STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Watseka	715 East Raymond Road Watseka, IL 60970

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure Registered Nurse (RN) coverage of at least eight consecutive hours per day, seven days a week. This failure has the potential to affect all 62 residents within the facility.Findings Include: Facility Midnight Census dated 2/21/26 documents 62 residents in house. The Facility Assessment Tool dated 11/2025-11/2026 Appendix 3 documents staffing information for units per shift. The facility has two shifts, shift one is 6:00am to 6:00pm and shift two is 6:00pm to 6:00am. Shift one requires one Registered Nurse (RN), two Licensed Practical Nurses (LPN), and six Certified Nursing Assistants (CNA). Shift two requires one RN, one LPN, and five CNAs. Daily Schedules dated 1/3/26, 1/4/26, 1/17/26, 1/18/26, 1/31/26, 2/1/26, 2/7/26, 2/8/26, 2/21/26, and 2/22/26 document no RN coverage for each 24-hour timeframe. On 2/24/26 at 2:40PM V2 Director of Nursing stated she is aware they have a shortage of Registered Nurses (RN) and often do not have an RN in the building on the weekends. V2 stated facility is actively hiring RNs.

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services and failed to employ a person-in-charge (PIC) with the required Food Protection Manager Certification. These failures have the potential to affect all 62 residents in the facility.Findings include:1. On 2/24/2026 at 10:58AM, V7 (Dietary Manager) was actively supervising dietary operations in the facility kitchen. V7 reported being the full-time manager of the facility food service and reported not being a clinically qualified Certified Dietary Manager (also known as Certified Food Protection Professional) or having equivalent training. V7 denied meeting the State of Illinois standards to be a food service manager or dietary manager (required in states that have their own established standards to be a food service manager or dietary manager (483.60(a)(2)ii). V7 reported only completing a one-day course (Certified Food Protection Manager) on food service sanitation which did not include any instruction on clinical nutrition. V7 denied:-being a dietician;-being a certified dietary manager;-having an associate's or higher degree in food service management or in hospitality;-being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition; -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician; -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. 2. On 2/22/2026 at 8:34AM, V8 (Cook) was working in the facility kitchen and reported being the Person in Charge for the shift. On 2/24/2026 at 10:58AM, V7 (Dietary Manager) reported V8 was not a Certified Food Protection Manager.On 2/25/2026 at 11:03AM, V7 reported V8 was the Person in Charge for first shift on 2/22/2026. The U.S. Food and Drug Administration Food Code (2022) documents a dietary service Person in Charge (PIC) shall be a Certified Food Protection Manager.Throughout the duration of the survey from 2/22/2025-2/25/2025 on first and second shifts, the facility failed to effectively sanitize dishes, failed to follow manufacturer's instructions for safe disinfectant use, failed to utilize appropriate sanitation test equipment, failed to ensure an ice machine drain line was properly plumbed to prevent the potential for cross-contamination of ice, and failed to maintain sanitary floor surface areas. On 2/24/2025 at 11:25AM, V7 reported the food prepared in the kitchen is available for all residents in the facility to eat and reported the facility dietician does not work in the facility full-time but is present twice per month. The facility Midnight Census report (2/25/2026) documents 62 residents reside in the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to serve diets as planned on the menu. These failures have the potential to affect all 62 residents in the facility. Findings include:The facility Diet Spreadsheet (2/13/2026) documents residents receiving regular diets are to receive a dinner roll/margarine with their lunch meal on 2/22/2026. The same record documents residents who receive pureed diets are to receive a #20 scoop of pureed dinner roll/margarine and a #12 scoop of pureed peaches with their lunch meal on 2/22/2026.On 2/22/2026 at the lunch meal service, no dinner rolls/margarine and no pureed dinner rolls/margarine and no pureed peaches were present at the service line where kitchen staff were preparing resident lunch meals. No resident lunch meals on 2/22/2026 included a dinner roll/margarine or a pureed dinner roll/margarine or pureed peaches. On 2/22/2026 at 12:32PM, V9 (Dietary Aide) reported pureed peaches were not made or served at lunch for residents who received puree diets, and dinner roll/margarine