Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Haywood Lodge and Retirement
Address: 251 Shelton St. Waynesville, NC 28786
County: Haywood
License Number: HAL-044-009

II. Date(s) of Visit(s): 4/28/25-5/2/25
Purpose of Visit(s): Complaint
Exit/Report Date: 6/9/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0902 HEALTH CARE Rule/Statutory Reference: 10A NCAC 13F .0902 HEALTH CARE (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: Type A2 Violation Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 11 sampled residents received referral and follow-up to meet the routine and acute health care needs related to prolapse uterus (Resident #1) and rectal prolapse (Resident #11). Findings: 1. Review of Resident #1's current FL-2 dated 5/30/24 revealed: -Diagnoses included hypothyroidism, cognitive impairment, left bundle branch block, and gastroesophageal reflux disease (GERD). -She was ambulatory with the assistance of a walker. -She was intermittently disoriented. Review of Resident #1's Care Plan dated 6/14/24 revealed there was no documentation of treatment for reoccurring uterine prolapse.	☐ POC Accepted _____ *DSS Initials*	

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 3/17/25 revealed there was no documentation for staff to provide care for reoccurring uterine prolapse.

Review of Resident #1's care note dated 6/18/23 revealed:
-There was documentation at 8:12am the resident was observed with large hard mass out of vagina. Resident was sent out by EMS (emergency medical services) and transported to ER (emergency room) for further evaluation.
- There was documentation at 9:13am the resident was transferred back to the facility with a diagnosis of a "prolapsed uterus".
-To make appointment with obstetrician-gynecologist (OBGYN) for uterine prolapse.

Review of Resident #1's hospital discharge instructions dated 6/18/23 revealed instructions to schedule a follow up appointment with OBGYN provider for uterine prolapse.

Review of Resident #1's care note dated 6/19/23 revealed a follow up appointment for uterine prolapse was scheduled with an OBGYN on 7/27/23 at 1:45pm.

Interview with a representative from the OBGYN office on 5/2/25 at 9:04am revealed:
-Resident #1 had an appointment scheduled for 7/23/23
-The appointment scheduled for 07/23/23 was cancelled by the facility.
-Resident #1 was not a patient and had not been seen by any provider at the office.

Interview with a personal care aide (PCA) on 4/28/25 at 2:36pm revealed:
-A week ago, Resident 1's uterus prolapsed, and she observed the medication aide (MA) "push" the uterus back into Resident #1's vagina.

Interview with a MA on 4/28/25 at 2:45pm revealed:
-Resident #1 had experienced prolapse recurrence of the uterus since she was admitted to the facility on 5/30/23.
-She assisted Resident #1 with her uterine prolapse "about 3 times" each month.
-Resident #1 would let her know when her uterus was prolapsed, and she provided care to correct the issue.
-Resident #1 would lay on her bed naked from the waist down, and with a gloved hand she would "push" Resident #1's uterus back inside her body through her vagina.

-The Resident Care Coordinator (RCC) showed her how to correct the prolapse sometime around 6/2023."
-All MA's were trained by the RCC to push Resident #1's uterus "back in" when it prolapsed.
-Resident #1 was not sent to the ER or any outside provider for treatment of her prolapsed uterus.
-She assumed Resident #1 was not being sent out for treatment was because her family declined surgery needed to prevent the uterus from prolapsing.
-She did not document when she corrected Resident #1's uterine prolapse.
-She informed the RCC whenever she had to push Resident#1's uterus back in, but she did no notify the facility's Nurse Practitioner.

Interview with a second MA on 4/30/25 at 2:10pm revealed:
-She had reinserted Resident #1's prolapsed uterus.
-Resident #1's uterus looked like a large mass about the size of a grapefruit that came out of the vagina.
-Resident #1 had notified her when she needed assistance with her uterus.
-In the last 60 days, Resident #1 would lay on her bed and she "pushed" the uterus back in.
-She has pushed Resident #1's uterus "back in about 3 times in the last 2 months."
-Resident #1 had not been sent out for treatment of the prolapsed uterus.
-She did not know how often Resident #1 needed care for uterine prolapse because first and third shift had not communicated how often each of them pushed the uterus back in.
-She did not document when she pushed Resident #1's uterus back in and did not notify the facility's Nurse Practitioner.

