

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Nokomis Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Stevens Street Nokomis, IL 62075	
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 - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to obtain conduct pre-employment screening, including the Illinois and National Sex Offender Registry, the Illinois Department of Corrections Inmate search, and obtain results of fingerprint checks, to determine if employees had a prior criminal history which would disqualify them for employment. This had the potential to affect all the 36 residents living in the facility. Findings include: The facility's Abuse Prevention Program Policy, dated 11/28/16, documents, This facility affirms the right out of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of our residents. This will be done by conducting required pre-employment screening of employees. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Health Care Worker Background Check Policy and Procedure, dated 2/28/12, documented it is the policy of the facility that all persons employed in the care facility are required to be free of conviction of committing, or attempting to commit any crime listed in the Health Care Worker Background Check Act. The facility will request a background check on all employees. Employees will be terminated if the background check or the results of the Health Care Worker Registry reveal a finding of ineligibility. Persons applying for employment will be hired conditioned upon results of the appropriate background check as follows: A fingerprint based criminal history records check will be required of all individuals applying for a direct care position or having access to long-term care residents or the living quarters or financial, medical or personal records of long-term care residents, hereinafter referred to as Direct Care Applicant. A UCIA non-fingerprint conviction background check will be required of all individuals licensed by the Department of Financial and Professional Regulation or the Department of Public Health under another law of this state, hereafter referred to as Licensed Applicant. It continues, 2. The Administrator/designee confirms the certification of an employee by checking the Health Care Worker Registry. Whether a fingerprint-based criminal history records check has previously been conducted is indicated by the identifier of Fee App or CAAPP. It continues, 5. In all cases, the facility shall conduct internet searches on certain web sites, including without limitation: the Illinois Sex Offender Registry; the Department of Corrections' Sex Offender Search Engine; the Department of Corrections Inmate Search Engine; The Department of Correction Wanted Fugitives Search Engine; the National Sex Offender Registry and the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud. On 11/12/24, ten employee files were reviewed for pre-employment screening. The following was documented: V13, Certified Nurse's Aide (CNA), was hired on 7/29/24. The facility initiated a Health Care Registry check, an Illinois Sex Offender search, an Illinois Department of Corrections (DOC), and an inmate/wanted fugitive search on 7/29/24. The facility did not have an Office of Inspector General (OIG) search to determine if V13 has a disqualifying conviction. V5, Activity Director, was hired on 9/27/24. The facility did not initiate a Health Care Registry check, an Office of Inspector General (OIG) search, a fingerprint based criminal background check, an Illinois Sex Offender registry, the National Sex Offender registry, or the Illinois Department of Corrections (DOC) inmate/wanted fugitive search to determine if V11 had a disqualifying conviction. On 11/13/24 at 11:25 AM, V1, Administrator, stated the facility failed to complete the required background checks for V5, Activity Director, upon hire. V1 stated she thought her BOM (Business Office Manager) V12 completed the required background checks and V12 thought V1 had completed the background checks, so they were missed. V1 stated she terminated V5 this am because she discovered V5 has disqualifying convictions after the surveyor requested V5's healthcare worker background checks. V8, Dietary Aide, was hired on 8/8/24. The facility did not initiate a Health Care Registry check, an OIG search, a fingerprint based criminal background check, an Illinois Sex Offender registry search, nor an Illinois DOC inmate/wanted fugitive search to determine if V8 had any disqualifying convictions. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 2:05 PM, V1 stated V8 was supposed to go and get a fingerprint background check but she did not. V1 stated she will inform V8 she must get the fingerprint background check completed, and she will not be able to work anymore until it is done. V14, CNA, was hired on 11/11/24. The facility initiated a Health Care Registry check, an Illinois Sex Offender search, an Illinois Department of Corrections (DOC), and an inmate/wanted fugitive search on 11/11/24. The facility did not have an Office of Inspector General (OIG) search to determine if V14 has a disqualifying conviction. V15, CNA, was hired on 10/21/24. The facility initiated a Health Care Registry check. The facility did not have an Illinois Sex Offender registry search, an Illinois DOC inmate/wanted fugitive search, nor an OIG search. V16, CNA, transferred to this facility from a sister facility on 6/25/24. The facility failed to complete a new Health Care Worker Registry check. The facility did not have an Illinois Sex Offender registry search, an Illinois DOC inmate/wanted fugitive search, nor an OIG search. On 11/13/24 at 2:08 PM, V1 stated the facility did not complete background checks on V16 because V16 transferred from a sister facility. V1 stated this facility and the sister facility are on separate