were not prepared or served today for any resident. At 2/24/2026 at 11:27AM, V7 (Dietary Manager) reported not knowing why staff did not prepare dinner rolls/margarine, pureed dinner rolls/margarine, or pureed peaches per the menu during lunch on 2/22/2026.The facility Midnight Census report (2/25/2026) documents 62 residents reside in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to effectively sanitize dishes, failed to follow manufacturer's instructions for safe disinfectant use, failed to utilize appropriate sanitation test equipment, failed to ensure an ice machine drain line was was properly plumbed to prevent the potential for cross-contamination of ice, and failed to maintain sanitary floor surface areas. These failures have the potential to affect all 62 residents residing in the facility. Findings include:1. On 2/22/2026 at 8:45AM, V8 (Cook) was operating the kitchen mechanical sanitizing dishwasher and reported being the Person in Charge for the shift. V8 retrieved chemical sanitizer test strips to test the sanitizer concentration in the dishwasher. The test strips did not detect any sanitizer was present in the operating dishwasher (a concentration of zero parts per million). V8 observed the test strip and stated I don't know anything about the dishwasher. V8 reported V8 would inform the dietary manager of the dishwasher sanitizer dispenser not dispensing sanitizer correctly into the dishwasher during operation. A data logsheet titled Low Temp Dish Machine Log (February 2026) was present on the wall adjacent to the dishwasher and documented the required operating conditions for the dishwasher to wash and effectively sanitize dishes. The log documented the dishwasher wash and rinse temperature are required to be between 120-140 degrees Fahrenheit and the sanitizer concentration between 50-100 parts per million to effectively wash and sanitize dishes. The statement see instructions on the dish machine was located at the bottom of the log sheet below the above operating parameters. No corrective action instructions were present on the log to guide kitchen staff on what steps to take if the required dishwasher temperatures and sanitizer levels were not maintained while operating the dishwasher.The above log contained blank lines for kitchen staff to document the kitchen dishwasher temperatures and sanitizer levels every day when dishes are washed after breakfast, lunch, and supper. The log documented staff recorded dishwasher wash and rinse temperature of 300 degrees Fahrenheit every breakfast, lunch, and supper from February 3, 2026 through February 24, 2026. The same record documented kitchen staff measured the dishwasher sanitizer concentration at 75 parts per million when washing dishes after every meal from February 1, 2026 through lunch on February 22, 2026. At 8:45AM, the log documented V8 recorded temperature and sanitizer levels during breakfast and lunch on 2/22/2026 even though lunch had not yet occurred in the facility and V8 was still washing breakfast dishes. The dishwasher Data Plate, located at eye level on the front of the dishwasher, was completely worn and no longer displayed the operating specifications (wash/rinse temperatures, sanitizer level) of the dishwasher as required by the U.S. Food and Drug Administration Food Code (2022).On 2/22/2026 at 12:05PM, V10 (Dish Washing Aide) was washing dishes with the above dishwasher. The dishwasher sanitizer concentration measured 25 parts per million by Survey Agency chemical test strip, again below the minimum level necessary to effectively sanitize dishes. On 2/22/2026 at 12:30PM, V8 (Cook) was working in the facility kitchen and reported not yet informing the Dietary Manager about the malfunctioning dishwasher.On 2/24/2026 at 11:15AM, V7 (Dietary Manager) reported the above dishwasher temperatures of 300F recorded by staff could not be correct and are not possible as the dishwasher temperature does not go that high. V7 reported the dishwasher had not been dispensing sanitizer correctly into the dishwasher on 2/22/2026. 2. On 2/22/2026 at 8:43AM, a three-basin sink was located in the kitchen dishwashing room to wash, rinse, and sanitize dishes in the first, second, and third sink basins, respectively. A chemical dispenser was attached to the wall above the sinks to dispense sanitizer into the third basin. The dispenser was supplied by a one-gallon jug of quaternary ammonia disinfectant. The chemical dispenser was designed to be supplied with sanitizer and not disinfectant. V8 (Cook) was present and reported the facility fills wiping buckets with the solution from the dispenser located at the three-basin sink and the buckets are then used to wipe food preparation surfaces in the kitchen and also to wipe resident dining room tables. V8 