STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to respect a resident's right to receive a second cup of coffee, as desired by the resident. This applies to 1 of 3 (R3) residents reviewed for resident rights in the sample of 8. The findings include: The EMR (Electronic Medical Record) shows R3 was admitted to the facility on [DATE]. R3 has multiple diagnoses including, cocaine dependence with cocaine-induced anxiety disorder, major depressive disorder, COPD (Chronic Obstructive Pulmonary Disease), cardiac arrhythmia, back pain, and suicidal ideations. R3's MDS (Minimum Data Set), dated March 5, 2025, shows R3 is cognitively intact, and requires supervision with all ADLs (Activities of Daily Living). R3 is always continent of bowel and bladder. On March 27, 2025 at 10:50 AM, R3 was sitting up in bed in his room. R3 said on March 25, 2025, he was in the dining room and wanted a second cup of coffee. R3 said, I went up to [V3] (CNA-Certified Nursing Assistant) and asked for a second cup of coffee. She refused to give me a second cup, and in a stern voice told me I had to go sit down and wait until everyone else had received their first cup of coffee. How on earth would I be able to tell all the other people living here had received their first cup of coffee? I tried to get creative and ask my roommate to go up and get me a cup of coffee because he doesn't drink coffee. I even saw another person go up and ask for a second cup of coffee, and she gave it to him. I was upset because I felt like she was playing favorites, and she was purposely doing it to upset me and show me she was the boss. I have only lived here a month, and no one told me there were rules about the coffee. On March 27, 2025 at 2:06 PM, V3 (CNA) said, I was serving coffee at lunchtime. [R3] asked if he could have extra coffee. Everyone has to get a cup first. I gave another resident coffee and [R3] became upset. I think the resident doesn't realize how it works. He had his roommate come up and ask for coffee, and I knew it was for [R3]. (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
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 27, 2025 at 3:56 PM, V4 (PRSC-Psychiatric Rehabilitation Services Coordinator) said R3 was having a very rough day on March 25, after receiving some bad news and he was very upset about V3 (CNA) not providing a second cup of coffee. V4 said, I would not have handled it the way [V3] did. V4 continued to say there are no rules regarding second helpings of coffee, and a second cup of coffee would have greatly helped R3 to feel better after the distressing day he was having. On March 31, 2025 at 2:40 PM, V1 (Administrator) said there are no rules at the facility regarding getting second helpings on coffee. V1 said, We have not had any issue of running out of coffee. There are no rules about getting seconds, or even thirds of coffee. On April 1, 2025 at 9:05 AM, multiple residents were observed drinking coffee in the main dining room and also getting second helpings of coffee. The facility did not have any rules posted regarding coffee service to residents. On April 1, 2025 at 9:24 AM, V1 said, This shouldn't have been an issue. [V3] (CNA) should have given the second cup of coffee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse. This applies to 3 of 6 residents (R3, R4, and R7) reviewed for physical assault in the sample of 8. The findings include: 1. The EMR (Electronic Medical Record) shows R3 was admitted to the facility on [DATE]. R3 has multiple diagnoses including, cocaine dependence with cocaine-induced anxiety disorder, major depressive disorder, COPD (Chronic Obstructive Pulmonary Disease), cardiac arrhythmia, back pain, and suicidal ideations. R3's MDS (Minimum Data Set), dated March 5, 2025, shows R3 is cognitively intact, and requires supervision with all ADLs (Activities of Daily Living). R3 is always continent of bowel and bladder. The EMR shows R4 was admitted to the facility on [DATE]. The EMR continues to show R4 was sent to the local hospital on March 26, 2025, and has not returned to the facility. R4 has multiple diagnoses including bipolar type schizoaffective disorder, heart disease, nicotine dependence, hearing loss, and cocaine and cannabis abuse. R4's MDS, dated [DATE], shows R4 is cognitively intact, requires setup with eating and showering, and supervision with all other ADLs. R4 is always continent of bowel and bladder. On March 25, 2025 at 7:45 PM, V10 (RN-Registered Nurse) documented, [R3] involved in physical/verbal altercation with a peer this afternoon around 3:30 PM. Resident states peers came down to his room and were threatening him which caused the situation to escalate. Staff intervened immediately and resident was escorted back to his room. Call placed to [V11] (Physician), and