payrolls. V18, CNA, was hired on 10/15/24. The facility initiated a Health Care Registry check, an Illinois Sex Offender search, an Illinois Department of Corrections (DOC), and an inmate/wanted fugitive search on 10/15/24. The facility did not have an Office of Inspector General (OIG) search to determine if V18 has a disqualifying conviction. V19, CNA, was hired on 6/24/24. The facility failed to check the Health Care Worker Registry, Illinois Sex Offender Registry, and Illinois DOC, and an inmate/wanted fugitive search until 9/24/24. The facility did not have any documentation showing that the facility completed an OIG search on V19. V23, CNA, was hired on 6/25/23. The facility failed to check the Health Care Worker Registry to ensure V23 was eligible to work until 12/29/23. The facility did not have an Illinois Sex Offender registry, the Illinois Department of Corrections (DOC) inmate/wanted fugitive search, nor an OIG search to determine if V23 had a disqualifying conviction. V12, Business Office Manger and CNA, transferred to the facility on [DATE] from a sister facility. The facility failed to complete a new Health Care Worker Registry check, Illinois Sex Offender registry search, an Illinois DOC inmate/wanted fugitive search, nor an OIG search. On 11/14/24 at 11:38 AM, V1 stated V12 transferred from a sister facility, and she did not complete any new background checks, including the Health Care Worker Registry. V1 stated she did not think it was required when an employee transfers to a sister facility. V1 stated these two sister facilities are not on the same payroll. V17, RN (Registered Nurse), was hired on 8/15/24. The facility failed to check the IDFP (Illinois Department of Financial and Professional Registry) to ensure V17's RN license is active until 11/13/24, after the surveyor requested the information. (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V2, RN/DON (Director of Nursing), was hired on 6/14/24. The facility failed to check the IDFPR to ensure V2's RN license is active until 11/13/24, after the surveyor requested the information. On 11/13/24 at 1:50 PM, V1 stated only 1 nurse of the 3 requested had proof that the IDFPR was checked for active nursing licenses. V1 stated she did not have anything showing the facility checked the IDFPR website to ensure V17 and V2 had active RN licenses prior to hire. On 11/14/24 at 11:06 AM, V1 stated she expects the facility to complete employee background checks prior to an employee working the floor. On 11/14/24 at 11:07 AM, V11, Regional Nurse, stated she expects the facility to complete employee background checks per the regulations and policy.		

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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. 40701 Based on interview, observation, and record review, the Facility failed to provide a RN (Registered Nurse) 8 hours a day 7 days a week. This has the potential to affect all 36 residents in the facility. Findings include: On 11/13/24 at 1:11 PM, V2, Director of Nursing (DON) stated, When I'm here we have RN coverage. We also have two prn (as needed) RNs. There was a week I wasn't here. I left the 30th (October) and came back this Monday (November 11th). On 11/14/2024 at approximately 10 AM, V2 provided a document titled, (Facility) RN Hours, documents there was no RN coverage on October 4th, 5th, 6th, or 13th, as well as November 1st, 2nd, 3rd, 4th or 5th, 8th, 9th, or 10th all 2024. The Facility's Nurse Staffing Policy, undated, documents, It is the policy of (Facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health. Each skilled care resident shall receive at least 3.8 hours of nursing and personal care each day and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. A minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by Registered Nurses. Registered Nurses and Licensed Practical Nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. The Facility's CMS-671, dated 11/12/2024, documents there are 36 residents residing at the Facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50908 Based on interview, observation, and record review, the facility failed keep their emergency medication kit sealed after use. This has the potential to affect all 36 residents living in the facility in the sample of 20. Findings include: On 11/12/24 at 10:55 AM, upon inspection of the facility's medication preparation room, an Emergency Medication Kit labeled DJ did not have a green lock tag securing it. The Emergency Medication Kit labeled DJ contained the following list of medications: Albuterol HFA Inhaler, Albuterol Sul Neb, Atropine 1% eye drops, Bacteriostatic saline, BD 3 mL syringe, BD Insulin Syringe, BD Luer-lok syringe, BD needles, Cefazolin, Ceftriaxone, Dexamethasone, Diphenhydramine, Enoxaparin, Epinephrine, Filter needle, Furosemide, Gentamicin, Glucose, Gvoke Hypopen, Haloperidol, Heparin, Ipratropium, Lidocaine, Naloxone, Ondansetron, Phytonadione, Promethazine, Scopalamine patch, Sodium Polystyrene powder, Solu-Medrol, Tobramycin, and water for injection. On 11/12/24, at 11:00 AM, V7, Licensed Practical Nurse (LPN), stated there would be no way of knowing what was still in the kit, or what was used, if anything. V7 stated those kits are supposed to be resealed with a new lock tag after each use and pharmacy is supposed to be notified. On 11/13/24 at 2:40 PM, V2, Director of Nursing, stated the Emergency kit labeled DJ includes medications that could be used on all the residents in the facility. On 11/14/24 at 9:30 AM, V1, Administrator, stated she expects that the Emergency Kits are kept locked, and that pharmacy is immediately notified after each time it is used. The facility's Pharmacy Emergency Box Policy, last review on 3/16/23, documented the box is to be properly sealed, and completely replaced each time the seal is broken. When the Emergency Box is opened, the pharmacy should be notified.