STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366466	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Trace Health and Rehabilitation	250 West Social Row Road Centerville, OH 45458

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, and review of the facility policy, the facility failed to notify the physician of a resident fall. This affected one (Resident #89) of 24 residents sampled. The facility census was 116 residents. Findings include:Review of medical record for Resident #89 revealed an admission date of 12/11/24 with diagnoses including epilepsy and mild intellectual disability. Review of the Minimum Data Set (MDS) assessment for Resident #89 dated 03/12/26 revealed the resident was cognitively intact. Review of the fall investigation for Resident #89 revealed the resident had a fall on 06/05/26 at 11:05 P.M. while trying to move the wheelchair and table closer to her reach. Review of the progress notes for Resident #89 revealed the resident's physician was not notified of the fall until 06/06/26 at 5:45 P.M. Interview on 06/10/26 at 2:25 P.M. with Assistant Director of Nursing, Licensed Practical Nurse (LPN) # 176 confirmed the facility did not notify Resident #89's physician of the resident's fall on 06/05/26 at 11:05 P.M. until 06/06/26 at 5:45 P.M. ADON/LPN #176 confirmed the facility should notify physicians immediately of resident falls and accidents. Review of the facility policy titled Fall Management dated 01/23/25 revealed the management of falls included physician notification of falls. This deficiency represents noncompliance investigated under Complaint Number 3022306.

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