STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maranatha Care Center	5409 69th Avenue North Brooklyn Center, MN 55429

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure assessment, monitoring, and documentation surrounding PRN (as needed) psychotropic medication administration included resident-specific target behaviors and non-pharmacological interventions for 3 of 3 residents (R1, R2, and R3) reviewed for psychotropic medications.Findings include:R1R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment, unclear speech, and impaired vision. R1 had disorganized thinking and no behaviors or rejection of care. R1's diagnoses included non-traumatic brain dysfunction, Alzheimer's, and non-Alzheimer's dementia. R1 received hospice services with a prognosis of less than six months of life.R1's care plan dated 5/27/26, indicated R1 had severe cognitive impairment related to neurocognitive disorder, Alzheimer's disease, and dementia and combative with cares. R1 received psychotropic medications. An intervention dated 6/21/24, directed staff to monitor occurrence for target behavior symptoms and document per facility protocol. A list of target behaviors was indicated, such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.; however, the list target behaviors were not individualized to R1. The care plan indicated activities R1 enjoyed and other non-pharmacological interventions related to cognitive impairment, such as communication techniques and keeping a consistent routine; however, R1's care plan did not indicate if there were individualized, non-pharmacological interventions effective for R1's target behaviors.R1's Treatment Administration Record dated 4/1/26 to 5/29/26, indicated staff checked every shift for behavioral expression and referred to Behavior Expression progress note template for assessment and documentation requirements.R1's physician Order Summary Report, indicated: -On 4/16/26 to 4/30/26, lorazepam (part of a class of prescription central nervous system depressants used to treat anxiety, insomnia, seizures, and muscle spasms) oral tablet 0.5 mg (milligrams) by mouth every 6 hours as needed for anxiety/agitation/restlessness for 14 days.-On 5/7/26 to 5/21/26, lorazepam SoluTab (orally disintegrating tablet) 0.5 mg by mouth every 6 hours as needed for anxiety/restlessness for 14 days.-On 5/21/26 to 6/4/26, lorazepam SoluTab place and dissolve 0.5 mg buccally every six hours as needed for anxiety/restlessness for 14 days.-On 5/22/26, every two hour checks to assess for comfort/safety and if needing PRN medications, and call hospice if medications were not effective.-On 5/22/26 to 6/5/26, lorazepam SoluTab place and dissolve 0.5 mg buccally every two hours as needed for anxiety/restlessness for 14 days.-On 5/25/26 to 6/8/26, lorazepam SoluTab place and dissolve 1 mg buccally every two hours as needed for anxiety/restlessness for 14 days.R1's Medication Administration Record reviewed from 4/14/26 to 5/28/26, indicated R1 received PRN lorazepam on 18 occasions between this period. In review of R1's medical record dated 4/14/26 to 5/28/26, the record did not consistently identify individualized target behaviors to indicate reason for PRN psychotropic medication use and non-pharmacological interventions attempted or offered prior to the administration:-On 4/16/26, R1 self-transferred from bed, appeared restless, and brought into the common area for staff supervision. At 3:13 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/agitation/restlessness and noted R1 had (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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restlessness and was unable to sleep. At 5:22 a.m., R1 was calm and sleeping. At 5:43 a.m., the PRN administration was identified as effective.-On 4/21/26 at 6:01 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/agitation/restlessness with note [R1] noted with anxiety. At 9:16 a.m., the PRN administration was identified as effective.-On 4/23/26 at 3:18 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/agitation/restlessness with note [R1] up and about. At 6:38 a.m., the PRN administration was noted as effective. At 1:03 p.m., a Hospice note identified R1 appeared comfortable with no signs/symptoms of pain or shortness of breath, and nursing staff did not have any new concerns besides R1 woke up at 2:00 a.m -On 4/25/26 at 9:55 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/agitation/restlessness. At 11:29 a.m., the PRN administration was noted as effective.-On 4/27/26 at 11:34 p.m., R1 received 0.5 mg of lorazepam as needed for anxiety/agitation/restlessness with note of non-pharmacological interventions attempted, which included snacks, repositioning, toileting, and music, and were not effective. R1 displayed restlessness and attempted to enter other residents' rooms. Redirection was somewhat effective. On 4/28/26 at 3:04 a.m., the PRN administration was ineffective. At 5:37 a.m., a note indicated R1 was awake most of the overnight shift and assisted to bed twice and had one-to-one observation.