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	08/28/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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F 0600 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 medical record reviews, staff interviews, review of a facility self reported incident (SRI), and policy review, the facility failed to ensure residents were free from sexual abuse. This affected two (#26 and #90) out of three residents reviewed for abuse. The facility census was 75. Findings include: Review of the medical record for Resident #26 revealed an admission date of 06/27/25 with medical diagnoses of dementia with psychotic disturbances, chronic obstructive pulmonary disease (COPD), and mood disorder. Review of an admission Minimum Data Set (MDS) assessment, dated 07/03/25, which indicated Resident #26 had severely impaired cognition and required supervision with toilet hygiene and was independent with bed mobility, transfers, and bed mobility. Review of a physician order dated 06/27/25 stated Resident #26 had a mental disorder with diagnosis of behavioral disturbances and met the criteria for placement on the Mental Health Unit (MHU) and would benefit from the structure and activity-based philosophy. Review of Resident #26's progress notes revealed a note dated 08/13/25 at 11:01 P.M. which stated Resident #26 was immediately separated from the other resident related to incident and resident assessment completed with no new skin impairments. Further review of the note revealed Resident #26 denied any pain and the physician, Administrator and Director of Nursing (DON) were notified. 2. Review of the medical record for Resident #90 revealed an admission date of 02/20/25 with medical diagnoses of dementia with agitation, Alzheimer's disease early onset, post traumatic stress disorder, and history of physical and sexual abuse. Review of the medical record revealed Resident #90 discharged from the facility to another facility on 08/15/25. Review of a quarterly MDS assessment, dated 05/29/25, indicated Resident #90 had severe cognitive impairment and required partial/moderate assistance with bathing and toilet hygiene and was independent with transfers and bed mobility. Review of a physician order dated 05/06/25 stated Resident #90 had a mental health disorder with diagnosis of behavioral disturbances and met the criteria for placement on the MHU and wound benefit from the structure and activity-based care philosophy. Review of Resident #90's progress notes revealed a note dated 08/13/25 at 11:01 P.M. which stated Resident #90 was immediately separated from the other resident related to the incident. The note stated Resident #90 was assessed and no new skin impairments were noted, and Resident #90 did not complain of pain. The note stated the Administrator and DON were noted and a message was left for family. Further review of progress note dated 08/13/25 at 11:45 P.M stated the police department was at the facility to investigate the incident. Review of a facility SRI, dated 08/13/25, stated Residents #90 and #26 were both residents on the MHU and were observed in a sexual encounter. Review of the FRI revealed State Tested Nursing Assistant (STNA) #210 observed Resident #26 and #90 sitting in a common area and Resident #90 was observed to be sitting on the couch with Resident #26 standing in front of her and his penis was in her mouth. The SRI indicated the residents were immediately separated and Resident #90 was put on one-on-one supervision. The SRI stated both resident families, the physician, and police department were notified. Interview on 08/28/25 at 11:12 A.M. with Administrator and DON confirmed they were notified on 08/13/25 around 11:00 P.M. of an allegation of sexual abuse involving Resident #26 and #90. DON stated she arrived at the facility and initiated an investigation which included staff and resident interviews, notifying the police department, families, and physician. Administrator stated neither Resident #26 nor Resident #90 had ever shown sexually aggressive behavior prior to the incident. Administrator stated Resident #90 remained on one-on-one supervision until her discharge on [DATE]. The Administrator and DON confirmed Resident #26 and #90 had cognitive impairment, resided on a secured/locked unit and were unable to provide consent to the sexual encounter. Interview on 08/28/25 at 2:44 P.M. with STNA #210 confirmed she was walking in the hallway and observed Resident #90 sitting on the couch in the common area with Resident #26 standing in front of her and his penis was in her mouth. STNA #210 stated she immediately separated the residents and called for help. STNA #210 stated she never left the residents alone at any time after her observation. STNA #210 confirmed both Resident #26 and #90 had severely impaired cognition and could not consent to sexual encounter. Review of the facility policy titled, Abuse Prevention, dated September 2021, stated the residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy stated as part of the abuse prevention, the administration would protect residents from abuse by anyone including but not necessarily