STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555893	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pasadena Nursing Center	1570 North Fair Oaks Ave Pasadena, CA 91103

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure (P&P) for Abuse Investigation and Reporting for two of three residents (Resident 1 and Resident 2) by failing to: 1. Conduct a thorough and complete investigation of an allegation of physical abuse to Resident 1 who was found with scratch marks on the right side of his face and the resident stated someone else had done it on 3/26/2025. 2. Report an allegation of physical abuse to Resident 1 to the State Survey Agency (SA, where state law provides for jurisdiction in long-term care facilities), ombudsman (OMB- advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement within two (2) hour timeframe from when the allegation was made by the resident on 3/26/2025. 3. Ensure facility staff provided Resident 2 with one-to-one (1:1) supervision (a dedicated staff member provides constant, continuous observation and care to a single resident, ensuring their safety and well-being) on 3/28/2025 in accordance with the physician's order. These deficient practices placed Resident 1 at risk for further physical abuse and for Resident 2 for potentially abusing another resident in the facility. Cross reference with F610 Findings: 1.During a review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought) and extrapyramidal (a group of involuntary movements that can occur as side effects of certain medications, most commonly antipsychotic drugs) and movement disorder. During a review of Resident 1's Minimum Data Set: (MDS- resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 1 was independent (resident completes the activity by themself with so assistance from a helper) to eat, perform oral and personal hygiene, for toileting, showering, upper and lower body dressing, putting on and taking off footwear, rolling left and right, sit to lying, sit to stand, and chair/bed transfer. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Change of Condition, dated 3/26/2025, indicated Resident 1 had been found with scratches on the right side of his face and had stated someone else had done it. During a review of Resident 1's Orders, dated 3/26/2025, indicated, Resident 1 had a new order to treat scratches on Resident 1's face with normal saline (a sterile solution of 0.9% of sodium chloride in water used for hydration and wound cleaning/ flushing solution), and antibiotic ointment. 2.During a review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of exposure to disaster, war and other hostilities, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and pulmonary edema (a condition where fluid accumulates in the lungs, making it difficult to breathe). During a review of Resident 2's Care Plan (CP), dated 11/22/2024, indicated Resident 2 had struck another resident in the face, and interventions included monitor closely for aggressive behavior, separate resident from others, and remove resident from situation. The CP, initiated on 3/28/2024, indicated Resident 2 had aggressive behavior directed towards others and staff was to monitor closely for aggressive behavior and separate resident from others when behavior present. During a review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate cognitive impairment skills for daily decision making. The MDS indicated Resident 2 required setup or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, Supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene and upper body dressing, partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for toileting, lower body dressing, putting on taking off footwear, rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, toilet transfer, and maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) to shower. During a review of Resident 2's Change of Condition, dated 3/26/2025 indicated Resident 2 was noted verbally and physically aggressive towards staff and roommate (not indicated who), increasingly agitated, striking out at staff. During a review of Resident 2's Order Summary, indicated Resident 2 was placed on 1:1 monitoring (1:1 supervision) for 72 hours on 3/26/2025. During a review of Resident 2's Medication Administration Record (MAR), the MAR indicated Resident 2 had two (2) behavioral episodes of yelling on the evening of 3/26/2025. During a review of the facility's Nursing Staffing Assignment Sign-In Sheet, dated 3/26/2025, indicated Certified Nursing Assistant 1 (CNA1) was assigned to care for residents in room [ROOM NUMBER] (previous room of Resident 1 and 2). (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview of 3/27/2025 at 4:25 PM, with CNA1, the CNA1 stated she was scheduled to work from 3 PM to 11 PM on 3/26/2025 and was assigned to take care of Resident 1 and 2 who were in room [ROOM NUMBER]. CNA1 stated on 3/26/2025 at around 5 PM or 6 PM during evening care for Resident 2, Resident 2 kept throwing towels on the floor and pressing the call light for staff to assist the resident. CNA1 stated she asked Resident 2 not to throw the towels on the floor, and when she was assisting Resident 2 during perineal hygiene, Resident 2 began to yell and punch her on the left side of her chest. CNA1 stated ran out of the room to find the charge nurse to report the incident. CNA1 stated during the time that she was out trying to find the charge nurse, Residents 1 and 2 got into an altercation. CNA1 stated one of the Licensed Vocational Nurse (LVN- CNA 1 cannot recall the name) began to reprimand Resident 2 for allegedly hitting Resident 1. CNA1 