-On 5/14/26, R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness at 7:29 p.m At 8:40 p.m., the PRN administration was noted as effective.-On 5/21/26 at 8:02 a.m., R1's left upper arm was swollen. The area was painful, and R1 was unable to move her arm. Vital signs were obtained, and the provider was notified. At 2:16 p.m., identified R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness. At 4:27 p.m., the PRN administration was noted as effective. A note at 10:00 p.m., indicated R1 was observed in bed trying to get her legs outside the bed around 3:00 p.m., so staff changed R1 and transferred R1 into wheelchair using full lift and pillow to support her left hand.-On 5/22/26 at 9:38 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness. At 12:38 p.m., the PRN administration was noted as effective.-On 5/22/26 at 2:50 p.m., R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness with note hospice nurse said ok to give, order being updated. At 7:42 p.m., the PRN administration was noted as effective. At 10:25 p.m., a hospice note identified R1 received comfort measures and had signs of pain with facial grimacing and yelling out. Agitation and restlessness noted in afternoon, and PRN medications were administered.-On 5/23/26 at 10:50 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness. At 1:18 p.m., the PRN administration was noted as effective.-On 5/24/26 at 10:05 a.m., R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness. At 10:16 a.m., a hospice note indicated R1 was slightly clammy, had facial grimacing, and requested facility nurse to give as needed morphine. Calming music was utilized. At 11:01 a.m., identified R1's PRN administration of lorazepam was effective.-On 5/24/26 at 2:10 p.m., R1 received 0.5 mg of lorazepam as needed for anxiety/restlessness. At 3:51 p.m., the PRN administration was identified as effective. A progress note at 10:44 p.m., indicated R1 was comfortable and without signs of distress and comfort medications were administered as scheduled.-On 5/25/26 at 10:25 a.m., R1 received 0.5 mg of lorazepam SoluTab as needed for anxiety/restlessness. At 12:26 p.m., the PRN administration was identified as effective. At 2:29 p.m., a hospice note identified increased lorazepam scheduled and PRN.-On 5/25/26 at 7:23 p.m., R1 received 1 mg of lorazepam as needed for anxiety/restlessness. At 9:06 p.m., the PRN administration was indicated as effective.-On 5/27/26 at 10:34 a.m., R1 received 1 mg of lorazepam SoluTab as needed for anxiety/restlessness. At 2:28 p.m., a progress note indicated R1 appeared comfortable with shallow respirations.-On 5/28/26 at 7:42 p.m., R1 received 1 mg of lorazepam SoluTab as needed for anxiety/restlessness. At 9:58 p.m., the PRN administration was indicated at effective. A progress note at 10:55 p.m. indicated R1 had no signs of distress and appeared comfortable.-On 5/28/26 at 2:40 a.m., R1 received 1 mg of lorazepam SoluTab as needed for anxiety/restlessness. At 5:04 a.m., the PRN administration was noted as effective.-On 5/28/26 at 2:22 p.m., R1 received 1 mg of lorazepam SoluTab as needed for anxiety/restlessness. At 5:54 p.m., the PRN administration was noted as effective. At 9:57 p.m., a general note indicated R1 had no signs of distress.During interview (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/2/26 at 3:20 p.m., nursing assistant (NA)-B stated R1 did not have anxiety or restlessness. NA-B stated R1 was busy and would not sit in one place and staff redirected her when needed.During interview on 6/2/26 at 3:38 p.m., registered nurse (RN)-B stated they knew which residents had anxiety by looking at their diagnoses. RN-B stated staff knew residents' behaviors and interventions from working with the residents and the care plan. RN-B stated they documented resident behaviors and non-pharmacologic interventions tried first before use of PRN psychotropic medication. RN-B stated R1 had anxiety and restlessness and wheeled herself around the building independently and would shout out hey one or two times and screamed when refused to eat or shower saying don't do it and I am not going. RN-B stated they spoke about R1's family to calm her down. Staff administered R1's as needed lorazepam when family stated R1 was anxious, and RN-B assessed R1's breathing pattern to identify if R1 was in distress and assessed relaxed breathing to know the as needed medication was effective.During interview on 6/2/26 at 4:53 p.m., the director of nursing (DON) reviewed R1's progress notes and care plan. The DON verified R1's PRN lorazepam medication administrations lacked consistent documentation of non-pharmacological interventions utilized prior to medication administration and nursing assessment to indicate reason for PRN lorazepam use. The DON stated the clinical coordinators updated care plans, resident monitoring, and Team sheets to indicate resident target behaviors and individualized