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	05/08/2025

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on medical record review, staff and resident interviews, observation, and review of policy, the facility failed to ensure residents had orders and were assessed for secured units resulting in involuntary seclusion. This affected two (#60 and #180) of two residents reviewed for involuntary seclusion and had the potential to affect 13 additional residents (#3, #4, #5, #7, #17, #26, #32, #34, #35, #62, #68, #73, and #76) residing in the secured mental health unit (MHU) that did not orders for and were not assessed for admission to the secured MHU. The census was 76. Findings include: 1. Review of Resident #60's medical record revealed an admission date of 01/26/24. Diagnoses listed included epilepsy, hypertension, anxiety, paranoid schizophrenia, and depression. Review of a significant change Minimum Data Set (MDS) revealed Resident #60 had severely impaired cognition and was receiving Hospice services. Further review of Resident #60's medical record revealed no order for admission to secured MHU. There was no documentation of any assessments being completed to ensure Resident #60 was appropriate for the secured MHU. Observations during the survey form 05/05/25 through 05/08/25 revealed Resident #60 resided in the MHU. Resident #60 was unable to be interviewed due to poor cognition. 2. Review of Resident #180's medical record revealed an admission date of 05/01/25. Diagnoses listed included alcohol dependence, post-traumatic stress disorder, anxiety disorder, major depressive disorder, hypertension, and obstructive sleep apnea. A MDS had not yet been completed for Resident #180. Review of progress notes revealed on 05/06/25 at 6:31 P.M. Resident #180 was assessed with a brief interview for mental status (BIMS) score of 15 (cognitively intact). Further review of Resident #180's medical record revealed no order for admission to secured MHU. There was no documentation of any assessments being completed to ensure Resident #60 was appropriate for the secured MHU. (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/05/25 at 9:57 A.M. Resident #180 stated he was transferred from another facility into this facilities MHU because he had been caught drinking at the other facility. Resident #180 felt he was rushed out of the other facility and had to sign to agree to come to this facility. Resident #180 stated he did not belong in secured MHU. Resident #180 thought it was vengeance from the previous facility. During an interview on 05/06/25 at 11:04 A.M. the Director of Social Services (DSS) #372 stated she was unsure why Resident #180 was admitted to the MHU, but believed he had threatened to blow up his previous facility. DSS #372 stated Resident #180 did not have an appointed guardian. During an interview on 05/06/25 at 11:08 A.M. Resident #180 stated he was getting depressed being the the MHU. Resident #180 stated facility staff had told him they were working on getting him out of the facility. Interview with the Director of Nursing (DON) and the Administrator on 05/06/25 at 2:04 P.M. confirmed Residents #60 and #180 did not have orders to be in the MHU. Assessments had not completed for Residents #60 or #180 to ensure they were appropriate for the MHU. The DON and Administrator confirmed none of the other 13 current residents (#3, #4, #5, #7, #17, #26, #32, #34, #35, #62, #68, #73, and #76) had orders to be in the secured MHU or had assessments completed to ensure they were appropriate for the secured MHU. Review of the facility's policy titled. Behavioral Assessment, Intervention and Monitoring dated September 2021 revealed the admissions team must screen residents referred to the behavioral unit to ensure caregivers are capable of providing the appropriate care for the resident. The admission team should identify and consider several factors prior to accepting the resident. It is not the intent that the presence of any one or combination of these factors necessarily precludes admission, but the overall presentation of the resident's status must be appropriate. Review of the Abuse Prevention Program policy, dated 09/2021 revealed it is the policy that the resident will be free from abuse, this includes freedom from involuntary seclusion.

