

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2026
NAME OF PROVIDER OR SUPPLIER Veranda Gardens Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Give residents a notice of rights, rules, services and charges. Based on record review and staff interviews, the facility failed to review Resident Rights with the residents on an ongoing basis both in writing and orally. This had the potential to affect all residents in the facility. The facility census was 82. Review of Resident Council Minutes for the past twelve months (December 2024 through December 2025) revealed a discussion of resident rights was not on the agenda nor discussed at monthly meetings. Interview on 01/21/26 at 2:08 P.M., Resident #47 stated he had recently received a copy of the Resident Rights document from the local Ombudsman who had come to their January resident council meeting. After reading the document, he began sharing it with other residents including the Resident Council President (Resident #16). Resident #47 stated he had not seen the Resident Rights information before. Interview on 01/21/26 at 2:17 P.M., Resident #16 stated she had not read the Resident Rights document until Resident #47 had brought it to her recently. Interviews on 01/26/26 at 2:00 P.M. to 3:45 P.M., Resident #20, #26 #41, and #70 stated they were not aware of the Resident Rights and did not recall a time when the staff went over them. Interview on 01/26/26 at 3:51 P.M., Activities Director #218 verified the Resident Rights were not discussed at the monthly Resident Council meetings.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and review of the facility policy, the facility failed to ensure food was stored and prepared in a manner to prevent foodborne illness. This had the potential to affect 80 out of 82 residents as the facility identified two Residents (#87 and #09) with a diet order of nothing by mouth. The facility census was 82. Observation of the kitchen's dry storage room on 01/12/26 at 8:50 A.M. with Dietary Supervisor (DS) #235, revealed a bag of baking cocoa with an open date of 07/12/25 and no discard date. Further observation revealed an open bag of egg noodles and penne noodles without a date. Interview with DS #235 at the same time, verified that the baking cocoa should have had a discard date for six months after opening and that both bags off pasta did not have an open date or a discard date. Continued observation of the kitchen on 01/12/26 at 8:54 A.M. with DS #235 revealed a pumpkin pie without a date or name being stored in the refrigerator in the main dining room. Interview with DS #235 at the same time, stated the refrigerator is for food that the resident's family brings in. DS #235 verified that the pumpkin pie did not have a date or the name of the resident that it belonged to. Continued observation of the kitchen on 01/14/26 at 12:13 P.M. with Dietician #351 revealed a red bucket containing chemicals on the food prep table next to two bags of Jello mix. Interview with Dietician #351 at the same time verified that the red bucket contained sanitizer and should not be stored near food. Review of the facility policy titled, Food Storage - Labeling and Dating revised July 2018, revealed food items must be dated with an open date and a use by date. Review of the facility policy titled Use and Storage of Food Brought in by Family and Visitors revised 08/01/2023, revealed food items brought in must be labeled and dated.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Dispose of garbage and refuse properly. Based on observation and staff interviews the facility failed to ensure trash cans in the kitchen were properly covered. This had the potential to affect 80 out of 82 residents as the facility identified two Residents (#87 and #09) with a diet order of nothing by mouth. The facility census was 82. Observation of the kitchen on 01/12/2026 at 8:39 A.M. Dietary Supervisor (DS) #235 revealed a trash can in the food prep area and in the dish washing area that did not have a lid. Interview with DS #235 at the same time, verified the trash cans were not covered. DS #235 attempted to cover both trash cans but was only able to locate one lid. Interview on 01/14/2026 at 11:27 A.M., Dietician #351 verified all trash cans should be covered when they are not in active use.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to include residents and families for care planning and care conferences. This affected three Residents (#54, #47, and #16) out of four residents reviewed for care planning and care conferences. Facility census was 82. Review of the medical record for Resident #54 revealed the resident was admitted to facility on 05/13/22. Diagnosis included cerebral infarction, chronic pain, stenosis of bilateral carotid arteries, depression, anxiety, aphasia following cerebral infarction, diabetes, hypertension, atrial fibrillation, and hyperlipidemia. Review of the Minimum Data Set (MDS) assessment for Resident #54 dated 12/15/25 revealed the resident had moderately impaired cognition with moderate depression. Interview with Resident #54 on 01/13/26 at 9:31 A.M. revealed he could not remember ever having a care conference with the interdisciplinary team (IDT) to discuss care concerns or his care plan. Interview on 01/13/26 at 4:10 P.M., Resident #54's Guardian stated she was assigned to be Resident # 54's guardian in August 2025 and she has not been invited to or attended a care conference for Resident #54. Review of medical record for Resident #47 revealed an admission date of 06/12/24 with diagnoses including quadriplegia, amputation of two or more toes, atherosclerosis of aorta, diabetes, myocardial infarction, colostomy, malnutrition, alcohol abuse, mood disorder, hypertension, contractures of multiple sites, neuro dysfunction of the bladder. Review of MDS assessment dated [DATE] revealed Resident #47 was cognitively intact. Interview with Resident #47 on 01/20/26 at 10:22 A.M. revealed the resident had one care conference upon admission to the facility in June 2024 but hasn't been invited to or had any additional care conferences since the initial care conference. Resident #47 stated he had never seen his care plan or been told what was in it. Review of medical record for Resident #16 revealed an admission date of 04/13/23 with diagnoses including quadriplegia, amputation of two or more toes, anemia, atherosclerosis of aorta, diabetes, hyperlipemia, old myocardial infarction, colostomy, malnutrition, alcohol abuse, mood disorder, seasonal allergies, hypertension, contractures of multiple sites, and neuro dysfunction of the bladder. Review of the MDS assessment dated [DATE] revealed Resident #16 was cognitively intact. Interview on 01/20/26 at 10:52 A.M. Resident #16 stated she has not been invited to or attended a care conference since she transitioned from skilled care to long term care sometime in late 2024. Resident #16 stated she has not seen her care plan nor been told what is included in her care plan. Interview on 01/15/26 at 1:29 P.M., SSD #321 stated she would do care conferences upon admission, quarterly, annually and upon request. SSD #321 revealed she invites residents as well as their responsible parties to all care conferences. SSD #321 stated that there are not many residents or responsible parties that attend care conferences. SSD #321 verified the facility had documented evidence of care conference invitations being sent out to residents or responsible parties. Interview on 01/20/26 at 3:01 P.M., the Administrator verified the facility had no documented evidence of care conferences or IDT Plans of Care for Residents (#54, #47, and #16) since 2024. This deficiency represents non-compliance investigated under Complaint Number 2621517.		