non-pharmacological interventions.R2R2's admission MDS dated [DATE], indicated R2 had moderate cognitive impairment. R2 exhibited verbal behavioral symptoms directed toward others 1 to 3 days, which significantly disrupted care and living environments. R2's diagnoses included seizure disorder or epilepsy, traumatic brain injury, and anxiety disorder. R2 received antipsychotic, antianxiety, and antidepressant medication. The MDS indicated activity preferences as very important included books, newspaper, and magazines, music, animals, news, groups of people, favorite activities, fresh air, religious services.R2's care plan dated 5/27/26, identified R2 had an alteration in mood or behavioral expression and received psychotropic medications, such as antidepressant, antianxiety, and antipsychotic medications. R2's care plan directed staff to monitor occurrence for target behaviors and document per facility protocol; however, the care plan did not identify R2's individualized target behaviors. R2's care plan directed staff to encourage R2 to participate in activities of interest, explain all procedures to R2, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove R2 from situation and take R2 to an alternate location as needed. The care plan did not specify individualized non-pharmacological interventions, such as music or television.R2's Order Summary Report, identified medications for anxiety with an order date of 5/19/26:-hydroxyzine HCl (hydrochloride) oral tablet 25 mg by mouth as needed three times a day for anxiety for 14 days.National Medical Association's Drug Information Database indicated hydroxyzine HCl is used for symptomatic relief of anxiety and tension associated with psychoneurosis (chronic emotional, mood, or anxiety disturbances) and as an adjunct in organic disease states in which anxiety is manifested. Hydroxyzine HCl is used as a sedative when used as a premedication and following general anesthesia. Hydroxyzine actions may be due to a suppression of activity in certain key regions of the subcortical area of the central nervous system.Review of R2's record dated 5/19/26 to 6/1/26, indicated POC (point of care) target behavior monitoring; however, the records did not indicate individualized target behavior for R2's anxiety or documentation of individualized non-pharmacological interventions.R2's progress and Medication Administration notes dated 5/19/26 to 6/1/26, indicated use of as needed medication for anxiety and lacked nursing assessment to indicate reason for PRN psychotropic medication and non-pharmacological interventions utilized first:-On 5/23/26 at 8:39 a.m., R2 received 25 mg of hydroxyzine as needed for anxiety and was identified as effective at 1:21 p.m -On 5/24/26 at 11:06 a.m., R2 received 25 mg of hydroxyzine as needed for anxiety and was identified as effective at 3:06 p.m -On 5/25/26 at 8:41 a.m., R2 received 25 mg of hydroxyzine as needed for anxiety and was identified as effective at 12:26 p.m -On 5/25/26 at 10:50 p.m., a progress note indicated R2 had an angry outburst, yelling loudly at dinner table, asking for double portions, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telling staff to wheel him around because he is paid to do it. The record did not indicate any further assessment or as needed medication use.R2's Psychotropic Medication assessment dated [DATE] at 11:24 a.m., identified R2 received 25 mg by mouth of hydroxyzine as needed for anxiety for 14 days three times a day and scheduled olanzapine 20 mg by mouth at bedtime for anxiety. R2's target behaviors/mood warranting the use of medication indicated anxiety and identified activities as non-pharmacological interventions currently used and effectiveness.During interview on 6/2/26 at 3:04 p.m., R2 stated they had been at the facility for two weeks. R2 stated he watched television or listened to music when anxious. R2 stated he had racing thoughts when he got anxiety but could not articulate what the specific thoughts were.During interview on 6/2/26 at 3:26 p.m., nursing assistant (NA)-A stated R2 yelled out and made loud sounds at times and could not articulate what he was saying. NA-A stated R2 had his music loud or on the phone often when she entered his room. NA-A stated they checked on R2 when they heard him, and R2 would sometimes say he would want his blinds closed and other times did not articulate why. NA-A stated they did not document resident behaviors, but they notified the nurse of resident behaviors. NA-A reviewed R3's Team sheet information dated 6/1/26, and the sheet indicated R3's ambulation and toileting status and other activity of daily living information. The sheet did not mention R3's behaviors or non-pharmacological interventions.During interview on 6/2/26 at 3:38 p.m., registered nurse (RN)-B stated they knew which residents had anxiety by looking at their diagnoses. RN-B stated staff knew residents' behaviors and interventions from working with the residents and the care plan. RN-B stated they documented