Interview with a third MA on 5/1/25 at 11:00am revealed:
-Resident #1 suffered from reoccurring uterine prolapse.
-She knew when Resident #1 required treatment for prolapse because "she could smell it."
-She had pushed Resident #1's uterus back into her vagina two times while being employed at the facility.
-The RCC showed her how to correct the prolapse.
-About a week ago, Resident #1 experienced prolapse. She attempted to push the uterus back in through the vagina, but the uterus would not go back in.
-She called the RCC and the RCC told she would come and get the uterus "back in" later.
-She did not know how long Resident #1 had to wait for the RCC to come and assist her.
-She assumed the RCC's attempt was "successful" because

the following day when she returned to work the uterus was back in.
-She did not document any care she provided for Resident #1's uterine prolapse because no one had instructed her to do so.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #1's reoccurring uterine prolapse.
-Resident #1 was hospitalized in 2023 for a prolapsed uterus, and treatment would include corrective surgery to tack the uterus which would prevent future prolapses.
- Resident #1's family declined the surgery.
-Resident #1's uterus prolapsed "about once a month."
-She "trained" all the MA's on how to reinsert Resident #1's uterus.
-Resident #1 would lay down on the bed, and with a gloved hand she pushed Resident #1's uterus "on all sides, and it goes back in."
-She had "always been able to get the uterus to go back in".
-There was no need to notify the facility's Nurse Practitioner because there was "nothing they could do".
-She did not think it was necessary "to send Resident #1 to the hospital because she has always been successful with getting the uterus to go back in."

Interview with facility LHPS nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #1 suffered from uterine prolapse.
-Reinsertion of uterine prolapse was not a task MAs could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a prolapsed uterus was not a task for an aide to perform.
-She was "nervous" the facility allowed staff to perform this task.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was aware that Resident #1 had a history of uterine prolapse.
-She was not aware that Resident #1 experienced recurring or a recent prolapse of her uterus.
-She remembered Resident #1 would need surgery to correct

her uterine prolapse, but this was not recommended because she would not recover well.
-She did not know staff were "correcting" Resident #1's uterine prolapse.
-She was concerned staff were treating Resident #1's uterine prolapse and this was a "problem" because staff had not communicated Resident #1's health care needs to her.
-She was not aware this was a current problem, and staff should have told her.
-She was concerned that staff had not told her Resident #1 was experiencing recurring uterine prolapse.
-She did not train the RCC or any staff on how to manage Resident #1's uterine prolapse.
-Staff should not manage Resident #1's uterine prolapse.
-Resident #1 should be seen by her or be sent out to the hospital.
-She was "worried" Resident #1 could be prolapsed and needed medical treatment.

2. Review of Resident #11's current FL-2 dated 7/3/24 revealed:
-Diagnoses included mild dementia, hearing loss, depression, and spinal stenosis.
-She was semi-ambulatory with the assistance of a walker.
-She was intermittently disoriented.
-Incontinence of bowel and bladder.

Review of Resident #1's Care Plan dated 9/2/24 revealed there was no documentation related to a rectal prolapse.

Review of Resident #11's Licensed Health Professional Support (LHPS) review dated 1/3/25 revealed there was no documentation for staff to provide care for reoccurring rectal prolapse.

Review of Resident #11's care note dated 3/16/23 revealed:
-Resident #11 stated her rectum was out.
-Resident #11's rectum was observed out with blood.
-Resident Care Coordinator (RCC) instructed to send out Resident #11.
-Resident #11 returned to the facility with no new orders.

Review of Resident #11's hospital discharge instructions dated 3/16/23 revealed:
-Rectal prolapse was a condition that caused the rectum to come through the anus. A prolapse may happen during a bowel movement.
-Instructions to schedule a follow up appointment with a general surgeon to explore surgical interventions for recurrent

rectal prolapse.

