

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Austin Trace Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interview, review of the facility dishwasher temperature logs, and review of manufacturer's manual, the facility failed to store and label food properly and failed to ensure low temperature dishwasher met proper temperature during the wash cycle. This had the potential to affect all residents in the facility with the exception of 13 facility-identified residents (#7, #9, #10, #26, #38, #44, #50, #67, #87, #90, #98, #102, and #108) who did not receive food from the kitchen. The facility census was 116 residents. Findings include: 1. Observation on 06/08/26 at 8:12 A.M. of the facility refrigerator with [NAME] #143 revealed it contained the following items: a container of coleslaw with use by date of 05/30/26, a container of unlabeled and undated cooked beef, two containers of opened and undated and unlabeled lettuce, a block of cheese with a used by date of 06/06/26. Interview on 06/08/26 at 8:12 A.M. with [NAME] #143 confirmed the container of coleslaw and cheese had use by dates which were prior to 06/08/26 and should have been discarded and the containers with beef and lettuce should have been labeled and dated when opened. 2. Review of the facility dishwasher temperature log dated 06/08/26 revealed the staff had run the dishwasher with the wash cycle temperature reaching 120 degrees Fahrenheit (F.) Interview on 06/08/26 at 8:15 A.M. with Dietary Staff (DS) #143 confirmed the dishwasher temperature log for 06/08/26 read 120 degrees F. Observation on 06/08/26 at 8:21 A.M. with DS #143 revealed he ran the dishwasher three times and the temperature was 110 degrees F. Interview on 06/08/26 at 8:25 A.M. with DS #143 confirmed the wash cycle of the dishwasher was supposed to reach 120 degrees F, but it only reached 110 degrees F during the three observations. Review of the dishwasher manual for Model 5AGES or WS2 page 13 revealed the operating temperature of 120 degrees F at a minimum. 130 to 140 degrees F was recommended. 3. Observation on 06/08/26 at 8:29 A.M. of dry storage with Dietary Manager (DM) #202 revealed there was a large plastic measuring cup inside the plastic flour bin. Interview on 06/08/26 at 8:29 A.M. with DM #202 confirmed the measuring cup should not be stored inside the plastic flour bin.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on medical record review, observation, staff interview, and review of manufacturer's guidelines the facility failed to ensure sterile equipment was used for tracheostomy care. This affected one (Resident #30) of 14 residents with tracheostomies. Based on medical record review, observation, and staff interview, the facility failed to follow proper infection control protocols during meal service. This affected one (Resident #79) of 10 residents observed for dining. Based on medical record review, observation, staff interview, review of the facility policy, and review of online guidelines per the Centers for Disease Control (CDC) the facility failed to ensure staff donned appropriate personal protective equipment (PPE) and failed to ensure staff could appropriately discard PPE. This affected two (Residents #107 and #121) of 11 residents with orders for transmission-based precautions (TBP.) The facility census was 116 residents. Findings include: 1. Review of medical record for Resident #30 revealed an admission date of 06/03/25 with diagnoses including nontraumatic intracerebral hemorrhage, contracture left hand, tracheostomy status, and gastrostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #30 dated 06/05/25 revealed the resident had intact cognition and required supervision with activities of daily living (ADLs.) Observation on 06/10/26 at 12:17 P.M. of tracheostomy care for Resident #30 with Respiratory Therapist (RT) #144 revealed RT took the following steps: removed and discarded the tracheostomy dressing, cleansed the area surrounding the tracheostomy with saline and gauze, patted the area dry with gauze, removed a closed suction tracheal catheter from a clear supply bag at bedside, connected the closed suction tracheal catheter to the tubing of the suction machine which was located on the bedside table, attached the suction to the resident's tracheostomy tube, suctioned a small amount of clear secretions using the closed system, removed the closed system from the tracheostomy tube and placed it back into the supply bag, removed the resident's inner cannula and discarded it, replaced a new inner cannula using sterile technique. Interview on 06/10/26 at 12:30 P.M. with RT #144 verified the closed system was stored at bedside in a supply bag. RT #144 verified tracheostomy care was a sterile procedure. She stated the inner cannula used for suctioning was contained in a plastic sheath which was stored approximately one half of an inch from the opening of the hard plastic t-piece of the closed system catheter. RT #144 acknowledged the t-piece was not a closed system and verified the piece which connected to the tracheostomy tube remained open during storage in a non-sterile, unclosed supply bag at bedside. Review of the closed suction tracheal catheter manufacturer's instruction revealed the intended use was for the removal of secretions for ventilator dependent patients. Precautions were to inspect the package prior to use and not to use if the product had been opened or damaged. Non-sterile contents could cause infection. Do not re-sterilize, reuse or repurpose. 