resident behavior and non-pharmacologic interventions tried first before use of PRN psychotropic medication. RN-B stated R2 had anxiety and verified R2 had psychotropic medication use. RN-B stated R2 called out for assistance instead of using his call light and had not seen any other behaviors for R2.During interview on 6/2/26 at 4:53 p.m., the director of nursing (DON) reviewed R2's progress notes, assessment, and care plan. The DON expected staff to document how the resident shows anxiety, such as tearfulness or calling out for help, and what soothes the resident, such as music or a calm space. The DON verified R2's care plan lacked individualized target behaviors and non-pharmacological interventions for PRN medication use related to anxiety.R3R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had moderate cognitive impairment and no hallucinations, delusions, behavioral symptoms, or rejection of care. R3's diagnoses included anxiety disorder and depression and received antipsychotic, antianxiety, and antidepressant medication.R3's Psychotropic Medication assessment dated [DATE], identified R3's target behaviors as agitation and non-pharmacological intervention currently used included social worker visits and watching television in the common area.R3's care plan dated 5/13/26, identified R3 received psychotropic medication and had an alteration in mood or behavioral expression related to anxiety and depression. The care plan directed staff to encourage R3 to participation in activities of interest, explain all procedures to R3, and intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove R3 from situation and take R3 to an alternate location as needed. The care plan did not indicate individualized target behaviors for R3. The care plan identified R3 enjoyed activities such as sorting poker chips, baking, crafts, sandbag toss, exercise class, devotionals.R3's Order Summary Report, indicated:-On 12/10/25, check and assess for agitation/restlessness and address accordingly every four hours.-On 12/19/25, behavioral expression: refer to behavior expression progress note template for assessment and documentation requirements every shift.In review of R3's PRN lorazepam administration documentation between 4/1/26 to 5/31/26, the record identified lack of individualized target behaviors to indicate reason for PRN psychotropic medication use and non-pharmacological interventions utilized first.-On 4/1/26 at 1:20 p.m. R3 received 0.5 mg of lorazepam as needed for anxiety/restlessness, and the PRN administration was identified as effective at 1:46 p.m -On 4/24/26 during 2:00 a.m. rounds, R2 was sitting at edge of bed looking for daughter who R2 thought was sleeping in the room next to her. The note indicated scheduled lorazepam was given, and R2 went back to bed.-On 4/29/26, R3 woke up (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around 1:00 a.m At 5:00 a.m., R3 received 0.5 mg of lorazepam as needed for anxiety/restlessness with a note indicating R3 had restlessness, and the PRN administration was identified as effective at 12:31 p.m -On 5/12/26, R3 was observed sitting on the floor at about 3:00 p.m. and stated she crawled out of bed to prepare the house for her child's birthday party. Physical assessment and vitals were completed. Full lift was used to transfer R3 to a chair.-On 5/13/26 at 12:00 a.m., R3 received 0.5 mg of lorazepam as needed for anxiety/restlessness, and the PRN administration was identified as effective at 7:08 a.m During interview on 6/2/26 at 3:20 p.m., nursing assistant (NA)-B stated R3 was anxious at times, such as suggesting going out the window to get to cars outside and not understanding the need to go through the building and out a door to get outside. NA-B stated they did not leave R3 alone in her room and encouraged R3 to read a book in the common area. NA-B stated they charted behaviors in POC (point of care) and told the nurse when they noticed R3 had anxiety or any behaviors. NA-B stated they knew about resident behaviors from their Team sheets. NA-B reviewed R3's sheet, and the sheet directed staff to not leave R3 in room alone, bring to common area, and talk to nurse if observed restlessness.During interview on 6/2/26 at 3:38 p.m., registered nurse (RN)-B stated they knew which residents had anxiety by looking at their diagnoses. RN-B stated staff knew residents' behaviors and interventions from working with the residents and the care plan. RN-B stated they documented resident behavior and non-pharmacologic interventions tried first before use of PRN psychotropic medication. RN-B verified R3 had as needed and scheduled psychotropic medication. RN-B stated R3's behaviors included crawling out of bed and thoughts of her children being young, such as needing to prepare a birthday party for a child, although her children were grown. RN-B stated R3 did not like to sit with people or noise, and RN-B would show R3 pictures on her wall of her grown children and grandkids.During interview on 6/2/26 