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40701 Based on observation, interview, and record review, the Facility failed to ensure repairs were made to the environment to provide peace of mind to residents. This failure has to potential to affect all 36 residents residing in the Facility. Findings include: On 11/12/2023 at 1:54 PM, R1 stated, The outside smoking area concrete needs fixed or someone is going to fall. On 11/13/2024 the patio area on the East side of the building was observed to have a 4-5-foot-long patch of cracked concrete. The Facility's Resident Council Minutes, dated 4/2024, documents, Maintenance: concrete by patio door. The Facility's Resident Council Minutes, dated 5/2024, documents, Old Business: Maintenance has ordered concrete supplies. The Facility's Council Memorandum, dated 5/23/2024, documents, Issue: Concrete by patio door needs replaced. It continues to document concrete patch material has been ordered. The Facility's Council Memorandum, dated 6/12/2024, documents, Patio concrete is getting worse. Residents are getting stuck. The Facility's Resident Council Minutes, dated July 2024, documents, Old business: Patio concrete. The Facility's Resident Council Minutes, dated 9/15/2024, documents, Concrete needs fixed by patio door. The Facility's Resident Council Minutes dated 10/7/2024, documents, Reports from the officers: Concrete on back patio needs fixed where table is. The Facility's Council Memorandum, dated 10/7/2024, documents, Nature of concern: Concrete on back patio needs fixed-as a dip in it. Resolution: I (V25, Maintenance) don't think a patch will work. It has been patched before. New owners noted a few areas on portion that need repaired. Hopefully they will address this when they take over. The Facility's Resident Council Minutes, dated 11/4/2024, documents, Maintenance-back patio. On 11/13/24 at 12:34 PM, V25 stated, It's been patched before. It just didn't stay. It has to get worked out with the new company. They are aware of it and it was pointed out to them in their tours both times. They (the residents) have asked several times in resident council about it. The patch just doesn't stay. I don't think it's that bad. There hasn't been any work orders put in for it. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/14/2024 at 11:57 AM, V24, Illinois Department of Public Health Life Safety Surveyor, stated the area of concrete on the East patio could be a tripping hazard and in need of repair. The Facility's Physical Plant & Environment Policy & Guidelines documents, Policy Statement: It is the utmost importance to provide a safe, hospitable, clean, and organized facility and grounds to ensure an environment that is conducive to providing the best care, comfort, and home-like surrounds for residents. A well-maintained building and environment is also important for creating safe work surrounds across all departmental staffing and their ability to effectively and efficiently provide care and great living environment to all residents and all necessary resources to do so. The building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping and ensuring compliance with current federal, state, local and NFPA codes. This includes making certain a safe and hospitable environment as possible is maintained in the event of an emergency for sheltering in place. It continues to document, Policy Implementation: The Facility administrator must ensure that the overall scope and effective procedures are followed by each department supervisor and staff or request of approved contractors for creating and maintaining work orders are completed in a timely manner and ensure items necessary for repairs are ordered to complete repairs. It further documents maintenance/approved contractors are responsible for a safe and clean designated outdoor resident and staff smoking areas. The Facility's CMS-671 dated 11/12/2024 documents there are 36 residents residing at the Facility.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview, observation, and record review, the facility failed to keep the medication preparation room free of ants where intramuscular medications are drawn up for 2 of 2 residents (R27 and R5) reviewed for pest control in the sample of 20. Findings include: R27 was admitted to the facility on [DATE], with diagnoses of antiphospholipid syndrome and hypogonadism. R27's orders, dated 11/13/24, documented a current order for Testosterone Cypionate Intramuscular Solution 100 MG/ML (Testosterone Cypionate) for hypogonadism. R5 was admitted to the facility on [DATE], with diagnosis of chronic fatigue. R5's orders, dated 6/25/24, documented a current order for Testosterone Cypionate Intramuscular Solution 200 MG/ML (Testosterone Cypionate) for Replacement therapy. On 11/12/24, at 10:55 AM, the facility's Medication Room was checked with V7, Licensed Practical Nurse (LPN). There were ants seen on the counter, in medication cabinets, and in the refrigerator. V7 stated there is an ant problem, but only in this room to her knowledge; unsure what from. On 11/13/24, at 2:45 PM, in a joint interview with V3, Minimum Data Set (MDS) nurse, and V10 (Licensed Practical Nurse/LPN) both stated the medication room is used to pull up vials of medications such as intramuscular injections. V3 stated the facility has two residents currently on Testosterone, which is be pulled up in the medication room. On 11/14/24 at 9:15 AM, V1, Administrator, stated she expects the facility to be free of insects and pests, and for the staff to be reporting any infestation of ants. The facility's Insect and Pest Control Policy undated, documented the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Any employee observing insects or rodents shall inform their supervisor giving the exact location and type of infestation.		