STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075235	A. BUILDING _____ B. WING _____	**07/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation of the medical record/PPE storage area during the facility tour, the facility failed to ensure appropriate closure of a fire door to prevent an accident. The findins includes: Observation of Maintenance Worker (MW) #1 on 7/5/2020 at 9:05 AM identified that MW#1 was observed on Unit 1, near the kitchen, at which time he provided a current count of PPE in stock. Interview with Licensed Practical Nurse (LPN) #1 on 7/5/2020 at 9:07 AM, while touring the medical record/PPE storage room area, identified that the fire door to the area was propped open LPN #1 identified that the fire door was propped open with a kardex three ring binder and the fire door should have been closed. Observation and interview with MW #1 on 7/5/2020 at 9:15 AM identified that he was located on the Unit 2 hallway speaking with a housekeeper. MW #1 identified that he had propped the fire door open to remove supplies from the storage area and had gotten busy and forgot to close the fire door. MW#1 identified that fire doors should never be propped open. Review of facility policy with the Administrator on 7/5/2020 at 10:45 AM identified that fire doors should never be propped open using something to wedge the door open.

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.