at 4:53 p.m., the director of nursing (DON) reviewed R3's progress notes and care plan. The DON verified the record did not consistently indicate the reason for PRN psychotropic administration. The DON stated the care plan did not indicate how R3 displayed anxiety, and although the care plan indicated what activities R3 enjoyed, the DON expected a more robust care plan related to non-pharmacological interventions for R3's anxiety.The facility Psychotropic Medication Use Policy dated 3/2025, directed staff to monitor specific target behaviors for psychotropic medications. The policy indicated resident care plans were to include resident-specific target behaviors associated with psychotropic medication use and individual interventions. The policy indicated documentation would demonstrate resident subjective or objective improvements or maintenance of function while the resident received the medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an injury of unknown origin within the two-hours for 1 of 1 resident (R1) who had an injury of unknown origin of the left humerus (the long bone located in the upper arm, from the shoulder to the elbow).Findings include R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment, unclear speech, and impaired vision. R1 had disorganized thinking and no behaviors or rejection of care. The MDS identified R1's diagnoses included non-traumatic brain dysfunction, peripheral vascular disease, renal failure, Alzheimer's, and non-Alzheimer's dementia. R1 had hospice services with prognosis of less than six months of life. R1 was independent with wheelchair use, required partial and/or moderate assistance with eating and substantial/maximum to dependent on staff for other activities of daily living, such as transfers, dressing, toileting, and bed mobility.R1's abuse and/or neglect care plan focus dated 6/3/24, directed staff to follow the facility Vulnerable Adult Policy and keep R1 safe at all times.R1's progress note dated 5/21/26 at 8:02 a.m., identified R1's left upper arm was swollen. The area was painful, and R1 was unable to move her arm. Vitals were 126/93 mmHg (millimeters of mercury; standard unit of measurement for blood pressure), 99.7 degrees F (Fahrenheit), 18 RR (respiratory rate; number of breaths a person takes per minute), and 68 pulse. The provider was updated.R1's progress note dated 5/21/26 at 3:25 p.m., identified a 2-view x-ray of the left humerus was ordered.R1's Radiology Report dated 5/21/26, identified R1 had an acute mid humeral shaft fracture.R1's progress note dated 5/22/26 at 5:50 a.m., identified the DON was contacted about the results of the x-ray. R1 received scheduled pain medication for pain in her left arm, and R1's left arm was warm to touch, red in color, and swollen.The facility reported incident (FRI), submitted to the state agency on 5/22/26 at 9:30 a.m., identified R1 had an acute fracture deformity of the mid humerus shaft with mild displacement of the left arm. The report identified a nursing assistant noticed R1 grimacing and holding left arm while getting R1 up for the day. The nursing assistant noticed R1's left arm was swollen, and a nurse assessed R1 around 8 a.m. and notified R1's hospice team. An x-ray was ordered STAT (immediately, without delay), obtained in the afternoon of 5/21/26, and results were confirmed on 5/21/26 at 11:42 p.m Alleged perpetrator 1 information indicated unknown.During interview on 6/2/26 at 9:02 a.m., registered nurse (RN)-A stated they received report from the evening shift on 5/21/26 about waiting for the results of R1's x-ray. RN-A did not remember what time the x-ray result was received and stated they reported the results to the director of nursing (DON) and the triage provider line.During interview on 6/2/26 at 12:42 p.m., the DON stated the overnight nurse notified them of the x-ray results at 11:47 p.m. on 5/21/26, and verified the facility submitted their initial report to the State Agency on 5/22/26 at 9:30 a.m During follow-up interview on 6/2/26 at 4:53 p.m., the DON stated they started to interview staff about R1 Thursday morning on 5/21/26. The DON stated at the time of R1's x-ray result they had interviewed staff, reviewed camera footage, and continued to interview staff. The DON stated they could not determine someone had harmed R1 at the time of the x-ray results. By the end of Friday, 5/22/26, they were concluding R1's fracture was not a result of abuse or harm and continued to interview staff.On 6/2/26 at 6:28 p.m., the administrator stated abuse had not been ruled out at the time of the fracture report.The facility Vulnerable Adult Abuse Prevention Plan dated 10/2025, indicated allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, will be reported immediately within the state and federal guidelines. The policy directed the administrator or designee to report no later than two hours after the allegation is made if the event that caused the allegation involved abuse or resulted in serious bodily injury.