Review of Resident #11's care note dated 10/30/23 revealed:
-Resident #11 complained of rectum falling out.
-Two staff, one of whom was a female aide, went to observe Resident #11.
-Resident #11's rectum was pushed back in.
-The resident was laying and resting.

Review of Resident #11's care note dated 5/7/24 revealed:
-Resident #11 stated her rectum fell out.
-The medication aide (MA) and personal care aide (PCA) pushed rectum back in.

Interview with a MA on 4/30/25 at 2:10pm revealed:
-Resident #11 experienced recurring rectal prolapse.
-She was trained by another MA and had pushed Resident #11's rectum "back in several times".

Interview with second MA on 5/2/25 at 8:45am revealed:
- Resident #11 experienced recurring rectal prolapse.
-The resident had experienced rectal prolapse for almost two years.
-She corrected the rectal prolapse on "6 separate occasions".
-Resident #11 had hemorrhoids and constipation and this was treated by pushing fluids and stool softeners.
-The RCC showed her how to push in Resident #11's rectum.
-All MA's were trained on how to push in Resident #11's rectum.

Interview with a PCA on 4/30/25 at 4:25pm revealed:
-Resident #11 experienced rectal prolapse.
-She observed Resident #11's rectal prolapsed when providing her assistance with showers.
-About a week ago, Resident #11 came to her saying her bottom burned and she was not able to have a bowel movement.
-She looked at Resident #11 and her rectum was out about 3 to 4 inches long and it was bright red.
-She informed the MA and "the MA pushed the rectum back in".
-The MA pushed the rectum back in while Resident #11 was standing.
-Resident #11 stated her bottom was burning and painful, but felt better after the rectum was pushed back in.

Interview with a second PCA on 5/1/25 at 8:48am revealed:
-When Resident #11 experienced rectal prolapse, she would say "my butt is hanging out".

-Resident #11 had experienced recurring rectal prolapse for a couple of years.
-The MAs corrected the prolapse and she had seen this done about 5-6 times.
-The MAs would put petroleum jelly on their gloved hands and push Resident #11's rectum "back in".
-In the past, Resident #11 complained of stomach pain and constipation.
-She had observed Resident #11's rectal prolapse and it was "very bright" red and about 3 to 4 inches long.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #11's recurring rectal prolapse.
-Resident #11 was hospitalized in 2023 for a prolapsed rectum, and treatment would include corrective surgery to prevent future prolapses.
-The surgeon did not recommend surgery because she did not think Resident #11 would be able to recover.
-She "trained" all the MAs on how to reinsert Resident #11's rectum and she learned how to correct prolapses from the facility Nurse Practitioner.
-She did not think it was necessary to send Resident #11 to the hospital because "there was nothing they could do".

Interview with facility Licensed Health Professional Support (LHPS) nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #11 experienced recurring rectal prolapse.
-A rectal prolapse was not a task any aide could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a rectal prolapse was not a task for an aide to perform.
-She was "nervous" the facility allowed staff to perform these tasks.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was aware that Resident #11 had a history of a rectal prolapse.
-She was not aware that Resident #11 experienced recurring or recent prolapse of the rectum.
-She remembered that Resident #11 would need surgery to correct her rectal prolapse, but this was not recommended

because she would not recover well.
-She did not know staff were correcting Resident #11's rectal prolapse.
-She was concerned staff were managing Resident #11's rectal prolapse and this was a problem.
-She was not aware this was a current problem and staff should have told her.
-She was concerned that staff had not told her Resident #11 was experiencing recurring rectal prolapse.
-She did not train the RCC or any staff on how to manage Resident #11's rectal prolapse.
-Staff should not manage Resident #11's rectal prolapse.
-Resident #11 should be seen by her or be sent out to the hospital.
-She stated she was worried Resident #11 could be prolapsed and needed medical treatment.

The facility failed to ensure 2 of 11 residents received referral and follow up resulting in the Resident Care Coordinator and the medication aides attempting to manage Resident #1's recurring uterine prolapse and Resident #11's recurring rectal prolapse. This failure resulted in substantial risk for serious physical harm constitutes a Type A2 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/2/25 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 7/9/2025.

