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 _____	C 03/13/2025

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
F 000	INITIAL COMMENTS A complaint investigation was conducted from 3/12/2025 to 3/13/2025. Event ID # MST011. The following intake was investigated NC00220450. One of the five allegations resulted in a deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F 583		4/9/25

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

Electronically Signed | 03/26/2025

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F 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: 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 8/28/2024 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	F 583	Interventions for the Affected Resident: Resident #2 remains in our facility with no complaints or further incidents. Immediatly when the LNHA and DON were made aware of the event we innitaited 100% education was started with all employees of Swift Creek Health center on our picture/video policy that prohibits employees of the center from taking photographs of residents without consent from the resident/RP/Administrator. In addition, employees were also educated that if they see any visitors taking pictures they are to report it to the LNHA/DON immediatly. The campus also sent out to all residents and RPs a notice of our Video/photograph policy as stated above. Interventions for resident identified as having the potential to be affected: The facility immediatly started 100% education to all employee of Swift Creek Health center on our picture/video policy that prohibits employees of the center from taking photographs of residents without consent from the resident/RP/Administrator. In addition, employees were also educated that if they see any visitors taking pictures they are to report it to the LNHA/DON immediatly.	

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F 583	Continued From page 2 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. 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	F 583	In addition, employees were also educated that if they see any visitors taking pictures they are to report it to the LNHA/DON immediatly. The campus also sent out to all residents and RPs a notice of our Video/photograph policy as stated above. Systematic Changes: 1. The facility has added to our monthly town hall meetings with our employees reminders of our video/photograph policy; 2. The facility has ordered a no video/photograph sinage for our campus; 3. Photograph/video adherance has been added to the leadership rounding sheet. Monitoring of the change for ongoing compliance: Monitoring of the monthly town hall meetings to ensure the topic of video/photograph compliance and monitoring of rounds on video/photographic adherence will be completed by the LNHA/DON or designee for a period of 3 months. The results will be brought to the QAPI committee until the QAPI committee deems that the results are sustained.	

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F 583	Continued From page 3	F 583		

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.