stated she reported the altercation and aggressive behavior of Resident 2 to the licensed nurses (unable to recall name), but the licensed nurses refused to report this altercation to law enforcement, the administrator, and state agency. CNA1 stated her and another male CNA with gray hair (CNA 1 unable to recall name of CNA) helped CNA 1 move Resident 1 from room [ROOM NUMBER]B to another room. CNA1 stated no one had reported the alleged physical abuse by Resident 2 to Resident 1. During an interview on 3/28/2025 at 9:37 AM with the Director of Staff Development (DSD), the DSD stated facility staff are required to report to SA, OMB and local law enforcement any type of abuse immediately and no later than two hours of the alleged abuse occurring. During a concurrent observation and interview on 3/28/2025 at 9:45 AM with Resident 2, in Resident 2's room, Resident 2 was laying down in bed, had a tenses jaw, furrowed brows, and had prolonged eye contact. Resident 2's body language was rigid and had clenched fists. Resident 2 stated he was moved from his room because he beat somebody up (unable to recall when). During an interview on 3/28/2025 at 9:58 AM with LVN1, the LVN1 stated Resident 2 was occupying bed C in room [ROOM NUMBER] and Resident 1 was in 18B on the evening of 3/26/2025. LVN1 verified, Resident 1 was moved to room [ROOM NUMBER]A, and Resident 2 was moved to 20A that same evening (3/26/2025). During a concurrent observation and interview on 3/28/2025 at 10:04 AM with Resident 1, in the activity room, Resident 1 was observed in the activity room sitting down, with gestures were slow and controlled and had a soft tone of voice. Resident 1 had dried up blood stains on the right side of his face, and a scratch and bruise on his right eye. Resident1 stated I was attacked yesterday (3/27/2025) or the day before (3/26/2025) by my roommate. Resident 1 stated he was in room [ROOM NUMBER]B before they moved him to 15A because he got into a fight with his roommate. Resident 1 stated no one helped him. During an interview on 3/28/2025 at 10:25 AM with LVN 2, the LVN2 stated Resident 2 was on 1:1 supervision order 3/26/25 due to his Behavior of being verbally and physically aggressive towards staff and roommate. The LVN 2 stated there should be a staff member present at all times watching Resident 2, and any licensed nurse can report abuse to the administrator and appropriate agencies immediately and within a two-hour window of when the suspected/ allegation of abuse was made or from when the abuse was identified. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2025 at 11:05 AM with Social Services (SS) staff, the SS staff stated he visited Resident 1 on 3/27/2025 to ask how the resident was doing and SS staff noted that Resident 1 had a scratch on the resident's face. SS staff stated, he did not report it to the licensed nurses nor the Administrator but should have reported it since SS staff does not know the cause of injury and could be a result of an abuse. During an interview on 3/28/2025 at 11:44 AM with LVN 3, the LVN 3 stated on 3/26/2025, she was in the office, which is located next to room [ROOM NUMBER], when CNA1 came to notify her that Resident 2 had attacked CNA 1. LVN 3 stated, at the same time she overhead the charge nurse say that Resident 1 had scratches on the resident's face. LVN 3 stated when she walked into room [ROOM NUMBER], LVN 3 found Resident 1 with a scratch to his nose and face while Resident 2 was noted to be yelling at everyone in the room. LVN 3 stated she asked Resident 1 what happened, to which Resident 1 answered someone else did it. LVN 3 stated she did not report this to the administrator because she believed Resident 1 had done this to himself, despite not having witnessed it. LVN 3 stated since she did not witness what happened to Resident 1, it was considered an unknown injury or allegation of physical abuse. LVN 3 stated the different types of abuse include physical, seclusion (isolation), and misappropriation (unauthorized use of funds, personal property) and are supposed to be reported immediately to the Administrator to ensure a thorough investigation will be conducted, however LVN 3 stated she did not report to the Administrator like she's supposed to. During a concurrent observation in Resident 2's room (room [ROOM NUMBER]) and interview on 3/28/2025 at 12:35 PM with CNA2, CNA2 stated he was watching resident in room [ROOM NUMBER] Bed B and Resident 2 was in room [ROOM NUMBER] Bed A. CNA2 stated he was not observing Resident 2 because he was not assigned to provide 1:1 sitter to Resident 2. CNA2 stated he was assigned to the resident room [ROOM NUMBER] in Bed B. Observed the resident in Rom 20 Bed A got up from his bed and left the room, and CNA2 followed the other resident and left the room, while Resident 2 was left in the room without other facility staff to provide 1:1 supervision to the resident. During an interview on 3/28/2025 at 4 PM, with CNA3, the CNA3 stated on 3/26/2025 he was in room [ROOM NUMBER], when he noted Resident 1 walked out of room [ROOM NUMBER] pointing to his face which was swollen. The CNA3 stated he notified LVN 3. During an interview on 3/28/2025 at 3 PM with the Administrator, the Administrator stated no one from the facility notified her to report the unknown injuries, resident-resident altercation and/ or any allegation if abuse to Resident 1 that occurred on 3/26/2025. The Administrator stated the facility staff are required to notify the Administrator when allegations of abuse and/or unknow injury occur, and she had not started an internal investigation to identify potential causes. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting dated December 2007, indicated the facility is to report events that threaten the welfare and safety or health of residents to the appropriate agencies within 24 hours of such incident, and a written report detailing the incident and actions taken by the facility delivered to the state agency within 48 hours of reporting the event. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Abuse Investigation and Reporting dated July 2017, indicated the individual conducting the investigation of the incident or suspected incident of resident abuse, mistreatment, or injury of unknown source is to interview any witnesses to the incident, interview staff members on all shifts who have had contact with the resident during the period of the alleged incident, and interview the resident's roommate, and review all events leading up to the alleged incident. The P&P indicated all reports of resident abuse, unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management immediately, but no later than 2 hours.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to conduct a thorough investigation of an allegation of physical abuse (intentional act causing injury or trauma to another person by way of bodily contact such as hitting/ scratching/ pinching) to one of three sampled residents (Resident 1) who was found with scratch marks on the right side of his face and the resident stated someone else had done it on 3/26/2025. This deficient practice resulted in compromising the safety of Resident 1 and placed the resident at risk for further physical abuse. Cross reference with F607 Findings: 1.During a review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought) and extrapyramidal (a group of involuntary movements that can occur as side effects of certain medications, most commonly antipsychotic drugs) and movement disorder. During a review of Resident 1's Minimum Data Set: (MDS- resident assessment tool), dated 1/7/2025, the MDS indicated Resident 1 had moderate cognitive impairment (ability to think, reason, and make decisions) skills for daily decision making. The MDS indicated Resident 1 was independent (resident completes the activity by themself with so assistance from a helper) to eat, perform oral and personal hygiene, for toileting, showering, upper and lower body dressing, putting on and taking off footwear, rolling left and right, sit to lying, sit to stand, and chair/bed transfer. During a review of Resident 1's Change of Condition, dated 3/26/2025, indicated Resident 1 had been found with scratches on the right side of his face and had stated someone else had done it. During a review of Resident 1's Orders, dated 3/26/2025, indicated, Resident 1 had a new order to treat scratches on Resident 1's face with normal saline (a sterile solution of 0.9% of sodium chloride in water used for hydration and wound cleaning/ flushing solution), and antibiotic ointment. 2.During a review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of exposure to disaster, war and other hostilities, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and pulmonary edema (a condition where fluid accumulates in the lungs, making it difficult to breathe). During a review of Resident 2's Care Plan (CP), dated 11/22/2024, indicated Resident 2 had struck another resident in the face, and interventions included monitor closely for aggressive behavior, separate resident from others, and remove resident from situation. The CP, initiated on 3/28/2024, indicated Resident 2 had aggressive behavior directed towards others and staff was to monitor closely for aggressive behavior and separate resident from others when behavior present. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate cognitive impairment skills for daily decision making. The MDS indicated Resident 2 required setup or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, Supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene and upper body dressing, partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for toileting, lower body dressing, putting on taking off footwear, rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, toilet transfer, and maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) to shower. During a review of Resident 2's Change of Condition, dated 3/26/2025 indicated Resident 2 was noted verbally and physically aggressive towards staff and roommate (Resident 1), increasingly agitated, striking out at staff. During a review of Resident 2's Order Summary, indicated Resident 2 was placed on one to one (1:1) monitoring (a caregiver or health worker who provides constant, one- on- one supervision and care to the patient) for 72 hours on 3/26/2025. During a review of Resident 2's Medication Administration Record (MAR), the MAR indicated Resident 2 had two (2) behavioral episodes of yelling on the evening of 3/26/2025. During a review of the facility's Nursing Staffing Assignment Sign-In Sheet, dated 3/26/2025, indicated Certified Nursing Assistant 1 (CNA1) was assigned to care for residents in room [ROOM NUMBER] (previous room of Resident 1 and 2). During an interview of 3/27/2025 at 4:25 PM, with CNA1, the CNA1 stated she was scheduled to work from 3 PM to 11 PM on 3/26/2025 and was assigned to take care of Resident 1 and 2 who were in room [ROOM NUMBER]. CNA1 stated on 3/26/2025 at around 5 PM or 6 PM during evening care for Resident 2, Resident 2 kept throwing towels on the floor and pressing the call light for staff to assist the resident. CNA1 stated she asked Resident 2 not to throw the towels on the floor, and when she was assisting