STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145952	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beardstown Health & Rehab Ctr	8306 St Lukes Drive Beardstown, IL 62618

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement appropriate infection control measures for residents with signs and symptoms of a potentially communicable skin condition. The facility failed to initiate/implement contact isolation precautions, failed to obtain a diagnosis and track the infection, and failed to clarify physician orders through the infection preventionist for two (R2, R3) of six residents reviewed for communicable diseases in a total sample of six residents. Findings include:The facility's General Approaches to Infection Prevention and Control Standard and Transmission Based Precautions for Communicable Diseases dated October 17th, 2022 documents contact precautions used in addition to standard precautions are intended to prevent transmission of pathogens that are spread by direct person to person or indirect contact with the resident or environment examples (C. diff, norovirus, and scabies) and require the use of appropriate personal protective equipment (PPE) including gown and gloves before or upon entering the room before making contact with the resident or residents environment the room or cubicle period prior to leaving the residents room or cubicle the PPE is removed and hand hygiene is performed. Contact precautions should also be used in situations when a resident is experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for excessive extensive environmental contamination and risk of transmission of a pathogen. Even before a specific Organism has been identified.1.) R2's medication administration record documents a new order dated 6/10/25 for Permethrin External Cream 5% (used to treat certain conditions caused by tiny insects, such as scabies and head lice) to be applied to R2's entire body except the face on night shift for one day, leave on for 8 hours then wash off for a rash.R2's Physician Notes dated 6/10/25 documents rash becoming an issue, roommate with same issue, Permethrin cream ordered.R2's record does not document that contact isolation precautions were implemented during treatment, despite the use of a topical antiparasitic medication typically used for contagious skin infestations.2.) R3's skin assessment dated [DATE] documented multiple scabs and scratches all over the body, including bilateral lower extremities, abdominal area, trunk, and neck. The treatment in place at that time was the use of cocoa butter, per V5 (Physician) order.R3's Physician Order dated 6/10/25, documents Permethrin 5% cream, to be applied to the body (except face) and washed off after 8 hours. However, the medical record does not indicate that contact isolation precautions were implemented during this treatment. R3's Nurse Progress Note dated 6/17/25 documents R3's bilateral upper extremities (BUE) were reddened and weeping fluid from scratched areas and there was increased scratching since Permethrin treatment on 6/11/25. Although the V5 (Physician) was notified, no new infection control measures or follow-up assessment was documented. R3's Nurse Progress Note dated 6/19/25 documents that another Permethrin treatment was applied the night before and washed off the following morning. The note further documents observed the BUE to be scaly, bleeding, and weeping serous fluid. The symptoms were noted to have worsened over the past 48 hours, and V5 was notified again. However, the record contains no documentation of additional precautions or medical reevaluation, and no infection prevention documentation or review.On 8/5/25 at 12:30 PM, V2 (Director of Nursing) stated she was unable to locate any documentation from the former Infection Preventionist (IP) indicating that infection tracking was completed, or that follow-up with the physician occurred to clarify the diagnosis or orders for R2 or R3. V2 stated she does not have any record that R2 and R3 were placed on Contact Isolation Precautions. On 8/5/25 at 10:50 AM, V3 (Licensed Practical Nurse) stated she spoke with V5 (R2 and R3's Physician) who ordered treatment for R3's rash, and although the physician did not explicitly state it was for scabies, V5 treated the condition as such. V3 confirmed that R2 and R3's room was not placed on contact isolation during the treatment. V3 further stated the nurses were concerned when V5 ordered this treatment because it's normally ordered for treatment of scabies.On 8/5/25 at 2:00 PM, V1 (Administrator) stated the facility currently does not have an Infection Preventionist as of last week.