Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

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 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to implement their abuse policy when the Administrator was not immediately notified of an allegation of staff to resident abuse resulting in delayed investigation, protection, and reporting to the State Agency, law enforcement, and Adult Protective Services for 1 of 3 residents review for abuse (Resident #1).A facility policy dated 9/1/24 titled Abuse, Neglect, and Exploitation indicated the following:-all alleged violations were to be reported to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement) when applicable with in specified time frames: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.-An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.-The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Included but not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; removal of alleged perpetrator or suspension of employee; examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Resident #1 was admitted to the facility on [DATE]. Her diagnoses included dementia without behavioral disturbances.During an interview with Nurse Aide (NA) #1 on 2/23/26 at 3:22 PM he revealed that sometime in September 2025 he observed NA #2 push Resident #1's head to the side with her hand. He said NA #2's hand was open and positioned on the left side of Resident #1's head above her ear and temple area when she pushed Resident #1's head to the side. NA #1 stated if an employee put their hands on a resident, then he believed it would be considered abuse. NA #1 indicated he did not report the incident to anyone until sometime in January 2026 when he reported the incident to Nurse #1 (an agency nurse). He did not have a reason why he did not report the incident at the time it occurred. NA #1 revealed he observed NA #2 working on the floor after this incident in September 2025, to include care provided to Resident #1.A telephone interview was conducted with Nurse #1 on 2/24/26 at 4:50 PM. Nurse #1 indicated that during the last week of January 2026 (unable to recall the exact date) NA #1 informed her he had witnessed NA #2 hit Resident #1 upside the head in the past. The date of the incident was not known. Nurse #1 reported that NA #1 had acted out the motion of how NA #2 hit Resident #1 on the side of the head and stated what NA #1 had shown her was that NA #2 popped Resident #1's head with an open hand. She stated NA #1 told her that sometime after the incident she observed NA #2 alone with Resident #1. Nurse #1 stated from the way NA #1 described what he had observed, she thought that NA #1 should have reported the incident. Nurse #1 stated she did not tell anyone at the facility about what NA #1 told her because NA #1 told her that NA #2 was friendly with the supervisor. Nurse #1 said after her shift ended, she called APS and reported what NA #1 had told her.An initial allegation report dated 1/30/26 completed by the Administrator (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

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 02/26/2026
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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated APS came to the facility on 1/30/26 to investigate a report for Resident #1 that included an allegation that NA #2 slapped the resident. The report indicated when the facility became aware of the allegation NA #2 was removed from the schedule. The investigation report dated 2/6/26 completed by the Administrator indicated the allegation was not substantiated.During an interview with the Director of Nursing (DON) on 2/25/26 at 3:25 PM she stated if someone had concerns about abuse, they were supposed to report it immediately. The DON said abuse could be reported to her but that it had to be reported to the Administrator. The DON said NA #1 should have reported the incident with NA #2 touching Resident #1's face when it happened if he suspected abuse.An interview was conducted with the Administrator on 2/26/26 at 10:30 AM. The Administrator stated if someone had concerns about abuse, suspected abuse, or saw something concerning related to abuse, they were supposed to report it immediately to their supervisor. She indicated that the supervisor should then contact her immediately to report the abuse allegation. The Administrator stated if NA #1 had concerns about NA #2 putting her hands on Resident #1's face and pushing her head to the side then it should have been reported immediately so it could have been investigated to determine if it was or was not abuse at that time and not months later. The Administrator indicated she was not aware it was an agency nurse, Nurse #1, who NA #1 had reported the allegations involving NA #2 to in January 2026. She revealed that Nurse #1 should have reported the abuse allegation to her supervisor, the DON, or her (Administrator) immediately so it could have been investigated by the facility. She further revealed that Nurse #1 did not follow the facility's policy on reporting abuse.

