

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/29/2025	
NAME OF PROVIDER OR SUPPLIER RIVERBEND		STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE, JEFFERSONVILLE, , 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 466746 and 466848. Intake 466746 - No deficiencies related to the allegations are cited. Intake 466848 - No deficiencies related to the allegations are cited Survey date: December 29, 2025 Facility number: 010885 Residential Census: 79 Riverbend Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 466746 and 466848. Quality review completed on January 5, 2026.	R 0000					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE