

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER River Bend Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 213 Richmond Hill Drive Asheville, NC 28806	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and pharmacist interviews, the facility failed to protect the resident's right to be free from misappropriation of controlled narcotic medications for 6 of 6 residents reviewed for misappropriation of residents' property (Residents #6, #7, #8, #9, #10, and #11). Findings included: The facility's Abuse, Neglect and Exploitation policy revised on 9/01/24 read in part that it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. a. Resident #6 was admitted to the facility on [DATE]. The physician's order dated 10/27/25 revealed Resident #6 had an order to receive Oxycodone (narcotic pain medication) 10 milligrams (mg) tablet three times daily for pain. Review of Resident #6's narcotic record revealed Nurse #1 had signed out one (1) Oxycodone 10 mg tablet on 11/14/25 at 7:30 PM and 11:30 PM. Nurse #1 also signed out one (1) Oxycodone 10 mg tablet on 11/14/25 at an illegible time as wasted with Nurse #2 signing as a witness. The November 2025 Medication Administration Record (MAR) revealed Resident #6's Oxycodone scheduled administration times were 9:00 AM, 1:00 PM and 9:00 PM. Nurse #1 documented on the MAR that the scheduled Oxycodone 10 mg had been administered to Resident #6 on 11/14/25 at 9:00 PM. The physician's order dated 10/27/25 also included an order for Oxycodone 5 mg tablet every 4 hours as needed for pain. Review of Resident #6's narcotic record revealed a second narcotic record sheet of Oxycodone 5 mg. On this narcotic sheet Nurse #1 had signed out one (1) Oxycodone 5 mg tablet on 11/14/25 at 9:00 PM and one (1) Oxycodone 5 mg tablet on 11/15/25 at 1:00 AM and 5:00 AM. Review of Resident #6's narcotic record revealed a third narcotic record sheet of Oxycodone 5 mg. On this narcotic sheet the tablet count had been changed from 28 to 26, but the record lacked dates and signatures. The November 2025 MAR revealed Resident #6's Oxycodone 5 mg as needed had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. b. Resident #7 was admitted to the facility on [DATE]. The physician's order dated 11/07/25 revealed Resident #7 had an order to receive Hydromorphone (narcotic pain medication) 2 mg tablet every 6 hours as needed for pain. Review of Resident #7's narcotic record revealed Nurse #1 had signed out one (1) Hydromorphone 2 mg tablet on 11/14/25 at 8:00 PM and one (1) Hydromorphone 2 mg tablet on 11/15/25 at 2:00 AM. The November 2025 MAR revealed Resident #7's Hydromorphone had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. c. Resident #8 was admitted to the facility on [DATE]. The physician's order dated 11/14/25 revealed Resident #8 had an order to receive Oxycodone (narcotic pain medication) 5 mg tablet every 3 hours as needed for pain. Review of Resident #8's narcotic record revealed Nurse #1 had signed out one (1) Oxycodone 5 mg tablet on 11/14/25 at 7:30 PM and 10:00 PM. Nurse #1 also signed out one (1) Oxycodone 5 mg tablet on 11/15/25 at 12:30 AM, 3:00 AM, and 6:00 AM. The November 2025 MAR revealed Resident #8 Oxycodone had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. d. Resident #9 was admitted to the</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 345432	If continuation sheet Page 1 of 4

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>facility on [DATE]. The physician's order dated 11/06/25 revealed Resident #9 had an order to receive Oxycodone (narcotic pain medication) 10 mg tablet every 3 hours as needed for pain. Review of Resident #9's narcotic record revealed Nurse #1 had signed out one (1) Oxycodone 10 mg tablet on 11/14/25 at 7:30 PM and 10:30 PM. Nurse #1 also signed out one (1) Oxycodone 10 mg tablet on 11/14/25 at an illegible time wasted with Nurse #2 signing as a witness. In addition, Nurse #1 had signed out one (1) Oxycodone 10 mg on 11/15/25 at 1:20 AM, 3:30 AM, and 6:30 AM. The November 2025 MAR revealed Resident #9's Oxycodone had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. e. Resident #10 was admitted to the facility on [DATE]. The physician's order dated 9/06/25 revealed Resident #10 had an order to receive Tramadol (narcotic pain medication) 25 mg tablet