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 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Medical Director interviews, the facility failed to assess a resident (Resident #1) after a fall when a Nurse Aide (NA #2) did not report a fall to the nurse on 11/24/25. X-ray's completed on 11/25/25 showed Resident #1 had a fracture (break in the bone) of her right olecranon (bony pointed tip of the elbow) and right femoral (thigh bone) neck requiring her to be transferred to the hospital on [DATE]. Resident #1's right arm and right hip were surgically repaired on 11/25/25 and she was readmitted to the facility on [DATE]. This deficient practice occurred for 1 of 3 residents reviewed for quality of care. The findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included dementia.A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had severe cognitive impairment. The MDS documented Resident #1 had sustained two or more falls with no injury. An undated written statement by NA #2 read: On 11/24/25 I was picking up trays. [Resident #1] was at her room with two lids with a plate in-between in her hand. She was giving them to me then as she was backing up to turn around, she fell. She started yelling as she stood back up on her own and I suggested to her that she sit down on her bed. She sat down on her bed then proceeded to lie down. I met the nurse coming down the hall as she asked me, was that [Resident #1] yelling. I told her yes and that she had fallen. The nurse went into [Resident #1's] room to check on her. I finished picking up the trays when the nurse was coming back up the hall and she said [Resident #1] said she was fine and staying in the bed.An interview was conducted with NA #2 on 2/24/26 at 4:53 PM. NA #2 stated Resident #1 fell in November; she did not remember the date but said that she did not report it right. NA #2 explained she should have reported the fall, but she didn't. NA #2 reported the fall happened around 6:30 PM. She said Resident #1 had been walking in the hallway near her room and she saw her fall. She said Resident #1 lost her balance and fell. NA #2 stated she helped Resident #1 up after she fell and assisted her back to her bed. She said Resident #1 had not complained of any pain after the fall and was able to walk fine after the fall. Toward the end of the interview NA #2 changed her recount of events and stated that she had told the nurse that Resident #1 had fallen but had not told her how she had helped her up.An interview was conducted on 2/25/26 at 10:00 AM with Nurse #2. She reported she was the day shift (7:00 am to 7:00 pm) nurse assigned to Resident #1 on 11/24/25. Nurse #2 said around 6:30 pm, she heard a resident scream and went to see what had happened. Nurse #2 said NA #2 was in the hallway outside of Resident #1's room at the meal tray cart. Nurse #2 said she went into Resident #1's room to check on her and she was lying in bed. She stated Resident #1 had a frightened expression on her face, was tense, and stiff. Nurse #2 said Resident #1 was unable to say what had happened. She reported Resident #1 did not seem like she was in pain and did not have any indicators of pain. She explained Resident #1 was not grimacing, holding, or guarding any parts of her body. She did not recall observing any bruising or swelling on her arms. Nurse #2 reported she went back to NA #2 who was still in the hallway at the tray cart and asked her what had happened. Nurse #2 reported NA #2 seemed agitated and was doing hand motions showing how Resident #1 had been taking the dirty tray lids off the cart. She stated she tried to ask NA #2 again what had happened, but NA #2 did not elaborate or talk to her further and went back to collecting trays. Nurse #2 stated NA #2 never reported that Resident #1 had fallen. An interview was conducted with NA #1 on 2/23/26 at 3:22 PM. He reported he was Resident #1's assigned NA on 11/24/25. He stated he was providing feeding assistance to another resident 1 or 2 rooms down from Resident #1's room. He said around 6:30 PM he heard Resident #1 scream. He stated he looked out into the hallway and saw NA #2 coming out of Resident #1's room and at that time Nurse #2 was coming down (continued on next page)

