meet the strict criteria for any other specific anxiety condition). The record states The severity of the patient's neurocognitive deficits (a significant, measurable decline in one or more areas of brain function that manage information processing), likely preclude the patient from being able to benefit from psychological services. The patient (Resident 1), continues to demonstrate significant neuropsychiatric symptoms (behavioral, emotional, and psychological changes that occur as a direct result of underlying diseases, injuries, or structural disruptions in the brain and central nervous system), despite pharmacotherapy (the medical treatment of diseases, disorders, or symptoms using medications), hence, psychiatric follow-up is recommended to determine an optimal treatment regimen. The record stated the patient shows poor insight secondary to anosognosia (a neurological condition where a person is completely unaware of their own medical condition or disability), and level of cognitive impairment. During a review of the AR for Resident 2 printed on 6/9/26, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior), anxiety, encephalopathy (any brain disease that alters brain function or structure, manifested by declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms), and a developmental delay (when a child fails to reach age appropriate milestones in one or more areas of growth and development). During a record review of MDS Section C: Cognitive Patterns for Resident 2 dated 3/16/26, the record indicated Resident 2 had a BIMS of 12 out of 15 indicating moderate cognitive impairment (stage of neurological decline where symptoms clearly interfere with daily independence and complex tasks, though basic self-care remains intact). During a review of the AR for Resident 3 printed on 6/9/26, the record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (a long term condition where the kidneys are damaged and cannot filter blood as well as they should), anxiety, depression (mood disorder that causes persistent feelings of sadness and hopelessness), and cancer of the kidney (uncontrolled growth and spread of abnormal cells in the kidney) with nephrectomy (surgical removal of the kidney). During a review of MDS Section C: Cognitive Patterns for Resident 3 dated 3/30/26, the record indicated Resident 3 had a BIMS score of 15 of 15 indicating no cognitive impairment. During a review of the AR for Resident 7 printed on 6/9/26, the record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain (progressive loss of brain cells, tissue volume and cognitive function that occurs with advanced age), (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	anxiety and depression. Resident 7 is non-English speaking and MDS Section C: Cognitive Patterns dated 4/12/2026 indicated the BIMS score was incomplete and Visitor 1 is the responsible party for Resident 7. During a review of the AR for Resident 8 printed 6/19/26, the record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (occurs when blood flow to part of the brain is blocked), and paraplegia (partial or complete loss of voluntary movement of the lower half of the body). During a review of MDS Section C: Cognitive Patterns dated 5/6/26, the report indicated Resident 8 had a BIMS score of 13 of 15 indicating no cognitive impairment. During a review of the AR for Resident 9 printed 6/19/26, the record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses of end stage renal disease (final, permanent stage of kidney failure), and dementia. During a review of MDS Section C: Cognitive Patterns for Resident 9 dated 5/14/26, the report indicated Resident 9 had a BIMS score of 0 out of fifteen indicating severe cognitive impairment (significant loss of intellectual capacity that disrupts a person's ability to live independently). During a review of the AR for Resident 10 printed on 6/19/26, the record indicated Resident 10 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (chronic mental health condition that combines symptoms of schizophrenia (like hallucinations{a false sensory perception that occurs in the absence of an external stimuli} or delusions {a firmly held false belief that persists despite clear, undeniable evidence to the contrary}) with a mood disorder (such as depression or bipolar disorder), and diabetes. During a review of MDS Section C: Cognitive Patterns for Resident 10 dated 4/22/26, the record indicated Resident 10 had a BIMS score of four out of 15 indicating severe cognitive impairment (significant loss of intellectual capacity that disrupts a person's ability to live independently). 