every 6 hours as needed for pain. Review of Resident #10's narcotic record revealed Nurse #1 had signed out one (1) Tramadol 25 mg tablet on 11/14/25 at 8:00 PM and one (1) Tramadol 25 mg tablet on 11/15/25 at 2:00 AM. The November 2025 MAR revealed Resident #10's Tramadol had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. f. Resident #11 was admitted to the facility on [DATE]. The physician's order dated 11/13/25 revealed Resident #11 had an order to receive Hydrocodone-Acetaminophen (narcotic pain medication with acetaminophen) 5-325 mg tablet every 6 hours as needed for pain. Review of Resident #11's narcotic record revealed Nurse #1 had signed out one (1) Hydrocodone-Acetaminophen 5-325 mg tablet on 11/14/25 at 7:19 PM and one (1) Hydrocodone-Acetaminophen 5-325 mg tablet on 11/15/25 at 12:20 AM and 6:20 AM. The November 2025 MAR revealed Resident #11's Hydrocodone-Acetaminophen had not been signed as administered on 11/14/25 or 11/15/25 by Nurse #1 or any other nurse. Review of the initial allegation report dated 11/17/25 revealed the facility became aware of the misappropriation of residents' property on 11/17/25 at 9:00 AM when Nurse #3 reported a concern to the Director of Nursing (DON) about as needed narcotics being signed out for a resident who usually did not ask for pain medication. The facility reported the incident to the North Carolina Division of Health Service Regulation (DHSR) on 11/17/25 at 2:02 PM and the local law enforcement on 11/17/25 at 2:30 PM. The investigation report dated 11/21/25 revealed on 11/17/25 the Director of Nursing (DON) was notified by Nurse #3 that as needed pain medication was signed out for a resident who did not usually ask for as need pain medication. A review of the narcotic sign out sheets revealed Nurse #1 had signed out narcotics but had not signed them as administered on the MAR. A review of the narcotics sheets revealed discrepancies which were attributed to Nurse #1. A completed audit revealed 6 residents had multiple entries on their narcotic sheets not documented on their MAR. An unsuccessful attempt was made on 1/29/26 at 2:02PM to conduct a phone interview with Nurse #1. An unsuccessful attempt was made on 1/29/26 at 2:03 PM to conduct a phone interview with Nurse #2. Review of an email dated 11/17/25 at 10:30 pm between the DON and Nurse #2 showed that Nurse #2 signed the narcotic sheets as witness to waste medications for Residents #6 and #9 at Nurse #1's request without observing the medication disposal. An interview on 1/29/26 at 1:46 PM with the DON revealed Nurse #1 was an agency nurse who worked one 12-hour shift at the facility on 11/14/25 at 7:00 PM until 11/15/25 at 7:00 AM. Nurse #2 was an agency nurse who had worked 12 shifts prior to that night between 6/12/25 and 11/15/25. She stated when Nurse #3 had signed the narcotic sheet, she noticed the number of narcotics signed out, became concerned and reported it to her. The DON contacted Nurse #1 who told her that narcotics did not have to be signed on the MAR since they were on the narcotic sheet. The DON contacted Nurse #2 who stated she signed as the narcotic waste witness without visualization of the waste. Nurse #1 and Nurse #2 were blocked from working future shifts at the facility or any of their sister facilities. The DON completed an audit of narcotics and a pain assessment audit for all residents. The DON stated that local law enforcement, the North Carolina Board of</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing, the Tennessee Board of Nursing, the pharmacy, and the Medical Director had been notified of the misappropriation of narcotics. An interview on 1/30/26 at 8:38 AM with Nurse #3 revealed she had reported her concerns to the DON after she noticed that Resident #6 had some as needed Oxycodone medication missing. She stated he denied taking the pain medication and they were not signed as administered on the MAR. An interview on 1/30/26 at 9:51 AM with the Pharmacist revealed she remembered the misappropriation of resident narcotics in November. She stated the pharmacy did not participate in the investigation and the facility replaced all unaccounted-for narcotic medications at facility expense. An interview on 1/30/26 at 10:04 AM with the Administrator revealed she felt this was not the first time Nurse #1 had taken narcotics from a facility. She stated he had been reported to local law enforcement, the North Carolina Board of Nursing and to the Tennessee Board of Nursing where he was originally licensed.