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 02/26/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hallway. He stated Nurse #2 stopped and asked him if he heard a scream and after he told her yes, she then proceeded to go to Resident #1's room. NA #1 stated he heard Nurse #2 asking NA #2 what happened. He reported hearing NA #2 tell Nurse #2 Resident #1 was taking the tray lids off the cart. NA #1 stated he did not hear NA #2 tell Nurse #2 Resident #1 had fallen.An interview was conducted with NA #3 on 2/25/26 at 9:53 am. NA #3 was Resident #1's assigned night shift (7:00 pm to 7:00 am) NA on 11/24/25. NA #3 reported Resident #1 was in bed at the start of her shift. She said between 7:00 pm and 8:00 pm she tried to get Resident #1 up for her scheduled shower and she could not get Resident #1 to stand up. She explained Resident #1 was struggling to stand and seemed weak. NA #3 reported she went and told Nurse #3 and Nurse #3 went to check on Resident #1.An interview was conducted with Nurse #3 on 2/25/26 at 8:46 AM. Nurse #3 reported she worked night shift (7:00 pm to 7:00 am) on 11/24/25 and was Resident #1's assigned nurse. She did not remember the exact time but said it was sometime between 8:00 pm and 9:00 pm when NA #3 came and reported to her she could not get Resident #1 up to take a shower. She stated NA #3 thought it was behavioral. Nurse #3 stated when she went to Resident #1's room she was lying on the bed. Nurse #3 said she was able to get Resident #1 to stand up but she was only able to take one or two steps. She stated Resident #1 yelled out and grabbed her right leg. She reported she sat Resident #1 back down on her bed and asked her where she hurt and Resident #1 pointed to her right elbow. Nurse #3 reported she looked at Resident #1's right arm and hip. She recalled Resident #1's right elbow was swollen; she did not recall seeing anything that looked abnormal to her right leg or hip. Nurse #3 said nothing had been mentioned in shift report about Resident #1 having a new fall on 11/24/25 but said she knew Resident #1 had fallen a couple of days prior on 11/22/25. Nurse #3 reported she contacted the on-call provider, and the provider ordered an x-ray of Resident #1's right elbow, right hip, and right leg. Nurse #3 stated she called the mobile x-ray company to schedule the x-rays that night, she did not recall the time. Nurse #3 reported she checked on Resident #1 several times throughout the night. She said mobile x-ray did not come on her shift to complete Resident #1's x-rays. She reported if x-rays were ordered at night, it was sometimes the next day when the mobile x-ray company came to the facility to complete the x-rays. She stated Resident #1 remained in her bed all night and did not have any indicators of pain.An order dated 11/24/25 at 9:15 PM read: x-ray 2 view of right elbow, femur, and hip related to pain/ edema (swelling).An interview was conducted on 2/25/26 at 10:00 AM with Nurse #2. Nurse #2 reported she was Resident #1's assigned nurse on 11/25/25 day shift (7:00 am to 7:00 pm). She said when she returned to work on 11/25/25 she received in report from the night shift Nurse (Nurse #3) that Resident #1 was unable to walk, her right arm was swollen, and x-rays had been ordered but they had not been done yet. Nurse #2 reported after report she went to check on Resident #1. She said her right arm around her elbow was swollen and bruised. She reported she looked at Resident #1's right leg and hip. Nurse #2 recalled there was also bruising to her right hip but did not recall swelling. She stated the Supervisor came to Resident #1's to check on her that morning. She stated while the Supervisor was in Resident #1's room she was trying to get out of bed. She said Resident #1 stood up but was only able to take a couple of steps before she sat down in a bedside chair in her room. She reported that the Supervisor went to get a wheelchair for Resident #1 because she was having difficulty walking. She said sometime that morning, she was not sure of the time an NA, told her Resident #1 was up walking in the hallway but was having trouble walking and they had sat her in the wheelchair. She could not remember the NAs name. Nurse #1 explained after that she kept Resident #1 with her at her medication cart to keep a close eye on her. She recalled around 9 :00 AM Resident #1 had an episode where she became unresponsive. She recalled the Supervisor, DON, and NP came to assess Resident #1 during (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the episode and she was assisted back to bed. She reported that Resident #1 remained in her bed after that until the mobile x-ray technician came to complete the x-rays of her right arm and right leg around lunch time. She said when the x-ray results returned, they showed Resident #1 had fractured her right elbow and right hip. Nurse #2 reported the provider was contacted, she thought by the Director of Nursing (DON) about the x-ray results and gave orders for Resident #1 to be transferred to the hospital.An interview was conducted with the Supervisor on 2/25/26 at 11:26 AM. She recalled Resident #1 had a fall on 11/22/25. She stated she was not present for the fall that occurred on Saturday 11/22/25, but recalled she had an abrasion she thought to her right elbow from the fall