Rule/Statute Number: 10A NCAC 13F .0909 Resident Rights

Rule/Statutory Reference: 10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

Level of Non-Compliance: Type A2 Violation

Based on the observations, record reviews, and interviews, the facility failed to ensure 2 of 11 sampled residents received appropriate care and services for medical conditions that required management by a health care professional related to

a recurring uterine prolapse (Resident #1) and a recurring rectal prolapse (Resident #11).

Findings:

1. Review of Resident #1's current FL-2 dated 5/30/24 revealed:
-Diagnoses included hypothyroidism, cognitive impairment, left bundle branch block, and gastroesophageal reflux disease (GERD).
-She was ambulatory with the assistance of a walker.
-She was intermittently disoriented.

Review of Resident #1's care note dated 6/18/23 revealed:
-There was documentation at 8:12am the resident was observed with large hard mass out of vagina. Resident was sent out by EMS (emergency medical services) and transported to ER (emergency room) for further evaluation.
- There was documentation at 9:13am the resident was transferred back to the facility with a diagnosis of a "prolapsed uterus".
-To make appointment with obstetrician-gynecologist (OBGYN) for uterine prolapse.

Review of Resident #1's care note dated 6/19/23 revealed a follow up appointment for uterine prolapse was scheduled with an OBGYN on 7/27/23 at 1:45pm.

Interview with a representative from the OBGYN office on 5/2/25 at 9:04am revealed:
-Resident #1 had an appointment scheduled for 7/23/23
-The appointment scheduled for 07/23/23 was cancelled by the facility.
-Resident #1 was not a patient and had not been seen by any provider at the office.

Interview with a personal care aide (PCA) on 4/28/25 at 2:36pm revealed a week ago, Resident #1's uterus prolapsed, and she observed the MA "push" the uterus back into Resident #1's vagina.

Interview with a MA on 4/28/25 at 2:45pm revealed:
-She assisted Resident #1 with her uterine prolapse "about 3 times" each month.
-Resident #1 would let her know when her uterus was prolapsed, and she provided care to correct the issue.
-The Resident Care Coordinator (RCC) showed her how to correct the prolapse sometime around 6/23.
-All MA's were trained by the RCC to push Resident #1's

uterus "back in" when it prolapsed.
-Resident #1 was not sent to the ER or any outside provider for treatment of her prolapsed uterus.
-She informed the RCC whenever she had to push Resident #1's uterus back in, but she did no notify the facility's Nurse Practitioner.

Interview with a second MA on 4/30/25 at 2:10pm revealed:
-She had reinserted Resident #1's prolapsed uterus.
-Resident #1 had notified her when she needed assistance with her uterus.
-Resident #1 had not been sent out for treatment of the prolapsed uterus.
-She did not document when she pushed Resident #1's uterus back in and did not notify the facility's Nurse Practitioner.

Interview with a third MA on 5/1/25 at 11:00am revealed:
-She had pushed Resident #1's uterus back into her vagina two times while being employed at the facility.
-The RCC showed her how to correct the prolapse.
-About a week ago, Resident #1 experienced prolapse. She attempted to push the uterus back in through the vagina, but the uterus would not go back in.
-She called the RCC and the RCC told she would come and get the uterus back in later.
-She did not know how long Resident #1 had to wait for the RCC to come and assist her.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-She was aware of Resident #1's reoccurring uterine prolapse.
-Resident #1's uterus prolapsed "about once a month."
-She trained all the MA's on how to reinsert Resident #1's uterus.
-There was no need to notify the facility's Nurse Practitioner because there was nothing they could do.
-She did not think it was necessary to send Resident #1 to the hospital because she has always been successful with getting the uterus to go back in.

2. Review of Resident #11's current FL-2 dated 7/3/24 revealed:
-Diagnoses included mild dementia, hearing loss, depression, and spinal stenosis.
-She was semi-ambulatory with the assistance of a walker.
-She was intermittently disoriented.
-Incontinence of bowel and bladder.

Review of Resident #1's Care Plan dated 9/2/24 revealed there was no documentation of treatment for reoccurring

rectal prolapse.