order received to send resident out to hospital per protocol. Resident calm and cooperative with staff/EMS (Emergency Medical Services) and was transported to [local hospital] via ambulance service around 5:30 PM. On March 25, 2025 at 6:07 PM, V12 (RN) documented, [R4] got involved in physical aggression with another peer in the facility. Resident reported been the aggressor. Resident reported went into other peer room with and made verbal altercation threatening another peer. Resident was difficult to be redirected and other peer called police department for intervention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Final Report of Abuse Investigation regarding R3 and R4, received by the state agency on March 31, 2025 shows the date of the incident as March 25, 2025 at approximately 3:00 PM. The report shows, At approximately 3:00 PM, [R3] head-butted [R4]. In retaliation, [R4] struck [R3] in the face with his fist . Staff members were interviewed. Per staff, [R3] was yelling and cursing at [V3] (CNA-Certified Nursing Assistant) over some coffee. [V3] was noted to be upset about this and was counseled by DON (Director of Nursing). It was then observed by several staff members that [V3] (CNA) was outside in the parking lot speaking with another staff member, while residents [R4], [R6] and [R5] were within earshot. Shortly thereafter, the three residents entered the building and went towards [R3's] room. [R3] was interviewed. [R3] stated that [R6], [R5], and [R4] came to his room saying that they heard what he did to a CNA, and that they would f**k him up if he did it again. [R3] stated that he got up and walked out of his room. He stated that [R6], [R5], and [R4] followed him. He then stated that [R4] walked in front of him and got in his face. He said they were nose-to-nose, with his back against the wall. [R3] stated that he pushed forward and [R4] punched him in the face. [R3] stated that as they were walking down the hall one of the residents stated that [V3] (CNA) told them to straighten him out and [R4] stated that he would knock his head off his block . [R4] was interviewed. [R4] stated that he, [R6], [R5], [V8] (Activity Director), and [V3] (CNA) were outside in the parking lot. He stated that [V3] (CNA) told them that [R3] had cursed her out during lunch. [R4] stated he and [R6] and [R5] went to [R3's] room to ask him if he got into it with a CNA. He said that [R3] said no. He stated that she wouldn't lie. [R4] stated that [R3] got up and left them in the room. The three other residents followed. He stated that he and [R3] began to argue and that when they got to the end of the hallway, [R3] head-butted him, and that he hit him back. On March 27, 2025 at 10:50 AM, R3 was sitting up in his bed in his room. R3 said on March 25, 2025, he wanted a second cup of coffee. He asked V3 (CNA) for a second cup of coffee and she was rude to him and refused to give him a second cup of coffee. R3 continued to say he walked back to his table and muttered b**ch under his breath. R3 said, A few hours later, [V3] (CNA) was leaving and stood outside talking to five other guys and they came to my door and said I called her a b**ch. It escalated to the point where [R4] had his face up against my face, nose-to-nose, and he head-butted me, and then swung at me. Each time I ducked out of the way, so he just ended up hitting my head on the side of my head with his fist. They sent me to the hospital, and they did a cat scan and stuff on me, but nothing was wrong with me, and they sent me back. On March 27, 2025 at 10:14 AM, V2 (DON) said, [R4] was sent out for a psychiatric evaluation and has not returned to the facility. It will be at least five days until he returns. The initial report was that [R3] head-butted [R4]. We found the situation was quite different. [R4], [R5], and [R6] went down to [R3's] room, and basically said he shouldn't talk to staff because [R3] called [V3] (CNA) a b**ch. [R3] got agitated and walked out of his room and they walked behind him. [R4] got in front of him and came to his face and punched [R3] in the face. By then we heard the commotion and stopped the fight and separated them. In that instance, they (R4, R5, and R6) ganged up on [R3]. All the residents admitted going down to [R3's] room. Those three (R4, R5, and R6) hang together. We counseled them on boundaries and going into his room. [R4] was the only one who was aggressive. During lunch, [R3] wanted an extra cup of coffee and [V3] said he had to wait until they were done serving coffee. His roommate went to get him a cup of coffee because [R3] wanted more and [V3] refused to give him the coffee. [V3] (CNA) was on her way home, and voiced her concerns to the residents (R4, R5, and R6) while they were outside smoking, and they came in and had an