STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366347	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veranda Gardens & Assisted Living	11784 Hamilton Avenue Cincinnati, OH 45231

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, review of the hospital record, review of the facility investigation, staff interviews, and review of the facility policy, the facility failed to provide adequate assistance while providing a resident incontinence care resulting in an avoidable fall. This resulted in Actual Harm to Resident #13 on 07/26/25 when staff rolled the resident away from them during care, the resident began to shake the side rail, the side rail gave way during care and the resident fell from the bed onto the floor. Resident #13 was subsequently transferred to the hospital for treatment for a head laceration requiring sutures. This affected one (#13) of three residents reviewed for falls. The facility census was 89.Findings Included:Review of the medical record revealed Resident #13 was admitted to the facility on [DATE]. Diagnoses included dementia, schizoaffective disorder, Alzheimer's disease, cerebral vascular disease, and tardive dyskinesia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 had a Brief Interview of Mental Status (BIMS) score of five indicating the resident had impaired cognition. Resident #13 required substantial maximal assistance for toileting and personal hygiene. Resident #13 was dependent on staff for transfers and lower body dressing.Review of the hospital summary dated 07/26/25 revealed Resident #13 was seen at the hospital for a forehead laceration due to a fall at the facility when something broke on her bed, while receiving assistance moving this morning. The trauma unit in the emergency room had reviewed the resident and a Computed Tomography (CT) scan was ordered to further evaluate her fall injury. The CT scan showed no acute intracranial abnormality. Resident #13 had a laceration cleaned and sutured.Review of the physician order dated 07/28/25 revealed an order to remove the sutures in Resident #13's forehead in seven days on 08/04/25. Review of the progress note dated 07/29/25 written by the Director of Nursing (DON) on 07/26/25, the DON was called to Resident #13's room around 10:55 A.M. Resident #13 was found lying on the floor near the window and the heater and air conditioning unit face down with her oxygen on and blood surrounding her. Resident #13 was assessed and had a laceration on her forehead. Pressure was applied to the area. Emergency Medical Service (EMS) was called. Resident #13 was able to state she had pain at a 10, out of a pain scale of 1 to 10, with 10 being the highest level. Review of the facility fall investigation revealed on 07/26/25 at approximately 10:55 A.M. Licensed Practical Nurse (LPN) #210 was called to the room of Resident #13 to assist Certified Nursing Assistant (CNA) #249. The DON was in the facility and entered Resident #13's room around 10:56 A.M. The DON applied pressure to the cut on Resident #13's forehead while LPN #210 called nine-one-one (911). Resident #13 was sent to the hospital. Review of the fall investigation dated 07/26/25 by LPN #210 revealed Resident #13 had fallen out of bed face down after grabbing the handrail on the left side of her bed. Blood was coming from her forehead. An equipment failure was identified with the beds side rail, and a new fall intervention was a new bed for Resident #13. Review of the witness statement dated 07/26/25 by CNA #249 documented she was changing Resident #13 in bed at 10:55 A.M. and she rolled Resident #13 towards the window. Resident #13 grabbed the side rail and started shaking it which caused it to loosen up, and the side rail came off. Resident #13 fell out of bed onto her face. CNA #249 immediately ran to get the nurse. The nurse came into the room to look at Resident # 13, saw blood and called 911 immediately. Interview on 11/05/25 at 10:51 A.M., CNA #249 stated on the morning of 07/26/25 she provided incontinence care by herself and rolled Resident #13 away from her towards the window, on her left side, and she asked the resident to hold onto the side rail in the process. Resident #13 shook the left side rail with her hands during care. CNA #249 said the left side rail gave way, and Resident #13 fell off the bed landing on the floor face first. Resident #13 was screaming, and CNA #249 ran out of the room immediately, and called for the nurse. CNA #249 stated she was educated to check the side rails before using and get staff to assist with care. Interview on 11/13/25 at 11:43 A.M. with the DON stated she would educate an aid with one person assist who also was substantial maximal assistance, that included a confused resident with the following steps: at the bedside first make sure side rails are in position, educate resident on what you're doing, lower head of bed, elevate the bed at right height for proper body mechanics, stand on the side of the bed that she was closest to the bed rail, undress her bottoms including brief while on her back, ask the resident to assist in turning and grab the bed rail turning towards the aid, and stand there to have her roll towards the aid providing assistance in the turn with hands, protecting her head, and boney premises to provide incontinence