Review of Resident #11's care note dated 3/16/23 revealed:
-Resident #11 stated her rectum was out.
-Resident #11's rectum was observed out with blood.
-The RCC instructed to send out.
-Resident #11 returned to the facility with no new orders.

Review of Resident #11's care note dated 10/30/23 revealed:
-Resident #11 complained of rectum falling out.
-Two staff, one of whom was a female aide, went to observe Resident #11.
-Resident #11's rectum was pushed back in.
-The resident was laying and resting.

Review of Resident #11's care note dated 5/7/24 revealed:
-Resident #11 stated her rectum fell out.
-The medication aide (MA) and personal care aide (PCA) pushed rectum back in.

Review of Resident #11's hospital discharge instructions dated 3/16/23 revealed instructions to schedule a follow up appointment with a general surgeon to explore surgical interventions for recurrent rectal prolapse.

Interview with a MA on 4/30/25 at 2:10pm revealed she was trained by another MA and had pushed Resident #11's rectum back in several times.

Interview with second MA on 5/2/25 at 8:45am revealed:
-Resident #11 experienced recurring rectal prolapse for almost two years.
-She corrected the rectal prolapse on "6 separate occasions".
-"The RCC showed her how to push in Resident #11's rectum."

Interview with a PCA on 4/30/25 at 4:25pm revealed:
-About a week ago, Resident #11 came to her saying her bottom burned, and she was not able to have a bowel movement.
-She looked at Resident #11 and her rectum was out about 3 to 4 inches long and it was bright red.
-She informed the MA and "the MA pushed the rectum back in".

Interview with a second PCA on 5/1/25 at 8:48am revealed the MAs corrected the prolapse and she had seen this done about 5-6 times.

Interview with the RCC on 5/1/25 at 9:00am revealed:
-Resident #11 was hospitalized in 2023 for a prolapsed rectum, and treatment would include corrective surgery to prevent future prolapses.
-The surgeon did not recommend surgery because she did not think Resident #11 would be able to recover.
-She "trained" all the MAs on how to reinsert Resident #11's rectum and she learned how to correct prolapses from the facility Nurse Practitioner.
-She did not think it was necessary to send Resident #11 to the hospital because "there was nothing they could do".

Interview with facility Licensed Health Professional Support (LHPS) nurse on 5/1/25 at 1:12pm revealed:
-She was not aware Resident #11 experienced recurring rectal prolapse.
-A rectal prolapse was not a task any aide could perform or be trained to perform.
-The facility had not requested staff training for this type of care.
-She had been a registered nurse (RN) for 35 years and she had never inserted any type of prolapse.
-She confirmed with her supervisor that reinsertion of a rectal prolapse was not a task for an aide to perform.
-If a resident experienced any type of prolapse, they should be seen by a physician or be sent to the hospital.

Interview with facility Family Nurse Practitioner (FNP) on 5/2/25 at 9:05am revealed:
-She was not aware that Resident #11 experienced recurring or recent prolapse of the rectum.
-She did not know staff were correcting Resident #11's rectal prolapse.
-She was concerned staff were managing Resident #11's rectal prolapse and this was a problem.
-She did not train the RCC or any staff on how to manage Resident #11's rectal prolapse.
-Staff should not manage Resident #11's rectal prolapse.
-Resident #11 should be seen by her or be sent out to the hospital.
-She stated she was worried Resident #11 could be prolapsed and needed medical treatment.

The facility failed to ensure Resident #1 and Resident #11 received adequate and appropriate care and services when the staff did not inform the facility's contracted Nurse Practitioner of recurrence of Resident #1's uterine prolapse and for Resident #11's recurring rectal prolapse. This failure resulted

in substantial risk of serious physical harm will occur and constitutes a Type A2 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/2/25 for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 7/9/25.

IV. Delivered Via:	In person	Date: 6/9/25
DSS Signature:	Ali Hamlett, SW III	**Return to DSS By: 6/30/25**

V. CAR Received by:	Administrator/Designee (print name): Cathy Londermilk	
	Signature: Cathy Londermilk RCC	Date: 6/9/25
	Title: RCC	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			