1. During an interview on 6/9/26 at 4:15 p.m. with Resident 2, Resident 2 recalled walking in the hallway and stopping in front of Resident 1. Resident 2 stated Resident 1 reached out and touched Resident 2's genitals. Resident 2 stated staff saw the incident, called out to Resident 1 to stop, as Resident 2 stepped away from Resident 1 and went back to Resident 2's room. During an interview on 6/11/26 at 11:00 a.m. with Licensed Vocational Nurse 1 (LVN1), LVN1 stated on 5/24/26, an incident involving Resident 1 touching Resident 2's genitals was reported to LVN1 by Certified Nursing Assistant 1, (CNA1). LVN1 stated CNA1 reported upon seeing Resident 1 touching Resident 2, CNA1 called out to Residents 1 and 2 and immediately separated them. LVN1 stated she assessed Resident 1 and Resident 2 after the incident. LVN1 stated Resident 2 did not say anything about the incident during the assessment. LVN1 stated Resident 1 could not be understood during the assessment. LVN1 stated there were no injuries on either resident. LVN1 stated the incident was immediately reported to the charge nurse. During an interview on 6/11/26 at 11:20 a.m. with Registered Nurse 1 (RN1), RN1 stated the incident between Resident 1 and Resident 2 was reported to RN1 on 5/24/26 by LVN1. The residents were assessed by LVN1 and found to have no injuries. RN1 stated the DON (Director or Nursing) was notified of the incident between Resident 1 and Resident 2 immediately. RN1 stated the process for abuse reporting is that the staff reports all incidents to the Administrator (ADM) for investigation and reporting. RN1 stated at the time of the incident the residents lived on different units with Resident 1 at the 500 hallway and Resident 2 at the 400 hallway. RN1 stated at the time of the incident the residents went back to their respective rooms on different units. RN1 stated training about abuse prevention, recognition and reporting is important for all staff to protect the residents from abuse. During a review of Change of Condition Evaluation for Resident 1 dated 5/24/26, the record indicated CNA1 saw Resident 1's hand under the pants of Resident 2. CNA1 separated both residents and redirected the residents to their separate areas (Resident 1 to the 500 hallway and Resident 2 to the adjacent 400 hallway), to maintain a safe distance and prevent further inappropriate contact. 2.During a telephone interview on 6/8/26 at 2:15 p.m. with Visitor 1, Visitor 1 stated on 6/4/26 at lunchtime, Visitor 1 went to Resident 7's room and saw Resident 1 standing over Resident 7 with a closed fist poised to hit Resident 7. Visitor 1 immediately called for assistance. Visitor 1 stated as Visitor 1 was leaving Resident 7's room, Resident 1 hit Visitor 1's left shoulder. Visitor 1 notified the ADM, and called (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	911.During an interview on 6/8/26 at 2:30 p.m. with Resident 8, Resident 8 stated Resident 8 occupied the bed next to Resident 7. Resident 8 stated Resident 1 has wandered in and out of their room several times since Resident 1's arrival. Resident 8 stated Resident 8 did not see the incident with Resident 1, but Resident 8 heard Visitor 1 call for assistance and tell the staff Resident 1 was standing over Resident 7 as if to hit Resident 7.3. During an interview on 6/9/26 at 1:00 p.m. with Resident 3, Resident 3 stated on or about 6/4/26 Resident 3 heard Visitor 1 yelling from the hallway outside Resident 7's room for help. Resident 3 stated as Resident 3 was approaching the doorway to Resident 7's room, Resident 3 saw Resident 1's hand graze over Visitor 1's left arm. Resident 3 stated that as Resident 3 arrived at Resident 7's room, Resident 3 saw Visitor 1 heading away from Resident 7's room as Resident 1 proceeded to hit Resident 3 on the arms. Resident 3 stated fearing being hit on the head and face. Resident 3 stated the staff intervened and escorted Resident 1 back to Resident 1's room. Resident 3 stated Resident 1 was allowed to wander in and out of other resident's rooms without supervision. Resident 3 stated Resident 3 has observed Resident 1 being physically aggressive with staff and other residents. Resident 3 stated I do not feel safe when Resident 1 is wandering in the facility unattended. Resident 3 reported the incident and concerns to the ADM.During an interview on 6/9/26 at 10:05 a.m. with CNA2, CNA2 stated on 6/4/26, CNA2 saw Resident 1 hit Visitor 1 with an open hand on Visitor 1's left arm.During a review of Change of Condition Evaluation for Resident 1 dated 6/4/26, the record indicated @1230 Noted physical aggressiveness with another resident (Resident 3 & with a visitor (Visitor 1).Administrator made aware of the incident. Incident report completed. Resident on monitoring & visual check for safety. 4. During an interview on 6/9/26 at 4:15 p.m. Resident 2 stated several days after Resident 1 groped Resident2, Resident 1 was moved to a room on the same unit and two rooms down from Resident 2. Resident 2 stated Resident 1 would follow Resident 2 on the unit and into Resident 2's room. Resident 2 was very upset to have Resident 1 nearby going in and out of Resident 2's room. Resident 2 stated Resident 2 felt violated and unsafe in the facility. 