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on review of personnel files, staff interview, and review of facility policy, the facility failed to ensure new employees were screened against the state nurse aide registry for potential concerns with abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. This affected three (#381, #384 and #396) of six personnel records reviewed. This had the potential to affect all 76 residents residing in the facility. The census was 76. Findings include: 1. Review of Licensed Practical Nurse (LPN) #381's personnel file revealed a hire date of 09/24/24. Further review revealed LPN #381 was not screened against the state nurse aide registry upon hire. 2. Review of LPN #384's personnel file revealed a hire date of 09/01/23. Further review revealed LPN #384 was not screened against the state nurse aide registry upon hire. 3. Review of Business Office Manager (BOM) #396's personnel file revealed a hire date of 04/10/25. Further review revealed BOM #396 was not screened against the state nurse aide registry. Interview with Human Resources (HR) #400 on 05/08/25 at 1:52 P.M. confirmed LPN #381, LPN #384, and BOM #396 were not screened against the state nurse aide registry upon hire for potential concerns with abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property Interview with Administrator on 05/08/25 at 2:45 P.M. confirmed LPN #381, LPN #384, and BOM #396 were not screened against the state nurse aide registry upon hire for potential concerns with abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. During the survey LPN #381, LPN #384, and BOM #396 were screened against the nurse aide registry and there were no abuse concerns found. Review of the facility's policy titled, Abuse Prevention Program dated September 2021 revealed he facility will conduct employee background checks and will not knowingly employ or otherwise engage any individual who has have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property, or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and physician interviews, the facility failed to ensure a resident's physician progress notes accurately reflected an evaluation of the resident's condition and program of care. This affected one (#43) of three residents reviewed for physician services. The facility census was 76. Findings include: Review of medical record for Resident #43 revealed admission date of 09/19/25. The resident was admitted with diagnoses including neurocognitive disorder with Lewy bodies, type two diabetes with unspecified complications, anxiety and hypertension. The resident was admitted to Hospice on 02/06/25 and remained at the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had severely impaired cognition. She was dependent for eating, toileting hygiene, bed mobility and transfers. A plan of care revealed Resident #43 had a terminal illness care plan which included interventions to notify hospice with any changes, if pain medications were ineffective, and to provide care based on resident/family preferences related to end of life comfort measures. Review of the physician progress notes revealed Resident #43 was seen by a physician on 03/23/25, 04/02/25, 04/10/25, 04/14/25 and 04/21/25 for blood sugar. The notes documented all labs were reviewed and the plan was to continue the current treatment plan. Further record review of the medical record for Resident #43 revealed no glucose/blood sugar ordered or documented for 2025, the resident had no diabetic labs ordered and the resident was not receiving any diabetic medications. Interview on 05/07/25 with Director of Nursing (DON) #43 verified Resident #43 had not had her blood glucose ordered or checked in 2025, the resident had no diabetic labs ordered and was not receiving any diabetic medications. DON #43 shared Physician #550 had been contacted and would be in to document an addendum to the physician notes. Interview on 05/07/25 at 2:02 P.M. with Physician #550 verified he had been unaware Resident #43 had been receiving hospice services. Physician #550 shared the progress notes were a blanket statement for diabetic residents. Physician #550 acknowledged the nursing staff had not informed him of a concern for Resident #43's blood sugars. Physician #550 stated he overlooked the note on the resident list noting Resident #43 had been a hospice resident and if staff did not have a concern he would not have seen her had he known. Physician #550 further confirmed Resident #43 had not had her blood glucose ordered or checked in 2025, had no diabetic labs ordered and was not receiving any diabetic medications.