Resident 2 during perineal hygiene, Resident 2 began to yell and punch her on the left side of her chest. CNA1 stated ran out of the room to find the charge nurse to report the incident. CNA1 stated during the time that she was out trying to find the charge nurse, Residents 1 and 2 got into an altercation. CNA1 stated one of the Licensed Vocational Nurse (LVN- CNA 1 cannot recall the name) began to reprimand Resident 2 for allegedly hitting Resident 1. CNA1 stated she reported the altercation and aggressive behavior of Resident 2 to the licensed nurses (unable to recall name), but the licensed nurses refused to report this altercation to law enforcement, the administrator, and state agency. CNA1 stated her and another male CNA with gray hair (CNA 1 unable to recall name of CNA) helped CNA 1 move Resident 1 from room [ROOM NUMBER]B to another room. CNA1 stated no one had reported the alleged physical abuse by Resident 2 to Resident 1. During a concurrent observation and interview on 3/28/2025 at 9:45 AM with Resident 2 in the resident's room, Resident 2 was laying down in bed, had a tenses jaw, furrowed brows, and had prolonged eye contact. Resident 2's body language was rigid and had clenched fists. Resident 2 stated he was moved from his room because he beat somebody up (unable to recall when). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2025 at 9:58 AM with LVN1, the LVN1 stated Resident 2 was occupying bed C in room [ROOM NUMBER] and Resident 1 was in 18B on the evening of 3/26/2025. LVN1 verified, Resident 1 was moved to room [ROOM NUMBER]A, and Resident 2 was moved to 20A that same evening (3/26/2025). During a concurrent observation and interview on 3/28/2025 at 10:04 AM with Resident 1, in the activity room, Resident 1 was observed in the activity room sitting down, with gestures were slow and controlled and had a soft tone of voice. Resident 1 had dried up blood stains on the right side of his face, and a scratch and bruise on his right eye. Resident1 stated I was attacked yesterday (3/27/2025) or the day before (3/26/2025) by my roommate. Resident 1 stated he was in room [ROOM NUMBER]B before they moved him to 15A because he got into a fight with his roommate. Resident 1 stated no one helped him. During an interview on 3/28/2025 at 10:25 AM with LVN 2, the LVN2 stated Resident 2 was on 1:1 supervision order 3/26/25 due to his Behavior of being verbally and physically aggressive towards staff and roommate. The LVN 2 stated there should always be a staff member present watching Resident 2. During an interview on 3/28/2025 at 11:44 AM with LVN 3, the LVN 3 stated on 3/26/2025, she was in the office, which is located next to room [ROOM NUMBER], when CNA1 came to notify her that Resident 2 had attacked her. LVN 3 stated, at the same time she overhead the charge nurse say that Resident 1 had scratches on his face. The LVN 3 stated when she walked into room [ROOM NUMBER], she found Resident 1 with a scratch to his nose and face while Resident 2 was noted to be yelling at everyone in the room. LVN 3 stated she asked Resident 1 what happened, to which Resident 1 answered someone else did it. LVN 3 stated she did not report this to the administrator because she believed Resident 1 had done this to himself, despite not having witnessed it. LVN 3 stated since she did not witness what happened to Resident 1, it was considered an unknown injury or allegation of physical abuse. LVN 3 stated it is a possibility that Resident 1 could have gotten triggered by watching Resident 2 hit CNA1 and causing him to get aggressive as well. LVN 3 stated the different types of abuse include physical, seclusion (isolation), and misappropriation (unauthorized use of funds, personal property) and are supposed to be reported immediately to the Administrator to ensure a thorough investigation will be conducted. During an interview on 3/28/2025 at 4 PM, with CNA3, the CNA3 stated on 3/26/2025 he was in room [ROOM NUMBER], when he noted Resident 1 walked out of room [ROOM NUMBER] pointing to his face which was swollen. The CNA3 stated he notified LVN 3. During an interview on 3/28/2025 at 3 PM with the Administrator, the Administrator stated no one from the facility notified her to report the unknown injuries, resident-resident altercation and/ or any allegation if abuse to Resident 1 that occurred on 3/26/2025. The Administrator stated the facility staff are required to notify the Administrator when allegations of abuse and/or unknown injury occur, and she had not started an internal investigation to identify potential causes. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting dated December 2007, indicated the facility is to report events that threaten the welfare and safety or health of residents to the appropriate agencies within 24 hours of such incident, and a written report detailing the incident and actions taken by the facility delivered to the state agency within 48 hours of reporting the event. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Abuse Investigation and Reporting dated July 2017, indicated the individual conducting the investigation of the incident or suspected incident of resident abuse, mistreatment, or injury of unknown source is to interview any witnesses to the incident, interview staff members on all shifts who have had contact with the resident during the period of the alleged incident, and interview the resident's roommate, and review all events leading up to the alleged incident. The P&P indicated all reports of resident abuse, unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management immediately, but no later than 2 hours.