retrieved chemical test strips (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	designed to test quaternary ammonia sanitizer concentrations between 200-400 parts per million in prepared sanitizer solutions. The test strips turned a very dark green color when exposed to the quaternary ammonia solution from the dispenser, indicating a concentration well beyond the top limit (400 parts per million) capable of being measured by the test strips. The manufacturer's label on the jug of disinfectant documented the disinfectant was not labeled for use as a sanitizer or to wash dishes. The label documented the disinfectant should be prepared at a concentration of 875 parts per million and could be used to disinfect food contact surfaces, but only when disinfection was followed by a potable water rinse to prevent the potential for inadvertent toxic ingestion of disinfectant. On 2/22/2026 at 8:54AM, V8 (Cook) reported staff do not complete a potable water rinse after wiping kitchen and resident dining room table surfaces with the above prepared disinfectant. A data logsheet titled Sanitizing Bucket Chemical Log (February 2026) was present on the wall adjacent to the three-basin sink and attached chemical dispenser and documented the sanitizer solution dispensed from the chemical dispenser should be between 200-400 parts per million quaternary ammonia. No corrective action instructions were present on the log to guide kitchen staff on what steps to take if the chemical dispenser failed to dispense sanitizer at the required concentration. The log contained blank lines for kitchen staff to document the sanitizer concentration of prepared wiping bucket sanitizer solution when tested with the above chemical test strips. The log documented staff measured a wiping bucket sanitizer concentration of 200 parts per million of quaternary ammonia each day from February 1, 2026 to the morning of February 22, 2026. On 2/24/2026 at 11:20AM, V7 (Dietary Manager) reported kitchen staff had accidentally installed a jug of disinfectant instead of sanitizer at the above three-basin sink. V7 reported not knowing how long the disinfectant was in place and being used instead of sanitizer at the three-basin sink. 3. On 2/22/2026 at 9:05AM, the dietary service ice maker discharge drain was directly plumbed into the facility sewer. The ice maker drain line consisted of a flexible poly hose attached directly to a hole drilled through a pipe coupler located just above the floor surface beside the ice maker. No air gap or air break (a physical separation between a drain line and a sanitary sewer) was present to prevent the potential for sewage gas or liquid sewage from backflowing into the ice storage bin and no floor drain was present nearby the ice maker to prevent such backflow. The U.S. Food and Drug Administration Food Code (2022) documents any equipment in which food is placed may not have a direct connection to a sewer. On 2/24/2026 at 10:05AM, the ice maker remained as above.4. On 2/22/2026 at 9:00AM, the tiled flooring surfaces throughout the kitchen and pantry areas were excessively soiled with dark accumulations of food debris, silverware, paper, plastic, cellophane tape, cardboard, foam, and towels. The entire floor surface was unsealed, not easily cleanable, and numerous floor tiles were crumbling or partially detached from the floor. On 2/24/2026 at 11:30AM, the floor surfaces remained as above. V7 (Dietary Manager) reported the kitchen staff last cleaned the flooring areas about a month ago. V7 reported the floors definitely need cleaned. On 2/24/2025 at 11:25AM, V7 reported the food prepared in the kitchen is available for all residents in the facility to eat.The facility Midnight Census report (2/25/2026) documents 62 residents reside in the facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate a Pre-admission Screening and Resident Review (PASARR) for residents with mental illness diagnoses during their residency at the facility. This failure affects two (R5, R23) of five residents reviewed for PASARR II completion in the sample list of 34. Findings include: 1. R5's Face Sheet dated 2/24/26 documents R5 was admitted to the facility on [DATE]. R5's Electronic Medical Record documents R5 has the following medical diagnoses Psychotic Disorder and Mood Affective Disorder (9/17/24). R5's PASARR Level I dated 9/20/23 documents a Level II screening is not indicated because there is no evidence of a serious behavioral health condition/SMI/ID/RC (Serious Mental Illness, Intellectual Disability and/or Related Condition). If changes occur or new information refutes these findings, a new screen must be submitted. 