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of Resident #60's medical record revealed an admission date of 01/26/24. Diagnoses listed included epilepsy, hypertension, anxiety, paranoid schizophrenia, and depression. Review of a quarterly MDS dated [DATE] and significant change MDS dated [DATE] revealed Resident #60 had severely impaired cognition and was receiving Hospice services. Resident #60 resided in the secure mental health unit (MHU). Review of an admission agreement revealed Resident #60 signed and accepted the alternate dispute resolution agreement section on 05/14/24. Resident #60 was unable to be interviewed about the alternate dispute resolutions during the survey from 05/05/25 through 05/08/25 due to her impaired cognitive status. Interview with the Administrator and Admissions Coordinator (AC) #364 on 05/07/25 at 2:20 P.M. confirmed Resident #60 had severe cognitive impairment and would not be able to understand an arbitration agreement. AC #364 confirmed Resident #60 had signed an arbitration agreement. AC #364 stated that that when a resident signs the admission agreement on an electronic device the signature populates to all signature sections of the agreement, including the alternate dispute resolution agreement section. Based on medical record review, review of arbitration agreements and staff and resident interviews, the facility failed to ensure facility staff knew a residents' cognitive status and ability to understand before having the resident sign an arbitration agreement. This affected three (#29, #60, and #66) of three residents reviewed for arbitration agreements. The census was 76. Findings include: 1. Review of the medical record for Resident #29 revealed an admission date of 10/28/24 with diagnoses of pathological fracture, left ankle, subsequent encounter for fracture with routine healing, other fracture of unspecified lower leg, subsequent encounter for closed fracture with routine healing, Alzheimer's disease, and dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident was cognitively intact. Resident was independent with bed mobility and wheelchair mobility, resident required set-up assistance with eating, oral hygiene, and personal hygiene, resident required supervision assistance with toileting hygiene, dressing, transfers, and ambulating, and resident required partial assistance with bathing. Review of the Arbitration agreement revealed the resident signed the agreement on 10/29/24. Interview on 05/07/25 at 2:02 P.M. with Resident #29 revealed the resident voiced confusion about signing an arbitration agreement and he doesn't remember signing the document. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/25 at 1:21 P.M. with the Administrator confirmed Resident #29 has Alzheimer's disease and has periods of confusion, was moved to the memory care unit the day after signing the agreement and should not have signed the arbitration agreement. Interview with the Administrator also confirmed the facility does not have an arbitration agreement policy. 2. Review of the medical record for Resident #66 revealed an admission date of 04/19/24 with diagnoses of Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the admission MDS dated [DATE], revealed Resident #66 had severe cognitive impairment. Review of the Arbitration Agreement revealed Resident #66 signed the agreement on 05/15/24. Interview on 05/08/25 at 1:21 P.M. with the Administrator confirmed Resident #66 has Alzheimer's disease, has severe cognitive impairment and should not have signed the arbitration agreement.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed ensure Hospice provider contracts, plans of care, and/or communication binders were available at the facility. This affected (#60) of one reviewed for Hospice. The census was 76. Findings include: Review of Resident #60's medical record revealed an admission date of 01/26/24. Diagnoses listed included epilepsy, hypertension, anxiety, paranoid schizophrenia, and depression. Review of a significant change Minimum Data Set (MDS) dated [DATE] and a revealed Resident #60 had severely impaired cognition and was receiving Hospice services. Review of physician orders revealed an order dated 03/22/25 for Hospice services for intracranial hemorrhage. Further review of Resident #60's medical record revealed no documentation of the Hospice provider agreement or plan of care. Resident #60 was unable to be interviewed during the survey from 05/05/25 through 05/08/25 due to her impaired cognitive status. Interview with Registered Nurse (RN) #410 on 05/07/25 at 2:07 P.M. revealed a Hospice communication binder was not present in the facility for Resident #60. There was no sign in sheet for any Hospice staff that would visit Resident #60. There was no copy of Resident #60's Hospice provider agreement or Hospice provider plan of care in the facility. The Hospice provider had been called and they will be bringing one to the facility. RN #410 would be unable to determine when and what Hospice staff had seen Resident #60. Interview with the Director of Nursing (DON) on 05/07/25 at 3:07 P.M. confirmed Resident #60's Hospice provider agreement or Hospice provider plan of care was not available in the facility until obtained on 05/07/25. The DON confirmed there was not any Hospice provider staff signature logs or communication binder. Review of the facility's policy titled, Hospice Program September dated 2021 revealed the agreement with the Hospice provider will be signed by the facility representative and a representative from the Hospice agency before hospice services are furnished to any resident. A copy of the agreement is available through the facility business office and the hospice agency. Coordinated care plans for residents receiving Hospice services will include the most recent Hospice plan of care as well as the care and services provided by our facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being.