STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075235	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guilford House, The	109 West Lake Avenue Guilford, CT 06437

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of four (4) sampled residents (Resident #1) who were at risk for falls, the facility failed to ensure Resident #1's family was notified on the same day when the resident sustained a fall. The findings include:Resident #1's diagnoses included heart failure, muscle weakness, difficulty in walking and cellulitis. The admission record dated 6/7/25 identified family members were Resident #1's emergency contact. The admission nurse's note dated 6/7/25 at 6:10 PM identified Resident #1 was admitted to the facility from the hospital at 5:00 PM. The note indicated Resident #1 was alert, forgetful, anxious, calling out occasionally wanting to go home and redirected to place and time. The nurse's note dated 6/8/24 at 2:07 AM identified Resident #1 was found lying on his/her side next to his/her bed. The note identified Resident #1 appeared confused pupils were equal, round, and reactive to light, there was no internal or external rotation or lengthening or shortening of all extremities, and no new skin redness or open areas. The note identified the provider was notified and a new order was obtained to perform safety checks for three (3) days every two (2) hours. The note identified Resident #1's family needed an update in the morning. Review of the clinical record from 6/8/25 through 6/14/25 failed to reflect documentation Resident #1's family was updated regarding the 6/8/25 fall. The facility Accident and Investigation dated 6/8/25 identified the physician was notified on 6/8/25 at 2:20 AM of the fall however Resident #1's family was not notified regarding the fall until 6/14/24, six (6) days later. Interview and clinical record review with the Director of Nursing (DON) on 9/22/25 at 12:06 PM identified Resident #1's family should have been notified at the time of the fall. Review of the facility policy titled Fall-Unwitnessed directed, in part, notify family and provider of occurrence and re-notify if any changes. Review of the facility policy titled Resident's Change in Condition, directed, in part, any changes in condition must be reported to the family/responsible party along with any new orders from the provider.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one sampled resident (Resident #2) who was reviewed for misappropriation of personal property, the facility failed to ensure staff did not remove the resident's jewelry from the facility. The findings include:Resident #2's diagnoses included anemia, atrial fibrillation, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 rarely made decisions regarding tasks of daily life, and required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. The Resident Care Plan dated 7/14/25 identified impaired activities of daily living as evidenced by need for assistance with washing, dressing, transfers, and walking. Interventions directed for nursing to witness denture removal at hour of sleep and place in denture cup with tablet, 1/4 side rails can be used to facilitate self-repositioning and transfers, set up for self-care will be provided with encouragement to do as much as able and assistance as needed to perform the task, and assistance with activities of daily living as recommended by occupational therapy. The nurse's note dated 7/25/25 at 3:28 PM identified Resident #2 reported to a 7AM-3PM nurse aide, Nurse Aide (NA) #1, that his/her wedding band and engagement ring were missing. The note indicated the room, linen and garbage were searched, and the police and family were notified. The grievance log dated 7/25/25 identified NA #1 reported at 9:30 AM Resident #2 stated his/her rings were missing. The report indicated the charge nurse and NA #1 went into Resident #2's room at which time Resident #2 stated someone in pink took me into the bathroom, washed my hands and took my ring. The report identified the unit manager was notified. The Facility Reported Incident form dated 7/25/25 identified NA #1 informed the charge nurse that Resident #2 stated his/her rings were missing, stating someone in pink took me to the bathroom, washed my hands and took my rings. In a written statement dated 7/25/25 NA #1 indicated at approximately 9:30 AM while in the bathroom with Resident #2, she washed Resident #2's face, under the breasts, arms and bottom. NA #1 wrote once she was finished, she put Resident #2 in the wheelchair with the table and remote and began providing care to Resident #2's roommate, at which time Resident #2 yelled out hey have you seen my rings. NA #1 wrote she informed Resident #2 that she had not seen the rings and immediately reported the incident to the nurse. Interview with the Director of Nursing (DON) on 9/18/25 at 2:04 PM identified on 7/25/25 she was informed by the charge nurse Resident #2's rings were missing. The DON identified that she immediately initiated an investigation that consisted of interviews with Resident #2 as well as staff. The DON identified Resident #2 reported to her that his/her hands were sticky and the girl went in to wash his/her hands in the bathroom and while washing his/her hands, took the rings off. The DON identified in an interview with NA #1, she reported she had not noticed the rings that morning. The DON identified the investigation by the town police (a report was not available as the case was not complete), Resident #2's rings were found in a local pawn shop in a different city with NA #1's information. The DON identified she spoke with the police officer on 9/17/25, who informed her a warrant had been issued for NA #1's arrest. The DON identified her investigation substantiated the misappropriation of Resident #2's rings and NA #1 was terminated from employment. Review of the facility policy titled Abuse, Assault and Neglect, undated, directed, in part, each resident will be free from verbal, sexual, physical abuse, involuntary seclusion and neglect. The policy further directed, in part, misappropriation of resident property-means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy further directed, in part, any employee guilty of resident abuse will be terminated and the reason for such action will be part of his/her personal record. Review of the facility policy titled Resident Rights, undated, directed, in part, the resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.