2. R23s Face Sheet dated 2/24/26 documents R23 was originally admitted to the facility on [DATE]. R23's Electronic Medical Record documents R23 has the following diagnoses including Delusional Disorders (4/26/23), Anxiety Disorder (5/30/24), and Personal History of other Mental Disorders and Behavioral Disorders (7/1/25). R23's PASARR Level I dated 2/20/23 documents a Level II screening is not indicated because there is no evidence of a serious behavioral health condition/SMI/ID/RC (Serious Mental Illness, Intellectual Disability and/or Related Condition). If changes occur or new information refutes these findings, a new screen must be submitted. On 2/24/26 at 9:30am, V14 Social Services Director stated PASARR Level II screenings should have been done for R5 and R23 at the time their qualifying diagnoses were identified. The facility's Preadmission Screening and Annual Resident Review (PASARR) Policy dated 01/2026 documents the following: The PASARR will be evaluated annually and upon any significant change for those individuals identified. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review the facility failed to complete weekly skin assessments for one of one resident (R8) reviewed for pressure sores on a sample list of 34.Findings Include:The Facility Skin Condition Assessment & Monitoring - Pressure and Non-Pressure Policy with no revision date documents Pressure and other Ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record. Resident identified will have a weekly skin assessment by a licensed nurse and each resident will be observed for skin breakdown daily during care and on the assigned bath day by the Certified Nursing Assistant. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. The Wound Round assessment dated completed 2/19/26 by V4 Wound Nurse documents R8 has stage three pressure sores to the coccyx measuring 0.50 centimeters (cm) length, 0.50 cm width, and 0.10 cm depth, the left iliac crest measuring 3.00 cm length, 3.50 cm width and 0.10 cm depth and the right iliac crest measuring 2.0 cm length, 1.50 cm width and 0.10 cm depth. R8's medical record documents Skin Assessments were completed on 1/13/2026, 12/12/25, 12/6/26 and 11/27/26. On 2/24/26 at 10:13AM, V16 Licensed Practical Nurse stated three to four physician ordered dressing changes are completed daily at night and as needed for R8. On 2/24/26 at 10:35AM, V4 stated V4 completes wound assessments weekly on Thursdays and documents the assessments in the wound documentation application. V4 stated nurses are to be completing skin assessments on all residents on their shower days and documenting the assessments in the electronic medical record and reporting changes to V4. V4 confirmed there were no weekly skin assessments completed for R8. V4 stated R8's last skin assessment documented in the electronic medical record was dated on 1/13/26.On 2/24/26 at 10:40AM, V2 Director of Nursing confirmed weekly skin assessments have not been completed for R8 since 1/13/26 and the nursing staff should be completing the assessments weekly on showers days and documenting the assessments in the electronic medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to properly clean, store, change, and label oxygen tubing, and a nebulizer mask according to facility policy for one of four residents (R66) reviewed for respiratory care on the sample list of 34. Findings Include:R66's admission Record dated 2/24/26 documents an admission date of 2/7/26 with medical diagnoses of Alcohol Abuse, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Chronic Respiratory Failure with Hypoxia, Dependence on Supplemental Oxygen, Paroxysmal Atrial Fibrillation, Alcoholic Cirrhosis of Liver without Ascites, Pan Lobular Emphysema, Spinal Stenosis, Cervical Region, Vitamin D Deficiency, Nicotine Dependence, Major Depressive Disorder, Single Episode, Moderate, Developmental Disorder of Scholastic Skills, Other Nonspecific Abnormal Finding of Lung Field, Orthopnea, and Interstitial Pulmonary Disease.On 2/23/2026 at 2:31 PM R66 was moving down the hallway in the wheelchair. A portable oxygen tank with tubing was on the back of the wheelchair and was not being used by R66. R66 appeared short of breath but stated he would be fine and just needed to get his heartrate down. R66 complained of nose dryness and stated R66 did not want to use the oxygen. R66 stated staff have not connected R66's oxygen to humidification. R66 stated staff have not changed any of his tubing and he brought a nebulizer machine from home with a mask. R66 stated the facility gave him a new mask for the nebulizer but no one has cleaned the mask after R66's treatments.On 2/22/2026 at 9:35 AM R66's oxygen concentrator was between the bed and the window. The humidification bottle was in the holder on the tank and was not attached to the concentrator. There was no date on the bottle. A nasal cannula was attached