5. During an interview with Licensed Vocational Nurse (LVN1) on 6/9/26 at 4:00 p.m., LVN1 stated after an altercation on 6/4/26 with a resident and visitor, Resident 1 was moved from the 500 hallway to the 400 hallway. LVN1 stated LVN1 was concerned because of a sexual abuse allegation that Resident 1 had sexually abused Resident 2. LVN1 was concerned for Resident 2's safety because Resident 1 was placed two rooms away from Resident 2's room.During a review of Progress Notes-Administration Note for Resident 1, dated 6/8/26, the record indicated Resident 1 kept following Resident 2 into Resident 2's room. The record stated staff kept separating Resident 1 and Resident 2, despite Resident 1 being aggressive and combative when redirected.During a review of Facility Census dated 6/10/26, the census indicated Resident 1 was placed in a room with two vulnerable roommates (Resident 9 and Resident 10), while on the 400 hallway.During a review of Nurses Progress Note for Resident 1 dated 6/10/26, the record indicated Resident 1 was transferred from the 400 hallway to the 200 hallway and a sitter was assigned to Resident 1.During a concurrent observation and interview on 6/11/26 at 10:20 a.m. with CNA 3 in the 200 hallway, Resident 1 was observed to have moved into a private room. CNA 3 stated CNA 3 was the sitter for the day.During an interview on 6/15/26 at 3:00 p.m. with the DON, the DON stated the incident between Resident 1 and Resident 2 was reported to the DON on the day it occurred. The DON stated the ADM is the assigned abuse coordinator and has the responsibility to investigate and report abuse cases. When the DON was asked if the incident of 5/24/26 was reported to the ADM, the DON had no answer. The DON stated residents involved in abuse investigations should be separated to protect victims from further abuse. The DON could not articulate expectations of the staff regarding abuse prevention, recognition, intervention and reporting. The DON stated staff is trained annually for abuse and refreshed after any incidents. The DON stated staff training and monitoring are important to protect residents from abuse.Review of the facility's policy and procedure titled, Resident Rights, dated 12/2016, indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the right to be.free of abuse, neglect, misappropriation of property and exploitation.Review of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility's policy and procedure titled, Policy and Procedure on Patient Abuse and Prevention dated 10/2010 indicated .If the suspected perpetrator is another resident separate the residents immediately to avoid any further contacts.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, investigate, and report one sexual assault allegation within two hours of incident notification and one abuse allegation within 24 hours of incident notification to the California Department of Public Health (CDPH), and the Ombudsman for two of ten sampled residents (Resident 2 and Resident 3).This failure resulted in one allegation of physical abuse and one allegation of sexual abuse going uninvestigated and unreported resulting in emotional harm to Resident 2 and Resident 3, in addition to the potential for physical and/or emotional harm to other vulnerable residents.During a review of the AR for Resident 1 printed on 6/10/26, the record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease of the brain caused by a buildup of certain proteins that results in brain shrinkage affecting memory, thinking, and behavior), diabetes (a longˆterm disease in which the body cannot regulate the amount of sugar in the blood), anxiety disorder (a longˆterm mental health condition involving persistent, excessive, and uncontrollable worry that interferes with daily activities), restlessness (being unable to rest, relax, or remain still due to various forms of discomfort), and agitation (a state of extreme restlessness, excitement, or disturbance). During a review of the Minimum Data Set Assessment: admission Section C: Cognitive Patterns (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan) dated 4/15/26, the record stated the Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and the ability to register and recall information) score for Resident 1 was six out of 15, indicating severe cognitive impairment. During a review of the AR for Resident 2 printed on 6/9/26, the record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior), anxiety and encephalopathy (any brain disease that alters brain function or structure, manifested by declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching are common symptoms). During a record review of MDS Section C: Cognitive Patterns for Resident 2 dated 3/16/26, the record indicated Resident 2 had a BIMS of 12 out of 15 indicating moderate cognitive impairment.During a review of the AR for Resident 3 printed on 6/9/26, the record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease (a long term condition where the kidneys are damaged and cannot filter blood as well as they should), anxiety, depression (mood disorder that causes persistent feelings of sadness and hopelessness), and cancer of the kidney (uncontrolled growth and spread of abnormal cells in the kidney) with nephrectomy (surgical removal of the kidney). During a review of the MDS Section C: Cognitive Patterns for Resident 3 dated 3/30/26, the record indicated Resident 3 had a BIMS score of 15 out of 15 indicating no cognitive impairment. During an interview on 6/11/26 at 11:20 a.m. with Registered Nurse (RN1), RN1 stated the incident between Resident 1 and Resident 2 was witnessed by CNA1 and reported to