STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACON RIDGE, A CHOICE COMM	**1515 WAYNE AVENUE INDIANA, PA 15701**

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 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of residents' clinical records and information provided by the facility, as well as staff interviews, it was determined that the facility failed to ensure that documentation in the residents' records indicated that COVID-19 testing was completed (as appropriate to the resident's testing status) for 12 of 12 residents reviewed (Residents 1-12). Findings include: A facility documented timeline for COVID-19 testing for residents, undated, revealed that the facility's residents were tested for COVID-19 on August 31, and September 1, 8, 14, 21, and 28, 2020. Residents 11 and 12 were also retested on [DATE]. Review of Residents 1 through 12's clinical records for August and September 2020 revealed that there was no documented evidence that the resident's records contained documentation that testing for COVID-19 was completed on August 31, September 1, 8, 14, 21 and 28, 2020, and on October 1, 2020, for Residents 11 and 12. Interview with the facility's Registered Nurse Infection Preventionist on October 1, 2020, at 4:00 p.m. confirmed that there was no documented evidence in Residents 1 through 12's clinical records that COVID-19 testing was completed on the above dates. 28 Pa. Code 211.5(f) Clinical records.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.