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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 6/16/25 through 6/18/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EC0V11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 6/16/25 through 6/18/25. Event ID# EC0V11.	F 000		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 700	1. Corrective action for resident affected	7/11/25

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

Electronically Signed | 06/26/2025

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F 700	Continued From page 1 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 1/25/24 with a diagnosis of dementia. A review of Resident #1's annual Minimum Data Set (MDS) assessment dated 5/7/25 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.	F 700	by the alleged deficient practice: The Maintenance Director removed the bedrails for Resident #1 on 6/18/25. Residents responsible party was notified. The Director of Nursing (DON) initiated a review and risk assessment of the residents' medical records to ensure that the removal of bedrails was documented appropriately, that alternative measures were put in place to ensure the resident safety, that the care plan was updated accordingly and to assure that informed consent for bedrail use had been obtained. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents who have bedrails have the potential to be affected by the alleged deficient practice. On 6/18/25, the DON and Nursing Managers conducted an review and risk assessment of all residents' beds to ensure that any beds with side rails have appropriate documentation of tried and failed alternatives to ensure the resident safety, that the care plan was updated accordingly and to assure that informed consent for bedrail use had been obtained. The Maintenance Director will remove side rails that do not meet the criteria with appropriate documentation/failed alternatives under the direction of the DON. 3.Measures/Systemic changes to prevent	

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F 700	Continued From page 2 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. 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	F 700	reoccurrence of alleged deficient practice: The DON and Administrator has in-serviced Nursing Staff (Nurses, & CNAs) on the Proper Use of Bed Rails policy and the importance of ensuring that alternatives are attempted and documentation of the alternatives' failure to meet the residents' needs prior to the installation of Bed Rails by 6/27/25. All new Nursing Staff will be in-serviced by the Staff Development Coordinator during their orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning on June 30th 2025, the DON/Designee will complete Side Rail Audits on all residents, to include admissions and readmissions to ensure complete documentation. The monitoring will be done using a quality improvement tool weekly for 4 weeks, then monthly for 2 months. Any deficiencies found with the audits will be corrected immediately and re-education done as necessary by the DON. To ensure that this problem will not reoccur the Administrator will review the results from the monitoring and discuss audit results in the QAPI meeting monthly for 3 months. The next QAPI meeting is scheduled for 6/27/25.	

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F 700	Continued From page 3	F 700		

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.

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F 700	Continued From page 4 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.	F 700		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:	F 851		7/11/25

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F 851	Continued From page 5 (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: 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.	F 851	F851-PBJ Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified.	

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F 851	Continued From page 6 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.	F 851	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Administrator was educated by the Regional Clinical Consultant regarding the mandatory CMS requirement to electronically submit accurate direct care staffing information no less frequently than quarterly. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Workforce Management will send the Administrator a manual PBJ file monthly for 3 months then quarterly thereafter to ensure ongoing compliance in submitting direct care staffing information based on payroll data. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Data results will be presented by the Administrator reviewed and analyzed by the IDT at the centers monthly QAPI meeting for 6 months with a subsequent plan of correction as needed.	