STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365900	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Versailles Rehabilitation and Health Care Center	200 Marker Road Versailles, OH 45380

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on observations, resident and staff interviews, and policy review, the facility failed to ensure the facility was free from foul odors. This affected two (Resident #43 and #44) of two residents reviewed for concerns with foul odors. The facility census was 87. Findings include: Interview on 10/03/24 at 9:38 A.M. with Resident #44 revealed concerns with odor in the hall. Resident #44 stated all the time this guy has the hallways smelling like pot [cannabis]. It's ridiculous. Interview on 10/03/24 at 9:53 A.M. with Resident #43 stated she has a concern with the strong odor of cannabis coming into her room from next door. When she exits the room, she has to smell it in the hallway as well. I do not like being around drugs, I'm afraid I will get it into my lungs and my system. Interview on 10/03/24 at 11:21 A.M. with Registered Nurse (RN) #272 confirmed Resident #19 frequently has a strong odor coming from his room and stated room [ROOM NUMBER] does not smell like someone has smoked in the room, it just has a strong odor in the room and in the hallway outside of the room. RN #272 also confirmed the odor smells like cannabis and she was unsure if Resident #19 keeps any in his room. Observations on 10/03/24 at 11:40 A.M. and 1:05 P.M. revealed a strong pungent odor in hallway between Residents #4's room, #19's room, and #43's room. Interview on 10/03/24 at 1:06 P.M. with State tested Nursing Assistant (STNA) #212 stated the foul odor was from Resident #19's room. STNA #212 confirmed Resident #19 frequently has a strong cannabis type odor coming from the room. Licensed Practical Nurse (LPN) #247 confirmed the odor smells like cannabis and she was not sure if Resident #19 has any in his room or not. The odor coming from Resident #19's room was a frequent complaint received by multiple residents in the rooms around the area. Interview on 10/03/24 at 1:15 P.M. with Environmental Services #253 confirmed the hall outside of Resident #19's room smells of cannabis often and residents voice their concerns. When residents voice their complaints, environmental services will spray the hallways well with air freshener. This was an incidental finding discovered during the course of the complaint investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570 Based on resident and staff interviews, record review, and policy review, the facility failed to protect the residents and prevent further potential sexual abuse while the investigation was in process. This affected two (Residents #19 and #76) of two residents reviewed for abuse. The facility census was 87. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus without complications, bipolar disorder, and current episode hypomanic. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 was cognitively intact. Resident #19 was independent with wheelchair mobility and required supervision from staff for bed mobility and transfers. Review of the care plan dated 08/30/24 revealed Resident #19 has behaviors related to refuses medications, resistant care, verbally aggressive toward others, will refuse therapy, and will make false allegations. Review of the medical record for Resident #76 revealed an admitted [DATE] with diagnoses including Alzheimer's disease with late onset, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the admission MDS assessment dated [DATE] revealed Resident #76 had severe cognitive impairment. Resident #76 required set-up assistance from staff with bed mobility and required supervision assistance with ambulating. Review of the care plan dated 09/16/24 revealed Resident #76 has impaired cognitive function related to Alzheimer's disease and dementia with a goal of to cope with their cognitive impairment evidenced by having no episodes of anxiety or frustrations through the next review. Review of the progress notes for Resident #76 revealed a progress note dated 09/28/24 at 4:16 A.M. by the Director of Nursing (DON). The DON was contacted around 11:30 P.M. on 09/27/24. Resident #76 and another resident (Resident #19) were found to be engaged in a sexual act. The two residents were separated, and police were notified due to Resident #76 having a Brief Interview of Mental Status (BIMS) score of five (indicating severe cognitive impairment). Floor nurse contacted on-call physician and received order to send to the emergency room (ER) for evaluation and treatment. Resident #76 was sent to the hospital around 12:35 A.M. on 09/28/24. Once Resident #76 was at the hospital for possible SANE (Sexual Assessment Nurse Examiner) exam, Resident #76 told the physician she consented to the sexual act. The ER physician stated he approached her on several occasions and Resident #76 proceeded to tell him the same story. She was asked if she needed to be evaluated, and Resident #76 told the physician no. The physician stated there was not a reason to continue with the