but no other injuries. The Supervisor explained she worked Monday through Friday 7:00 am to 7:00 pm. She stated she worked again on 11/24/25 and Resident #1 was her normal self and did not have any difficulty walking during the day. She recalled seeing her up walking around in the hallway during the day as she normally did. The Supervisor said Nurse #3 called her on the night of 11/24/25 on her drive home from work between 7:40 PM and 8:00 PM. She stated Nurse #3 asked her if something had happened with Resident #1 because she was unable to stand up or walk and her right elbow was swollen and bruised. The Supervisor said nothing had been reported to her about Resident #1. She told Nurse #3 she should call the on-call provider to let them know what was going on and that Resident #1 had a recent fall on 11/22/25, to see if they wanted to do x-rays. The Supervisor stated when she returned to work on the morning of 11/25/25 she went to Resident #1's room to check on her. She reported Resident #1 was in her bed and when she looked at her right elbow it was swollen around the elbow and a few inches above/ below her elbow. She stated there was a circular bruise over her elbow about the size of a nickel that was purple/ maroon colored, like a fresh bruise. She stated when she palpated her elbow it hurt because Resident #1 said ouch. She stated she checked Resident #1's legs and did not see any bruise, swelling, or abnormalities. She reported Resident #1 tried to get out of bed and stood up on her own. The Supervisor said she tried to redirect Resident #1 not to get up, but she got up anyways. The Supervisor said Resident #1 tried to walk and could not do so. She stated when Resident #1 tried to take a step she was off balance because she was limping, she thinks the limp was on her right side. She said Resident #1 sat down in a stationary chair that was next to her room door. The Supervisor stated Nurse #2 had come into the room and stayed with Resident #1 while she went to get a wheelchair. The Supervisor said she told Nurse #2 she could keep Resident #1 with her to keep an eye on her or Resident #1 could go to the dining room for breakfast, but she needed to have a close eye kept on her. The Supervisor reported Resident #1 went to breakfast and she had gone to the morning meeting. She stated the morning meeting was at 9:00 AM. She said sometime during the morning meeting Nurse #2 called and said Resident #1 was having what appeared to be an unresponsive episode, she reported the DON went to check on Resident #1 with her. She stated Resident #1 had previously had similar unresponsive episodes. The Supervisor stated the NP was in the building and came to assess Resident #1. She reported Resident #1's unresponsive episode resolved and she was assisted back to bed. She reported sometime after the episode that the mobile x-ray technician came to do the x-rays, she thought it was sometime around lunch. She did not know what time the x-ray results returned but knew they showed Resident #1 had a fracture of her right hip and right elbow. She could not remember who called, but said someone called the provider and they wanted her sent to the hospital. She said Resident #1 remained in bed after the unresponsive episode until she left the facility. An interview was conducted with the NP on 2/26/26 at 9:57 AM. She stated she had seen Resident #1 on the morning of 11/25/25 for follow up because the on-call provider had been called the night prior (11/24/25) about her not being able to walk and had ordered x-rays. She stated an NA reported to her they had seen (continued on next page)

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 02/26/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 walking earlier that morning on 11/25/25 but when she saw Resident #1, she was sitting in a wheelchair. She stated Resident #1 had x-rays ordered but they had not been done yet. She said it was unclear how much pain Resident #1 was having because she had dementia, she said the pain was not keeping her from getting up and trying to walk so it was hard to tell how much pain she was having. She reported she did not know at the time that Resident #1 had fallen on 11/24/25. She stated she looked at Resident #1's right arm and said there was bruising, it was tender to touch, swelling and she had decreased range of motion. She stated Resident #1's hip did not seem to bother her. She explained Resident #1 had not seemed to have a lot of pain and had been up walking. She reported she had seen Resident #1 again that same morning because she had an unresponsive episode. The NP stated Resident #1 had similar prior episodes. The NP reported when she arrived to the floor Resident #1 was already responsive, and the episode resolved after she was put back