altercation with [R3]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 27, 2025 at 2:06 PM, V3 (CNA) said she was serving coffee at lunchtime on March 25, 2025. R3 asked if he could have extra coffee, and she told the resident everyone has to get a cup before seconds could be given out. V3 continued to say, When I left, [V8] (Activity Director) was sitting in the car, and he asked what was wrong. I told him about the resident (R3) calling me a b**ch because of the coffee. He even sent his roommate up to get him a cup of coffee, and I know his roommate doesn't even drink coffee. There were three residents sitting in [V8's] car. I'm not sure if they overheard my conversation. [R5] tries to act like the boss over the other residents. On March 27, 2025 at 2:25 PM, V8 (Activity Director) said, There is no limit on coffee. On that day (March 25, 2025) I took [R4], [R5], and [R6] out for a special smoke break because they helped me earlier and I wanted to reward them. We were all sitting in my car smoking. I lit their cigarettes, and [V3] (CNA) came up to my car and started venting some stuff to me about what happened in the dining room with [R3]. About four minutes into the conversation, I felt uncomfortable because I thought the residents could hear the conversation. On March 27, 2025 at 3:56 PM, V4 (PRSC-Psychiatric Rehabilitation Services Coordinator) said, [R3] said that three or four male residents came to his room and threatened him. [R3] was upset about [V3] (CNA) not giving him a second cup of coffee. Apparently, she left for the day and was outside talking about the incident with another staff member. [R4], [R5], and [R6] were present while she was talking about the situation and shortly after she walked away, the three of them came inside the building and went to [R3's] room to set the record straight about upsetting the staff. The situation escalated and [R4] threw a punch at [R3] and hit him in the face. Both residents were sent out to the hospital for a psychiatric evaluation. [R3] returned to the facility, but [R4] remains in the hospital for psychiatric reasons. On April 1, 2025 at 2:40 PM, V1 (Administrator) said, This shouldn't have been an issue. There is no limit on coffee here. If we run out, we can make more. [V3] (CNA) should have given the second cup of coffee to [R3]. Then she went outside and started telling the story to [V8] (Activity Director) within earshot of [R4], [R5], and [R6]. [V3] (CNA) said she was leaving, and started her car and as she went to her car and saw [V8] (Activity Director) she told him the story of how [R3] was cussing her out earlier in the day over a cup of coffee. [R5] was sitting in the front passenger seat of the car. She couldn't have missed seeing the resident sitting there and knew he couldn't have missed the conversation. The residents heard the conversation, and the residents ran with it. [R4] is not back from the psychiatric hospital yet. He can be someone who can get upset easily. On April 1, 2025 at 10:21 AM, V16 (ADON-Assistant Director of Nursing) said, [R3] was so upset that day. [V3's] conversation should not have happened in front of those other residents (R4, R5, R6) because of their past behavior of thinking they are staff. They told [R3], [V3] (CNA) sent us here to put you in your place. 2. The EMR shows R7 was admitted to the facility on [DATE], with multiple diagnoses including, schizophrenia, nicotine dependence, alcohol abuse, heart failure, and frontal lobe and executive function deficit. R7's MDS, dated [DATE], shows R7 is cognitively intact, requires supervision with all ADLs, and is always continent of bowel and bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR (Electronic Medical Record) shows R8 was admitted to the facility on [DATE]. R8 has multiple diagnoses including, schizoaffective disorder, insomnia, COPD, diabetes, and blindness in one eye, and low vision in the other eye. R8's MDS, dated [DATE], shows R8 is cognitively intact, requires supervision with all ADLs, and is always continent of bowel and bladder. On March 31, 2025 at 12:22 PM, V13 (LPN-Licensed Practical Nurse) documented the following about R7, Writer told by staff member that resident was going outside for a smoke break and cut in front of another resident. The other resident got upset and started yelling. Resident and other resident went outside and got in each other's face. Resident was pushed by the other resident. Argument was able to be redirected. Both residents went their ways. No further involvement noted at this time. On March 30, 2025 at 8:32 PM, V5 (Registered Nurse/RN) documented the following about R8, Commotion heard in the smoking line. When this nurse approached, resident was outside yelling in the face of another resident, Do something. [R8] then proceeded