SANE examination due to Resident #76 giving consent and stating she wanted to do this. Resident #76 returned to the facility at 3:52 A.M. No signs or symptoms of distress or discomfort noted upon arrival to the facility. Resident was moved to another room temporarily until all evaluations were complete. The Social Worker will be notified in the morning to complete a new BIMS for this resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ER notes dated 09/28/24 at 1:34 A.M. revealed Resident #76 seen in the emergency room with chief complaint of sexual assault exam referral. Resident #76 was found to be having intercourse with another resident (#19) at the nursing home. The nursing home sent her over here for a SANE evaluation but the resident at this time stated she was not quite sure why she was at the hospital and there was no big deal with what occurred. Resident #76, after multiple attempts of speaking with her, stated this was consensual and he (Resident #19) did not force himself on her. Resident #76 has been interviewed on different occasions by the nurse alone and also by physician several times and she has stated the same response that they were making a bigger deal out of this then needs to be made. The final impression was history of consensual sexual intercourse. Interview on 10/02/24 at 2:03 P.M. with the DON confirmed she received a call from Licensed Practical Nurse (LPN) #219, that State tested Nursing Aide (STNA) #223 entered the room and saw Resident #19 and Resident #76 having sexual intercourse. The DON confirmed STNA #223 left the room and went and got LPN #220, who went and got LPN #219, and the nurses went into the room together. LPN #220 did not go into Resident #19's room without someone else with her. Upon entering the room of Resident #19, LPN #219 tells the residents to stop having sexual intercourse. Resident #19 said to LPN #219 that Resident #76 came on to him. Interview on 10/02/24 at 2:37 P.M. with the DON and the Regional Licensed Nursing Home Administrator (RLNHA) #500 confirmed not all staff interviews have been completed at this time and also confirmed the facility did not initiate one-on-one observations of Resident #19 or Resident #76 after the incident and before the investigation was complete to determine if sexual abuse occurred. RLNHA #500 felt residents should be able to have sex even though the resident's BIMS score was five, the resident wanted to have sex. The DON and RLNHA #500 confirmed STNA #223 observed the residents having sex, did not stop it, walked away to get a nurse, and did not know if it was consensual or not. Interview on 10/02/24 at 3:43 P.M. with Resident #19 stated he was outside smoking with Resident #76 when he decided to go to his room. Resident #76 came into the room and sat on the edge of his bed. Resident #76 went into the bathroom, and when she came out of the bathroom, she walked to the edge of the bed and dropped her pants to the floor and said oops, my pants fell down. Resident #76 then kissed him. Resident #19 asked her what she was doing, and Resident #76 said she wanted to have sex. Resident #19 stated I'm a man, and I was not going to say no. I didn't know anything about her health or her Alzheimer's disease. Telephone interview on 10/03/24 at 8:56 A.M. with Police Officer #600 stated he responded to an allegation of rape between two residents in the facility. He remained in the facility for one and a half hours on 09/27/24 and interviewed Resident #19. LPN #220 informed him Resident #76 could not consent due to her current BIMS score of 5. Resident #19 did not know Resident #76 had Alzheimer's disease and wasn't able to make sound decisions and stated he would not have sex with her again. Telephone interview on 10/04/24 at 9:27 A.M. with STNA #223 confirmed on 09/27/24 around 11:30 P.M., she heard noise coming from Resident #19's room, knocked and entered. When she entered, she confirmed she seen Resident #19 on top of Resident #76, with his arms on hers, like he was holding her down. STNA #223 closed the door, did not attempt to stop the potential sexual abuse, and got the charge nurse because she didn't know what to do. The charge nurse also voiced she did not know what to do either, so they had another nurse come over. Both nurses entered the room and stopped the potential sexual abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse Prevention, Intervention, Investigation & Crime Reporting dated 10/2022 revealed the purpose was to protect the psychosocial physical well- being and personal possessions of resident(s). The expectations were for the facility to take immediate steps to protect the resident(s) and staff. Steps will be documents and communicated via current facility process(es). The facility will complete a review and enact step(s) necessary to prevent future occurrence(s) which included protection. The facility will take prompt action to remove resident from immediate harm and take reasonable measures to separate residents involved in resident : resident altercation(s). This was an incidental finding discovered during the course of the complaint investigation.