STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345577	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swift Creek Health Center	221 Brightmore Drive Cary, NC 27511

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13030 Based on record review, family interview, and staff interview, the facility failed to protect a resident's right to privacy for 1 (Resident #2) of 3 residents reviewed for the provision of privacy. Findings included: Resident #2 was admitted to the certified section of the facility on 8/21/2024 with a diagnosis of dementia and a progressive neurodegenerative disorder. Documentation on an Admission Minimum Data Set assessment dated [DATE] revealed Resident #2 was severely cognitively impaired. Documentation in the nursing progress notes dated 9/23/2024 at 2:49 PM revealed Resident #2 was observed lying on the floor, had no apparent injuries, but was sent to the emergency room after reporting hitting her head. An interview was conducted with Nurse Aide (NA) #1 on 3/12/2025 at 1:45 PM and the following information was revealed. NA #1 was a private sitter hired by the family of Resident #1 and employed by the facility on an as-needed basis. NA #1 arrived at the facility on 9/23/2024 to act as a sitter for Resident #1 and found the Responsible Party (RP #1) for Resident #1 was also visiting Resident #1. While RP #1 and NA #1 were talking in the room of Resident #1 she heard a loud noise in the hallway. RP #1 and NA #1 rushed out of the room and saw Resident #2 had fallen out of her wheelchair. NA #2 came out of another resident's room and NA #1 told NA #2 that she would stay with Resident #2 while NA #1 went to get the floor nurse. NA #2 heard RP #1 taking photographs with her phone. NA #2 and Nurse #1 arrived to assess and assist Resident #2. NA #1 revealed she did not tell anyone about RP #1 taking photographs nor did she see the photographs. NA #1 stated she had only ever taken photographs of Resident #1 at the request of RP #1. RP #1 was interviewed on 3/12/2025 at 2:01 PM. RP #1 revealed the following information. RP #1 was with Resident #1 and NA #1 when they heard a clunk. RP #1 and NA #1 ran out to the hallway, and they saw a woman on the floor. RP #1 stated I took a photo of the woman on the floor. I still have it. NA #1 called for help and another nurse aide (NA #2) came out of another room. NA #1 told NA #2 to get a nurse. RP #1 then took photographs of Resident #2 on the ground and a photograph of the name label on her door so she, could report it. NA #2 was no longer employed by the facility and was unavailable for an interview. (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: 345577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Swift Creek Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Brightmore Drive Cary, NC 27511	

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 was interviewed on 3/12/2025 at 2:45 PM. Nurse #1 stated she was exiting the restroom when NA #2 found her to tell her Resident #2 fell in the dining area on 9/23/2024. Nurse #1 revealed she did not see RP #1 take any photographs of Resident #2 and was never told that photographs were taken. The Administrator was interviewed on 3/12/2025 at 1:52 PM. The Administrator stated she was not made aware that photos were taken of Resident #2 on the floor. The Administrator stated it was the facility policy staff were not to take photographs of the residents. The Administrator revealed it was likely NA #1 did not report that the photographs had been taken by RP #1 because she was worried, she would lose her position as a private sitter for RP #1. The Administrator stated the facility no longer allows the nurse aides to work in the facility as a private sitter and a nurse aide for the facility simultaneously. An interview was conducted with the power of attorney (POA) for Resident #2 on 3/12/2025 at 3:52 PM. The POA for Resident #2 revealed the following information. Resident #2 would have been very upset if she knew someone had taken her photo while on the floor after a fall. She was a very private person. When Resident #2 was admitted the POA was asked if photographs of Resident #2 could be taken to create brochures or an advertisement for the facility. The POA for Resident #2 stated he told the facility, Absolutely not. The POA revealed Resident #2 was very private and was embarrassed by her debilitating physical condition. The Director of Nursing was interviewed on 3/13/2205 at 9:30 AM. The Director of Nursing stated the facility staff are not allowed to take photographs of the residents for any reason. The Director of Nursing indicated the staff must immediately report to her if they know of someone taking pictures of other residents without their permission and who are not their family members.