RN1 on 5/24/26 by LVN1. RN1 stated the Director of Nursing (DON) was notified of the incident between Resident 1 and Resident 2 immediately. RN1 stated the process for abuse reporting is the staff reports all incidents to the Abuse Coordinator for investigation and reporting. RN1 stated the Administrator (ADM) acts as the Abuse Coordinator for the facility. RN1 stated training in abuse prevention, recognition, response and reporting is important to protect the residents from abuse.During an interview on 6/9/26 at 4:15 p.m. with Resident 2, Resident 2 stated Resident 2 was walking along the hallway when Resident 2 stopped in front of Resident 1, and Resident 1 touched Resident 2's genitals. Resident 2 stated the incident made Resident 2 feel vulnerable and unsafe.During a record review of Care Plan Report for Resident 2 dated 5/24/26, the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	report indicated the incident of sexual abuse between Resident 1 and Resident 2 was reported to the DON on 5/24/26.During an interview on 6/9/26 at 1:00 p.m. with Resident 3, Resident 3 stated on or about 6/4/26, Resident 3 heard Visitor 1 yelling from the hallway outside Resident 7's room for help. Resident 3 stated as Resident 3 was approaching the doorway to Resident 7's room, Resident 3 saw Resident 1's hand graze over Visitor 1's left arm. Resident 3 stated as he arrived at Resident 7's room, he saw Visitor 1 heading away from Resident 7's room and Resident 1 began hitting Resident 3 on the arms. Resident 3 stated Resident 3's arms were up around the face and head for protection. Resident 3 stated the staff intervened and escorted Resident 1 back to Resident 1's room. Resident 3 stated Resident 1 was allowed to wander in and out of other residents' rooms without supervision. Resident 3 stated Resident 3 has observed Resident 1 being physically aggressive with staff and other residents. Resident 3 stated he did not feel safe when Resident 1 was wandering around the facility unattended. Resident 3 reported the incident and concerns to the ADM.During an interview on 6/15/26 at 3:00 p.m. with the DON, the DON stated the DON was aware of the incident between Resident 1 and Resident 2. The DON stated the ADM is the designated abuse coordinator responsible for investigating and reporting abuse allegations. When the DON was asked if the incident between Resident 1 and Resident 2 was reported to the ADM, the DON had no response. When the DON was asked about reporting responsibilities, the DON could not articulate expectations of the staff regarding abuse prevention, recognition, intervention and reporting. The DON stated staff are trained annually for abuse and refreshed after any incidents. The DON stated abuse reporting and staff training and monitoring are important to protect residents from abuse.During a concurrent interview and record review on 6/11/26 at 10:45 a.m. with the ADM, the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) for the allegation of sexual abuse involving Resident 1 and Resident 2 that occurred on 5/24/26, and the SOC 341 for the allegation of abuse between Resident 1 and Resident 3 that occurred on 6/4/26 were reviewed. During a review of the submission receipts for the SOC 341 submitted for the incident on 5/24/26 and the SOC 341 submitted for the incident on 6/4/26, the receipts indicated the reports were submitted to the California Department of Public Health (CDPH), and to the Ombudsman simultaneously on 6/10/26 at 8:50 p.m. The ADM stated the SOC 341 for the incident between Resident 1 and Resident 2 dated 5/24/26 was due 2 hours after notification of the incident and the SOC 341 for the incident between Resident 1 and Resident 3 dated 6/4/26 was due to be reported within 24 hours of the incident. The ADM stated incident investigation summaries are due within five days of each incident, and the incidents were not reported or investigated as required.During a review of the facility's policy and procedure titled, Policy and Procedure on Patient Abuse and Prevention dated 10/2010 indicated: The facility shall ensure reporting of all alleged and/or substantiated violation to the state agency and all other agencies as required, and to take all necessary corrective actions based on the results of the investigation.Facility shall report the incident by calling DHS within 24 hours of the knowledge of such an incident followed by a letter explaining the circumstances surrounding the incident.The Administrator and Director of Nurses in the order written, shall report incidents of suspected abuse to the following agencies within 24 hours of occurrenceDepartment of Health-Licensing and CertificationLTC Ombudsman or designee orLocal law enforcement or Police DepartmentManaging physician for treatment orders as requiredFamily Members/Responsible Parties or Guardians.Facility Administrator shall report findings of investigation to the Department within five working days of the incident.The facility Administrator is the duly appointed Abuse Prevention Coordinator. In the absence of the Administrator the designated alternate or Assistant Administrator, if any, will take over the responsibilities.