Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Crossing	100 Hedrick Drive Thomasville, NC 27360

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on record review, and Resident Representative and staff interviews, the facility failed to provide the resident representative with a written notification of the bed hold policy upon a resident's transfer to the hospital for 1 of 2 residents (Resident #224) reviewed for discharge. Findings included: Resident #224 was admitted to the facility on [DATE] with the Resident Representative listed as his legal representative according to the medical record. A review of the baseline care plan dated 10/20/23 revealed Resident #224 was cognitively impaired. The discharge Minimum Data Set (MDS) Discharge Return Not Anticipated assessment dated [DATE] revealed Resident #224 was discharged to the hospital. Further review of the medical record revealed there was no written notice of the bed hold policy provided to the resident or resident representative when he was transferred to the hospital on 10/23/23. An interview was conducted with the Resident Representative on 2/12/25 at 9:24 AM. She indicated she was not provided with a written notice of the bed hold policy upon the resident's transfer to the hospital. An attempt was made to interview Nurse #1 who was assigned to Resident #224 at the time of discharge, but attempts were not successful. An interview was conducted with Administrator #1 on 2/14/25 at 11:24 AM. She indicated after Resident #224 was sent to the hospital, the facility team felt they could not permit Resident #224 to return to the facility due to his behaviors, and the resident was not offered a bed hold option.

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: 345310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Crossing	100 Hedrick Drive Thomasville, NC 27360

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on record review, Resident Representative (RR), Hospital Case Manager, Hospice Hospital Liaison, Ombudsman and staff interviews, the facility failed to permit a resident to return to the facility after being transferred to the hospital for evaluation due to a resident-to-resident altercation for 1 of 2 resident reviewed for discharge (Resident #224). The findings included: Resident #224 was admitted to the facility on [DATE] under hospice care with diagnoses that included neurocognitive disorder with Lewy bodies, dementia with mood disturbance, and dementia with agitation. A progress note written by the Director of Nursing (DON) on 10/22/23 at 9:38 PM documented that she had received a call from Nurse Supervisor #1 and was informed Resident #224 had become aggressive with staff and had an altercation with another resident. The altercation resulted in the resident being pushed to the floor. The on-call provider was notified of the incident and received a verbal order to send Resident #224 to the hospital. Resident #224's family member was present in the facility at the time of the incident. Emergency Medical Service (EMS) was called to the facility, but the Resident Representative declined hospitalization . The DON and Nursing Supervisor #1 went to the local magistrate's office and received a court order to have Resident #224 sent to the hospital for evaluation. Resident #224 was sent to the hospital on 10/23/23 at approximately 1:00 AM. A progress note written by Social Worker #1 on 10/23/23 at 12:54 PM indicated the local Ombudsman was contacted and informed Resident #224 had been sent to the hospital under involuntary commitment due to aggressive behavior. The note also indicated that the facility had no plans to accept Resident #224 back. A review of the investigation report completed by Administrator #1 on 10/24/23 indicated a resident abuse investigation was completed and was not substantiated. The allegation details indicated Resident #224 entered another resident's room as NA #1 was walking that resident to the dining room. Resident #224 was noted to be walking with his stepdaughter at that time and he walked into another resident causing that resident to fall onto the floor. The report further indicated that neither was injured. The report included an attached summary signed by Administrator #1 on 10/24/23. The summary indicated Resident #224 was so severely impaired both physically and mentally and had absolutely no idea that he was walking into other individuals. Resident #224 was not capable of making willful decisions and the allegation of abuse was not substantiated. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #224 had an unplanned discharge to the hospital with return not anticipated. An interview was conducted with the local Ombudsman on 2/10/25 at 2:18 PM. The Ombudsman indicated that she did recall speaking to Social Worker #1 regarding Resident 224's hospitalization and that the facility did not plan to readmit him to the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Piedmont Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Hedrick Drive Thomasville, NC 27360	

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Resident Representative on 2/12/25 at 9:24 AM. She indicated that she did not want Resident #224 sent to the hospital as his behaviors were related to his diagnosis. The facility was insistent on him going to the hospital, but she declined the first attempt at hospitalization . She further revealed that she was made aware by the DON that the facility had received a court order to have Resident #224 sent to the hospital for an evaluation as they felt they could not meet his needs. She indicated she had reached out to hospital staff for support but once the facility obtained the court order for involuntary commitment, she could not stop the discharge. The Resident Representative indicated that an unnamed staff member told her at the time of discharge to the hospital that the facility was selective in the type of residents they took and that they could not meet Resident #224's needs. She further revealed that she was not offered a bed hold option or an offer to readmit Resident #224 even though he was documented to be stable at the hospital. An interview was conducted with the Hospice Hospital Liaison on 02/14/25 8:29 AM. The liaison recalled the Hospital Case Manger contacted her to let her know the facility would not allow Resident #224 to readmit and would need to seek alternate placement. She further revealed that she had spoken with the Resident Representative and the family did want Resident #224 to be admitted back to the facility, but she was told the facility could not meet Resident #224's needs. An interview was conducted with the Hospital Case Manager on 2/14/25 at 11:08 AM. She indicated she was the case manager assigned to Resident #224 and attempted to have him admitted back to the facility. She recalled contacting Administrator #1 when Resident #224 was cleared to return to the facility. Administrator #1 indicated the facility would not readmit resident #224 because the facility could not meet the resident's needs. Resident #224 was placed at another skilled nursing facility. An interview was conducted with the DON on 2/13/25 at 4:37 PM. She stated Resident #224 was involved in an incident where he walked into another resident and the resident fell to the floor. The DON further indicated she did not feel this was intentional and that Resident # 224 had no safety awareness. The Resident Representative denied the initial attempt at hospitalization and therefore she consulted with the local law enforcement and was directed to seek involuntary commitment (IVC) from the local magistrate's office. She indicated that she and Nursing Supervisor #1 presented their request to the local magistrate, and it was granted. The DON returned to the facility and explained the IVC process to the family. EMS and law enforcement arrived at the facility approximately 1:00 AM on 10/23/23 and transported Resident #224 to the local hospital. She further revealed that she did not have any discussion with the family or hospital staff regarding readmission status. An interview was conducted with Administrator #1 on 2/14/25 at 11:24 AM. She indicated that after Resident #224 was sent to the hospital, the facility team felt they could not permit Resident #224 to return to the facility due to his behavior.