STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366496	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allbridge Rehabilitation and Nursing Center	5500 East Broad Street Columbus, OH 43213

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff and resident interviews, review of the facilities Self-Reported Incidents (SRI), and facility policy review, the facility failed to ensure a resident's allegation of physical abuse was timely reported to the State Survey Agency. This affected one (Resident #3) of three residents reviewed for abuse. The facility census was 43. Findings include:Review of the medical record for Resident #3 revealed an admission date of 08/01/23. Diagnoses included type two diabetes mellitus, muscle wasting and atrophy, anxiety, mood disorder, and dementia. Review of the annual Minimum Data Set (MDS) 3.0 assessment completed 10/02/25 revealed Resident #3 was cognitively intact, exhibited no behaviors or delusions and was dependent on staff for bathing and toileting. Review of the care plan revised 10/29/25 revealed Resident #3 had a history of anxiety and will yell out/scream during showers accuse staff of breaking teeth when brushing, and had of history shower refusals and oral care. Interventions included assessing and monitoring for anxiety, behavioral health services, encourage resident to express feelings and provide active listening. Review of the dental screen completed 10/31/25 revealed no abnormalities in correlation to previous dental assessment. Resident #3 identified with broken teeth and no mouth pain or chewing problem. Review of the weekly skin assessment completed 10/31/25 revealed bruises to bilateral hands, right elbow and right forearms. In addition, scabs to bilateral upper extremities and left shoulder. Review of the facilities SRIs dated 10/29/25 to 12/29/25 revealed there was no SRI reported for allegation of physical abuse involving Resident #3.Interview on 12/30/25 at 9:10 A.M. with Resident #3 reported on 10/29/25, the resident was assaulted by two staff members in the shower room down the hallway. The resident was unable to identify the two individuals but voiced not seeing them since the incident. Resident #3 reported the Former Administrator (#122) was made aware of her concerns and had worked on an investigation. The resident reported the police had also came into the building pertaining to the incident. Resident #3 had said one staff member placed the water nozzle into her mouth while another placed two towels on top of her face to smother her. The staff then removed the towels and knocked her teeth out.Interview on 12/30/25 at 12:16 P. M. with Registered Nurse (RN) #149 confirmed an incident was reported two to three months ago for Resident #3 where she claimed staff members took her into the shower and knocked her teeth out. The resident reported this to a friend, who then called the police on 10/29/25. RN #149 confirmed management completed an investigation on the alleged incident. Interview on 12/30/25 at 12:47 P.M. with [NAME] President of Business Development (VPBD) #391 stated Resident #3 exhibited typical behaviors of false accusations and frequently changes her story. VPBD #391 was unsure why the Former Administrator (#122) did not submit an SRI to the State Survey Agency immediately and complete a formal investigation into Resident #3's allegation of physical abuse by two staff members. VPBD #391 stated the facility did conduct a soft investigation where staff members were interviewed, and a skin and dental assessment on Resident #3 was completed. Interview on 12/30/25 at 2:11 P.M. with the Director of Nursing (DON) confirmed police came in on 10/29/25 in the evening. The DON first heard of the incident on 10/31/25 where both a skin assessment and dental assessment were completed identifying no abnormalities. The DON confirmed Resident #3 alleged staff members knocked her teeth out during a shower. The DON confirmed a full investigation was not completed and she asked the Former Administrator (#122(who said it was not necessary. The DON voiced she should have gone up the chain and asked clinical management for advice on how to proceed with the alleged abuse. Interview on 12/30/25 at 2:14 P.M. with Admissions #674 confirmed on 10/29/25, police entered the building due to a call placed involving Resident #3. Interview on 12/30/25 at 2:19 P.M. with Medical Records #581 confirmed she was in the facility on 10/29/25 when police entered the building due to a call pertaining to Resident #3. A couple hours after police left, Resident #3 reported staff knocked the resident out during a shower on 10/29/25.Interview on 12/30/25 at 2:28 P.M. with Former Administrator #122 confirmed Resident #3's friend called the city police department, and the police arrived on 10/29/25 on the day of the alleged incident. Former Administrator #122 was aware Resident #3 made accusations her teeth were knocked out but that was typical behavior for the resident. Former Administrator #122 denied hearing Resident #3 claimed two staff members knocked her teeth out while in the shower that day. Direct care staff members were aware of the allegations and should've been reported those to management to report to the State Survey Agency immediately.A local police report was requested on 12/30/25 for the police involvement on 10/29/25 involving Resident #3 but has not been received yet. Review of the facilities Abuse, Neglect, Exploitation and Misappropriation of Property policy dated 11/01/19