to push the other resident in the chest. Another resident stepped in-between to attempt to break up fight. This resident was able to get [R8] to stop and go back inside. Resident is now calm, in his room and does not want PRN (as needed) medication. The facility's initial Incident Report Form submitted to the state agency on March 30, 2025 shows, At approximately 8:00 PM, staff witnessed residents [R7] and [R8] arguing by the door leading to the smoking patio about who would go outside first. Per staff, [R8] suddenly put his hands on [R7's] chest and pushed him. On March 31, 2025 at 10:45 AM, V8 (RN) said, I worked the other night when [R7] and [R8] got into an altercation. I saw [R8] physically push [R7]. [R7] stumbled backwards due to being pushed but did not fall to the ground. They were having an argument about the smoking patio. Thankfully, we have some residents who stepped in and stopped the altercation from escalating. On April 1, 2025 at 9:24 AM, V1 (Administrator) said, Psych/Social goes out with the residents for smoke breaks. The CNAs also go out if it is in the evening. The other night, [R7] cut in line during the smoking break, that's when the chaos ensued, and [R8] pushed [R7]. The facility's policy entitled Guideline Name: Abuse), effective 3/2022, shows, Policy: The facility affirms the right of our consumers to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of consumers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to follow Nurse Practitioner's orders to obtain a laboratory test. This applies to 1 of 3 residents (R1) reviewed for delay of care in the sample of 8. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on September 26, 2024 and diagnosed with an elevated bilirubin and low sodium level. R1 did not return to the facility. R1 had multiple diagnoses including bipolar type schizoaffective disorder, UTI (Urinary Tract Infection), abnormal gait, muscle weakness, left ulna fracture, insomnia, encephalopathy, COPD (Chronic Obstructive Pulmonary Disease), heart failure, pulmonary edema, heart disease, diabetes, myocardial infarction, and rheumatoid arthritis. R1's MDS (Minimum Data Set), dated September 6, 2024, shows R1 was cognitively intact, required setup assistance with eating, oral hygiene, showering, personal hygiene, and bed mobility, and supervision with all other ADLs (Activities of Daily Living). R1 was always continent of bowel and bladder. R1's laboratory results, dated August 27, 2024, showed R1's sodium level reading was low, with a reading of 128 mEq/L (Milliequivalents/Liter) and a normal reference range of 138 to 147 mEq/L. R1's laboratory results also showed R1's direct bilirubin level reading was high, with a reading of 0.60 mg/dL (Milligrams/deciliter) and a normal reference range of less than 0.10 to 0.31 mg/dL. On August 31, 2024, V14 (NP-Nurse Practitioner) ordered to, Check BMP (Basic Metabolic Panel) Tuesday (September 3, 2024). The order was confirmed by V15 (RN-Registered Nurse) on September 2, 2024 at 10:17 AM. The facility does not have documentation to show the laboratory order was completed by the facility. On April 1, 2025 at 9:56 AM, V16 (ADON-Assistant Director of Nursing) said, The BMP should have been done. [V15] (RN) confirmed the order and should have carried it out. Hospital documentation, dated September 26, 2024 at 10:35 AM, shows R1's sodium level was 121 mEq/L. On September 26, 2024 at 2:09 PM, V15 (RN) documented, Writer called hospital for status update, [R1] admitted to [room number], diagnosis: elevated bilirubin, hyponatremia (low sodium), AKI (Acute Kidney Injury). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled, Laboratory and Diagnostic Testing, effective 3/2021, shows, Guideline: To accurately complete, report, and monitor laboratory and diagnostic testing. Standard: Laboratory and diagnostic testing are performed according to the order; testing is based upon the resident condition and/or to monitor therapeutic blood levels for medication management. Oversight and coordination are completed by the Director of Nursing or designee. The facility will coordinate transportation for diagnostic testing outside of the facility. Procedure: 1. The licensed nurse receives the order for laboratory or diagnostic testing and: .c. Completes requisitions according to the date the test is to be completed. Laboratory requisitions are filed in designated accordion folder. Diagnostic test requisitions are maintained at the nursing station in a designated location until the provider arrives to complete the testing. 2. Laboratory and diagnostic results are received and reviewed by the licensed nurse. 3. The nurse receiving the laboratory or diagnostic results documents in the medical record communication with the physician and or extender regarding results.