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to have effective systems in place for accurate reconciliation of narcotic medications when Nurse #2 signed narcotic records as witness to wasting without visually observing narcotic medications being wasted for 2 of 6 residents reviewed for misappropriation of residents' property (Residents #6 and #9). Findings included: a. Resident #6 was admitted to the facility on [DATE]. The physician's order dated 10/27/25 revealed Resident #6 had an order to receive one oxycodone (narcotic pain medication) 10 milligram (mg) tablet three times daily for pain. Review of Resident #6's narcotic record revealed Nurse #1 (an agency nurse) had signed out one (1) oxycodone 10 mg tablet on 11/14/25 at 7:30 PM and 11:30 PM. Review of Resident #6's narcotic record revealed Nurse #2 (an agency nurse) signed as a witness to Nurse #1's disposal of one (1) oxycodone 10 mg tablet on 11/14/25 at an illegible time. b. Resident #9 was admitted to the facility on [DATE]. The physician's order dated 11/06/25 revealed Resident #9 had an order to receive oxycodone 10 mg tablet every 3 hours as needed for pain. Review of Resident #9's narcotic record revealed Nurse #1 had signed out one (1) oxycodone 10 mg tablet on 11/14/25 at 7:30 PM and 10:30 PM. Review of Resident #9's narcotic record revealed Nurse #2 signed as a witness to Nurse #1's disposal of one (1) oxycodone 10 mg tablet on 11/14/25 at an illegible time. Review of the initial report of alleged misappropriation of residents' property on 11/17/25 revealed the facility became aware of the allegation of misappropriation of residents' property on 11/17/25 at 9:00 AM when Nurse #3 reported a concern to the Director of Nursing (DON) about as needed narcotics being signed out for a resident who usually did not ask for pain medication. The facility reported the allegation to the North Carolina Division of Health Service Regulation (DHSR) on 11/17/25 at 2:02 PM and the local law enforcement on 11/17/25 at 2:30 PM. The investigation report dated 11/21/25 revealed on 11/17/25 that the DON was notified by Nurse #3 that as needed pain medication was signed out for a resident who did not usually request it. A review of the narcotic sign out sheet revealed Nurse #2 had signed as a witness to Nurse #1's disposal of narcotic medications for Residents #6 and #9. An interview on 1/30/26 at 8:38 AM with Nurse #3 revealed she had reported her concerns about excessive pain medication being signed out for residents by Nurse #1 to the DON after she noticed that Resident #6 had some as needed oxycodone medication missing. Nurse #2 stated Resident #6 denied taking the pain medication and they were not signed as administered on the MAR. Review of an email dated 11/17/25 at 10:30 PM from Nurse #2 to DON showed Nurse #2 communicated she had signed the narcotic sheets as a witness to the disposal of medications for Residents #6 and #9 at Nurse #1's request without observing the medication disposal. Attempts to interview Nurse #1 and Nurse #2, who were both no longer employed at the facility, were unsuccessful. An interview on 1/29/26 at 1:46 PM with the DON revealed Nurse #2 was an agency nurse who had worked multiple shifts at the facility since 6/12/25 but had not worked at the facility since 11/15/25. The DON explained Nurse #1, who was also an agency nurse that worked only one 12-hour shift at the facility from 7:00 PM on 11/14/25 until 7:00 AM on 11/15/25M. The DON stated when Nurse #3 signed the narcotic sheet, she noticed the number of narcotics signed out, became concerned and reported it to the DON. The DON further stated she contacted Nurse #2 who told her she signed as the narcotic waste witness without visualizing the waste. An interview on 1/30/26 at 10:04 AM with the Administrator revealed Nurse #1 and Nurse #2 were blocked from working at the facility as of 11/17/25. She stated it was the standard practice for nurses to visually witness narcotic medication being wasted prior to signing as a witness on the narcotic sheet and she did not know why Nurse #2 had not.</p>		