in bed.X-ray reports for Resident #1 dated 11/25/25 revealed the following:-The right elbow x-ray under impression read: Acute fracture of the olecranon (arm bone that forms the pointy tip of the elbow)-The right hip x-ray under impression read: acute right hip fracture-The right femur x-ray under impression read: acute right hip fractureDuring an interview with NP on 2/26/26 at 9:57 AM the NP said the x-ray results for Resident #1 were reported to the facility at 12:52 PM and she was notified of the results at 12:59 PM and gave orders to send Resident #1 to the hospital. She stated Resident #1 left the facility at 1:16 PM. NP #1 stated in her professional opinion if a resident had a fall an NA should not get them up until they were assessed by a Nurse, because a Nurse had schooling and could better assess them for an injury than an NA.A progress note by Nurse #1 dated 11/25/25 at 1:16 PM documented Resident #1 was transferred by Emergency Medical Services (EMS) to the hospital for evaluation and treatment following the x-ray results.A hospital Discharge summary dated [DATE] indicated Resident #1 was admitted to the hospital on [DATE] after presenting to the emergency room following a fall and sustaining a fracture of her right olecranon and a fracture of her right femoral neck. The discharge summary indicated she had procedures to surgically repair the right femoral neck fracture and right olecranon fracture on 11/25/25. A face sheet indicated Resident #1 was re-admitted to the facility on [DATE] after hospitalization. Her diagnoses included displaced mid cervical (middle portion of femoral neck) fracture of the right femur, displaced placed fracture of olecranon process. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 3:25 PM. The DON stated after Resident #1's x-rays returned on 11/25/25 showing she had fractured her right arm and right hip the provider was notified, and she was transferred to the hospital. The DON did not recall what time the facility received the x-ray results or who called the provider about the x-ray results. The DON reported that the facility started investigating how Resident #1's fractures occurred on 11/25/25. The DON said when NA #2 was interviewed she reported Resident #1 had a fall on 11/24/25 around 6:30 PM. The DON reported NA #2 said Resident #1 fell in her room on 11/24/25 and that Resident #1 had gotten herself up. She stated NA #2 said after Resident #1 got herself up she went and laid on her bed. The DON recalled NA #2 said when Resident #1 fell she screamed and Nurse #2 came down the hallway a couple minutes later and asked what happened. The DON explained NA #2 reported she had told Nurse #2 that Resident #1 fell and Nurse #2 went into Resident #1's room and assessed her. The DON said Nurse #2 was also interviewed and said NA #2 did not tell her that Resident #1 had fallen. She did not know why Nurse #2 would say NA #2 did not tell her that Resident #1 had fallen. The DON said Residents were not supposed to be moved after a fall until they were assessed by a nurse for injury.An interview was conducted with the Medical Director on 2/26/26 at 3:03 PM. The Medical Director stated what was done for Resident #1 was appropriate. He stated the on-call provider was notified and x-rays were ordered. The (continued on next page)

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 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Director said it was not unusual if x-rays orders were placed at night that they were not done until the next day. He stated when the x-ray results returned showing the fractures on 11/25/25 Resident #1 was transferred to the hospital. He stated Resident #1's x-rays not being completed until 11/25/25 and her not being transferred to the hospital until 11/25/25 was not impactful to her care. The MD did not think Resident #1 being moved or attempting to get up would make her fractures worse. He stated the facility should follow their fall protocol. He said it made sense that an NA should not move a resident after a fall until they were assessed by a nurse for injury because Nurses had more training to assess for injuries.An interview was conducted with the Administrator on 2/26/26 at 10:30 AM. She stated NAs should not get a resident up after a fall. The Administrator explained after a fall the NA should get a nurse so the nurse could assess the resident for injuries and decide if the resident was okay to be moved. The Administrator stated NA #2 was interviewed and had said Resident #1 was playing with the tray lid covers, lost her balance and fell on [DATE]. She said NA #2 reported Resident #1 had gotten herself up after falling, she had told Nurse #2 that Resident #1 fell, and that Nurse #2 had then gone into the room and checked on Resident #1.