to the concentrator and was being used by R66. The cannula tubing was not dated. A nebulizer machine was on the bedside table with tubing and mask attached. The mask was uncovered and lying on top of the nebulizer machine. The mask had a dried white crystal looking substance covering the inside of the mask and filter. No date was noted on the mask or mask tubing. A nasal cannula was attached to the portable oxygen tank on the back of R66's wheelchair and the cannula was not dated.On 2/24/26 at 2:40PM V2 Director of Nursing (DON) stated all respiratory tubing, and masks should be changed weekly and dated. On 2/24/26 at 3:15 PM V4 Assistant Director of Nursing (ADON) stated that R66's tubing had not been labeled. V4 ADON stated that all of R66's respiratory tubing and masks were changed and labeled just now. The facility's policy titled Oxygen & Respiratory Equipment-Changing/Cleaning with last approved date of 12/2025 documents handheld nebulizer, nasal cannulas and oxygen humidifiers should be changed weekly and as needed (PRN). A clean plastic bag with zip lock or draw string will be provided with each new set up and marked with date set up was changed.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to follow physician orders to complete laboratory tests for two of two (R14, R16) residents reviewed for Laboratory Services on a sample list of 34.Findings Include:R14's admission Record dated 2/24/26 documents an admission date of 5/27/25 with medical diagnoses of Cerebral Infarction, Essential (Primary) Hypertension, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Epilepsy, Major Depressive Disorder, Single Episode, Chronic Pain Syndrome, Hyperlipidemia, Nicotine Dependence, Cigarettes, Long Term (Current) Use Of Aspirin, Abnormalities Of Gait And Mobility, Unsteadiness On Feet, Difficulty In Walking, and Dysphagia.R14's Physician Order dated 2/5/26 documents an order to collect a Keppra (anti-epileptic drug) level.R14's Laboratory Results Report dated 2/6/26 documents no specimen collected for the Keppra level and nurse to order redraw.R14's Progress Notes dated 2/24/26 do not document physician notification of the missed Keppra level or that a new order was obtained for redraw.On 2/24/2026 at 2:40 PM V2 Director of Nurses confirmed R14's ordered Keppra level blood draw for 2/6/26 was not completed, and no attempt had been made to collect the level. V2 verified there is no documentation of physician notification or order to redraw the level in R14's medical record. 2. R16's admission Record dated 2/24/26 documents an admission date of 11/12/24 with medical diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Embolism and Thrombosis of Deep Veins of Right Lower Extremity, Hypertension, Congestive Heart Failure, Muscle Weakness, Asthma, Protein-Calorie Malnutrition, Long Term (Current) Use of Insulin, Long Term (Current) Use of Oral Hypoglycemic Drugs, Long Term (Current) Use of Anticoagulants, Hyperlipidemia, Nicotine Dependence, Muscle Wasting and Atrophy, Morbid (Severe) Obesity Due To Excess Calories, Type 2 Diabetes Mellitus, Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Venous Insufficiency, Anxiety Disorders, and Acute and Chronic Respiratory Failure.R16's Physician Order Sheet dated 2/24/26 documents an order for a Basic Metabolic Panel (BMP) including Glomerular Filtration Rate and a Brain Natriuretic Peptide (BNP) to be drawn on 2/11/26.R16's Laboratory Results Report dated 2/16/26 documents all laboratory results as pending due to no specimen collected and nurse to redraw.R16's Progress Notes dated 2/24/26 do not document physician notification the 2/11/26 laboratory tests were not collected.R16's Medication Administration Record dated the Month of February documents on 2/18/26 blood was collected for a BMP and BNP.On 2/24/2026 at 2:40 PM V2 Director of Nursing stated R16 had laboratory tests ordered to be collected on 2/11/26. V2 confirmed R16's laboratory report dated 2/16/26 documents all results are pending. V2 confirmed there is no documentation in R16's medical record of physician notification or new orders to redraw the BNP or BMP. V2 confirmed that no blood was drawn for R16 on 2/18/26. V2 stated the expectation of nursing staff is to communicate all laboratory results, missed laboratory draws and any laboratory abnormalities to the physician as well as documenting that communication in the resident's chart.The Facility's Physician Notification of Laboratory/Radiology/Diagnostic Results with last approved date of 12/2025 documents a nurse is responsible for monitoring the receipt of test results. Test results should be reported to the ordering physician or practitioner, and a licensed nurse is responsible for documenting the notification of results in the clinical record.