2. Review of the medical record for Resident #79 revealed an admission date of 02/26/25 with diagnoses including Alzheimer's disease, peripheral vascular disease, and chronic kidney disease. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment for Resident #79 dated 06/01/26 revealed the resident had moderately impaired cognition and required set-up assistance with eating. Observation on 06/08/26 at 11:35 A.M. revealed Certified Nursing Assistant (CNA) #164 removed Resident #79's lunch tray from the meal cart and placed the tray on the table in front of the resident. CNA #164 opened the lid on Resident #79's tray and then grabbed the resident's bread with her bare hands and buttered the bread. Interview on 06/08/26 at 11:43 A.M. with CNA #164 confirmed she used her bare hands and touched Resident #79's bread to butter the bread. 3. Review of the medical record for Resident #107 revealed an admission date of 08/02/25 with diagnoses including nontraumatic intracerebral hemorrhage, diabetes mellitus, and hypertension. Review of the MDS assessment for Resident #107 dated 05/08/26 revealed Resident #107 was cognitively intact and required staff assistance with ADLs. Review of the physician's orders for Resident #107 revealed an order dated 06/07/26 for maintain contact precautions every shift for klebsiella pneumonia, indwelling devices, and wounds. Observation on 06/09/26 at 12:44 P.M. revealed Resident #107's room had a contact precaution sign posted on the door and a personal protective equipment (PPE) cart located outside of his room. CNA #125 knocked on Resident #107's door and entered to deliver the lunch tray and closed the door. CNA #125 had not donned PPE prior to entering Resident #107's room. Interview on 06/09/26 at 12:46 P.M. with CNA #125 confirmed she had not donned PPE prior to entering Resident #107's room to deliver the lunch tray. CNA #125 verified Resident #107 had a contact precaution sign on his room door, and a PPE cart was located outside of his room. 4. Review of medical record for Resident #121 revealed an admission date of 06/04/26 with diagnoses including respiratory failure, heart failure, and type two diabetes mellitus. Review of the physician's orders for Resident #121 revealed an order dated 06/06/26 for contact isolation due to infection with vancomycin-resistant enterococci (VRE.) Observation on 06/08/26 at 11:25 A.M. of Resident #121's room revealed there was a contact isolation sign and a cart containing PPE at the entrance of the resident's room. There were no bins or containers inside the room for staff to discard gowns before leaving the room. Interview on 06/08/26 at 11:36 A.M. with Licensed Practical Nurse #170 verified there were no bins in Resident #121's room for staff to discard used gowns prior to exiting the room. Review of the facility policy titled Standard and Transmission-based Precautions revised 03/24/24 revealed the facility staff would take appropriate precautions, including isolation, to prevent (continued on next page)		

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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.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review, staff interview, review of the facility policy, and review of online medication resources, the facility failed to ensure nonpharmacological interventions were attempted prior to administering as needed psychotropic medications. This affected one (Resident #3) of five residents reviewed for unnecessary medications. The facility census was 116 residents. Findings include: Review of the medical record for Resident #3 revealed an admission date of 10/14/24 with diagnoses of acute and chronic respiratory failure with hypoxia, type two diabetes mellitus, major depressive disorder, and chronic kidney disease. Review of the physician's orders for Resident #3 revealed an order dated 11/18/25 revealed an order for Ativan one milligram (mg) give one tablet by mouth every six hours as needed for anxiety with a stop date of 05/19/26. Review of the physician's orders for Resident #3 revealed an order dated 05/30/26 for Ativan one mg give one tablet by mouth every six hours as needed for anxiety. Review of the Medication Administration Record (MAR) for Resident #3 dated November 2025 revealed Ativan was administered seven times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated December 2025 revealed Ativan was administered 17 times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated January 2026 revealed Ativan was administered nine times without nonpharmacological interventions attempted prior to administration. Review of the Mar for Resident #3 dated February 2026 revealed Ativan was administered 22 times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated March 2026 revealed Ativan was administered 22 times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated April 2026 revealed Ativan was administered 14 times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated May 2026 revealed Ativan was administered five times without nonpharmacological interventions attempted prior to administration. Review of the MAR for Resident #3 dated June 2026 revealed Ativan was administered three times without nonpharmacological interventions being attempted prior to administration. Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 05/15/26 revealed the resident was cognitively intact, required assistance with activities of daily living (ADLs), and took antianxiety medication. Interview on 06/11/26 at 9:13 A.M. with Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) #176 confirmed there was no documentation of nonpharmacological interventions being attempted prior to administering as needed Ativan to Resident #3. RN ADON LPN #176 verified nonpharmacological interventions had not been attempted prior to administration of Ativan on multiple dates since 11/18/25. ADON LPN #176 stated the facility expectation was for staff to attempt nonpharmacological interventions prior to administration of any psychotropic medication to include Ativan for Resident #3. Review of the facility policy titled Medication Administration dated 06/21/17 revealed medications should be administered consistent with accepted standards of practice. Review of the online medication resource Medscape at https://reference.medscape.com/drug/ativan-loreev-xr-lorazepam-342906#4edation revealed Ativan had the following potential adverse effects: dizziness, unsteadiness, weakness, fatigue, drowsiness, confusion, disorientation, depression, suicidal ideation, vertigo, ataxia, respiratory depression, seizures, visual disturbances, hypotension, paradoxical reactions (anxiety, excitation, agitation, hostility, aggression, rage.) Ativan was recommended for short term use and carried a black box warning which indicated physical dependence could occur even when taken as prescribed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and staff interview, the facility failed to develop comprehensive resident care plans. This affected one (Resident #30) of 24 residents sampled. The facility census was 116 residents. Findings include: Review of the medical record for Resident #30 revealed an admission date of 06/03/25 with diagnoses including nontraumatic intracerebral hemorrhage, contracture left hand, tracheostomy status, and gastrostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #30 dated 06/05/25 revealed the resident had intact cognition, required staff assistance with activities of daily living (ADLs), and had impairment to one side of his upper extremity. Review of the physician's orders for Resident #30 revealed an order dated 11/14/25 for the resident to wear a left-hand splint at his own discretion and for staff to check under the brace as the resident would allow every dayshift. Review of the care plan for Resident #30 revealed it did not include the resident's left-hand contracture and/or interventions to prevent worsening or decreased range of motion. Interview on 06/11/26 at 2:25 P.M. with the Director of Nursing (DON) confirmed Resident #30 had a left-hand contracture which was not addressed in the resident's care plan.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and staff interview, the facility failed to ensure resident care plans were updated with pertinent changes. This affected one (Resident #89) of two residents reviewed for accidents and hazards. The facility census was 116 residents. Findings include: Review of the medical record for Resident #89 revealed an admission date of 12/11/24 with diagnoses including epilepsy and mild intellectual disabilities. Review of the Minimum Data Set (MDS) assessment for Resident #89 dated 03/12/26 revealed the resident had intact cognition and required assistance with activities of daily living (ADLs). Review of the fall investigation for Resident #89 dated 06/05/26 at 3:45 PM revealed the resident fell while trying on new pants. A new intervention of chair alarm was initiated to prevent further falls. Review of the fall investigation for Resident #89 dated 06/05/26 at 11:05 P.M. revealed the resident fell while trying to move wheelchair and table closer to her reach. New interventions were initiated to prevent recurrence included the following: bed alarm, handrails on sides of toilet, non-slip socks, lock wheels on bed, restorative nursing, assistive device (reacher), low bed. Review of the care plan for Resident #89 revealed the resident was at risk for falls. The care plan was not updated with the following new interventions initiated following the resident's falls on 06/05/26: handrails on sides of toilet, non-slip socks, lock wheels on bed, restorative nursing, assistive device (reacher), low bed. Interview on 06/10/26 at 1:58 P.M. with Regional Director of Clinical Operations (RDOC) #229 confirmed the facility had not updated Resident #89's care plan with the new interventions determined by the facility following the resident's falls on 06/05/26. Review of the facility policy titled Fall Management dated 01/23/25 revealed a plan would be identified and implemented to protect the resident from recurrence of falls and management of the fall would include updating the care plan to reflect the resident's health status and safety needs.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review, observation, and staff interview, the facility failed to ensure staff obtained a physician's order to provide wound treatment. This affected one (Resident #89) of 24 residents sampled. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility also failed to accurately document resident skin condition. This affected two (Residents #8, #37) of three residents reviewed for skin documentation. The facility census was 116 residents. Findings include: 1. Review of the medical record for Resident #89 revealed an admission date of 12/11/24 with diagnoses including epilepsy and mild intellectual disabilities. Review of the Minimum Data Set (MDS) assessment for Resident #89 dated 03/12/26 revealed the resident had intact cognition and required assistance with activities of daily living (ADLs). Review of the progress note for Resident #89 dated 06/06/26 at 9:09 P.M. per Registered Nurse (RN) # 167 revealed the nurse cleansed a laceration to the resident's head with normal saline, applied steri strips and covered with bordered gauze. Review of the physician's orders for Resident #89 revealed an order dated 06/07/26 for wound care to left forehead vertical linear laceration: monitor placement of steri strips, steri strips to remain in place until wound is resolved, notify provider of signs and symptoms of infection or abnormal findings every shift for wound healing. Review of the Treatment Administration Record (TAR) for Resident #89 dated June 2026 revealed staff were signing off completion of the treatment to the resident's left forehead wound every shift. Observation on 06/09/26 at 9:15 A.M. revealed Resident #89 had a laceration to her left forehead with steri strips in place. Interview on 06/10/26 at 2:25 P.M. with Assistant Director of Nursing (ADON) Licensed Practical Nurse (LPN) # 176 confirmed RN #167 had not obtained an order from the physician for the treatment to Resident #89's left forehead laceration and the nurse should have obtained an order for wound care. 2. Review of the medical record for Resident #8 revealed an admission date of 04/30/24 with diagnoses including atherosclerotic heart disease, bipolar disorder, and congestive heart failure. Review of the MDS assessment for Resident #8 dated 05/13/26 revealed the resident had intact cognition and required staff supervision with activities of daily living (ADLs.) Review of the care plan for Resident #8 revealed the resident was at risk for bleeding, bruising and abnormal lab work related to use of anticoagulant (Aspirin) medication. Interventions included to monitor for bruising. Review of recent progress notes for Resident #8 revealed they did not include documentation of bruises or skin tears. Review of the shower sheets for Resident #8 dated 06/02/26, 06/05/26 and 06/09/26 revealed all areas of the skin should be checked, including skin folds, behind the ears, feet and crevices between toes. Any skin impairment, new and old including bruises, red areas, open areas, skin darker than surrounding skin, rashes, scratches, should be noted. There were no bruises or skin tears noted on Resident #8's shower sheets. Review of the non- pressure skin assessment for Resident #8 dated 06/08/26 revealed it did not include documentation of bruises or skin tears. Observation on 06/08/26 at 8:03 A.M. of Resident #8 revealed the resident had multiple bruises of varying sizes in various stages of healing to his upper extremities and two small open areas to his left lower extremity. Interview on 06/08/26 at 8:03 A.M. with Resident #8 confirmed he had bumped into things which resulted in bruises to his arms. Resident #8 stated he bumped his leg which had caused the two skin tears to his left leg, but the resident was unable to recall when this happened. Interview on 06/10/26 at 9:48 A.M. with Registered Nurse Unit Manager (RNUM) #213 verified there were two open skin tears on Resident #8's left leg and multiple bruises to the resident's arms which had not been documented in the resident's medical record. RNUM #213 stated it was the expectation nursing would monitor the bruises to ensure they were not getting (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Austin Trace Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure an adequate indication for administration of pain medication. This affected one (Resident #37) of five residents reviewed for unnecessary medications. The facility census was 116 residents. Findings include: Review of medical record for Resident #37 revealed an admission date of 02/23/26 with diagnoses including intraspinal abscess and granuloma, bipolar disorder, schizoaffective disorder and osteomyelitis of vertebra. Review of the Minimum Data Set (MDS) assessment for Resident #37 dated 04/07/26 revealed she the resident had intact cognition and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #37 revealed an order dated 04/30/26 for oxycodone five milligram (mg) tablet every four hours as needed for pain. Review of the Medication Administration Records (MARs) for Resident #37 dated May 2026 and June 2026 revealed oxycodone was given on the following dates for pain documented as zero on a scale of one to 10 with 10 being the worse pain: 05/02/26, 05/03/26, 05/10/26, 05/10/26, 05/16/26, 05/23/26, 05/31/26, 06/06/26. Interview on 06/10/26 at 9:05 A.M. with Registered Nurse Unit Manager (RNUM) #195 verified staff gave oxycodone in May and June 2026 to Resident #37 even though the resident's pain was documented at a pain level of zero. RNUM #195 acknowledged she would not expect pain medication would be given for a pain level of zero. Interview on 06/11/26 at 2:25 P.M. with the Director of Nursing (DON) verified staff documented Resident #37's pain level zero prior to multiple administrations of as needed oxycodone. The DON stated pain medication should be given only when indicated. Review of the facility policy title Pain Assessment and Management dated 03/31/16 documented the alert and oriented resident may be asked to describe pain status and pertinent information may include a numeric rating scale of zero to ten; with zero being no pain and ten being the most severe pain the resident can imagine. Pharmacological interventions would be provided in accordance with physician orders. Review of the facility policy titled Medication Administration dated 06/21/17 revealed medications should be administered consistent with accepted standards of practice.		