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	06/18/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure alternatives were attempted, a risk assessment was conducted and informed consent was obtained before bilateral grab bars were utilized on the bed for 1 of 2 residents reviewed for bedrails (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with a diagnosis of dementia. A review of Resident #1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. She had functional limitation in range of motion on one side of her upper extremities, and both sides of her lower extremities. She required substantial/maximal assistance with rolling left to right in bed. Resident #1 was dependent in going from lying to sitting on the edge of the bed, and for transfers. Bed rails were not used as a physical restraint. A review of Resident #1's comprehensive care plan revealed a focus area for the use of grab bars while in bed to enable Resident #1 to maintain as much independence with bed mobility as possible with increased risk for complications including entrapment and injuries related to grab bar use. The goal, last revised and dated 6/16/25, was Resident #1's risk for injuries/complications related to the use of grab bars would be minimized through the next review. Interventions included to assess for the continued need for grab bar use, and the possibility of reducing to less restrictive device to aid with bed mobility (Device/Bed Rail Assessment Quarterly) and grab bars on both sides of bed. On 6/16/25 at 10:43 AM Resident #1 was observed in her recliner chair. Her bed was observed to have grab bars in place at the head of the bed on the left and right side. These metal grab bars measured approximately 6 inches in width and were in the upright position. A review of Resident #1's medical record did not reveal any evidence of attempted alternatives, a Device/Bedrail assessment or an informed consent for the use of the grab bars on Resident #1's bed. On 6/18/25 at 7:35 AM Resident #1 was observed in her recliner chair. Her bed was observed to have grab bars in place at the head of her bed on the left and right side. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 7:39 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #1. She stated Resident #1 had grab bars on her bed for quite some time. She went on to say Resident #1 used the grab bars at times to assist with turning and repositioning. She stated the facility's process prior to the use of grab bars was for a risk assessment to be completed, and if grab bars were determined to be appropriate, a consent from the resident or their representative would be obtained. The DON stated documentation of these things should be in the resident's medical record. She reported if grab bars were implemented, they should also be reassessed quarterly using a Device/Bedrail assessment. In a follow up interview with the DON on 6/18/25 at 8:52 AM she reported she had looked through Resident #1's medical record and had not been able to find a completed Device/Bedrail assessment or an informed consent for Resident #1's grab bars. She stated the facility's previous DON would have been responsible for ensuring these were in place before implementing grab bars for Resident #1. She reported the use of grab bars and ensuring a Device/Bedrail assessment and informed consent were in place was not something she had reviewed since she took over the role of DON at the facility in May of 2025. On 6/18/25 at 8:01 AM an interview with Nurse Aide (NA) #1 indicated he was assigned to care for Resident #1 on the 7:00 AM to 3:00 PM shift that day. He stated he was familiar with Resident #1 and had cared for her regularly for at least the past year. NA #1 reported Resident #1 liked to get up early, and he usually assisted her up into her recliner chair when he first came onto his shift. He stated prior to him assisting Resident #1 up into her chair this morning, she had been in her bed. He reported Resident #1 had grab bars on both sides at the head of her bed and had these as long as he had been caring for her. He stated Resident #1 sometimes was able to use the bars, in particular the right one, to assist herself when he turned and repositioned her in her bed. On 6/18/25 at 8:59 AM a telephone interview with Nurse #1 indicated she had been the facility's DON from June 2024 until just a few weeks ago. She reported she would have been responsible for ensuring that a Device/Bedrail assessment and informed consent were in place if a resident had grab bars on their bed. She stated she did not know how this had been missed for Resident #1. On 6/18/25 at 12:42 PM a telephone interview with the Administrator indicated the facility should have a process in place to ensure alternatives were attempted, a risk assessment was completed, and informed consent was obtained prior to the use of grab bars or any bed rail for a resident. She reported the documentation of these things should be in the resident's medical record.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and staff interview, the facility failed to submit the Payroll Based Journal (PBJ) data for the 4th quarter in fiscal year (FY) 2024 and 1st quarter in fiscal year 2025 for 2 of 4 quarters reviewed. Findings included: Review of the Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Data Report Certification and Survey Provider Enhanced Reports (CASPER Report 1705D) revealed no data was submitted for: - July 1 - September 30 (FY Quarter 4 2024) - October 1 - December 31 (FY Quarter 1 2025) During an interview on 6/17/25 at 3:06 PM Administrator #2, who was working as the Administrator of the facility during the quarters with missing data, stated shortly after they reduced their bed count from 28 to 3 beds, they were reevaluating all the software they were using and thought they did not need a specific software used by the facility. Administrator #2 stated what they did not know was that this software would pull in the information from payroll and was then used by corporate to submit their PBJ data. Administrator #2 indicated when they stopped using this software for those two quarters, they thought corporate was sending their PBJ data and it was not being sent.