STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 The State Agency (SA) conducted an annual re-certification survey at the facility from 11/18/24 to 11/21/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies F641, F658, F692, F758, F759, and F880. Census at the time of the survey was 81 and the facility is licensed for 95 residents.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy reviews, the facility failed to ensure that the Minimum Data Set (MDS) assessment was coded accurately for three (3) of twenty-one sampled residents. Residents #18, #54, and #81. Findings include: Record review of the facility policy titled, "Conducting an Accurate Resident Assessment", dated 6/2023, revealed, "The purpose of this policy is to assure that all residents receive an accurate assessment of relevant care areas... Accurate assessments addressing each resident's status, needs, strengths, and areas of decline must be conducted by qualified staff that are knowledgeable about the resident and correctly document information about the resident's status."	F 641	Residents #54, #81, and #18 were reassessed on 11/22/24 to include fall identification, Hospice services, and Discharge-Return Not Anticipated by the Minimum Data Set (MDS) Coordinator and assessments were corrected to reflect accurate coding. The facility has determined that all residents in these categories have the potential to be affected. Director of Nursing (DON) conducted one on one education with the MDS Coordinator and Care Plan Nurse to ensure coding of Section J, Section O, and Section A of the MDS assessment is accurate citing the resident assessment instrument manual instructions on	12/30/24

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

Electronically Signed | 11/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 641	Continued From page 1 Resident #18 Record review of Resident #18's "Order Summary Report" revealed an Admit to (Proper Name) Hospice order dated 7/15/2024. Record review of Resident #18's MDS with an Assessment Reference Date (ARD) of 10-18-2024 revealed in Section O-K1 that hospice care was coded "No". During an interview on 11/19/24 at 1:30 PM, the MDS Coordinator confirmed that Resident #18 is receiving hospice services and that the MDS assessment for 10/18/24 had not been coded correctly. She revealed that it is important that the MDS assessments are correct, because it is supposed to reflect the residents plan of care. In an interview on 11/19/24 at 1:40 PM, the Director of Nurses (DON) confirmed that hospice should have been marked on the MDS assessment for Resident #18. She said that error could affect the residents' care and is also a financial issue. She confirmed that the MDS assessment from 10/18/24 did not represent an accurate assessment of the resident. A record review of Resident #18's "Admission Record" revealed the resident was admitted to the facility on 7/15/2024 with medical diagnoses that included Alzheimer's Disease and Anxiety Disorder. Resident #54 A record review of an "Unwitnessed Fall" dated 8/10/2024 revealed that Resident #54 was "found on the floor in his room...Fracture of one of the	F 641	11/22/24. An audit of all residents in these categories will be conducted and those within the 90-day assessment window will be corrected by MDS Coordinator no later than 12/30/2024. MDS coordinator will print daily incident reports to verify falls to include them on a spreadsheet as a reference for next MDS due. MDS coordinator will print new orders daily to verify all new admit to hospice orders and include them on spreadsheet for next MDS due. MDS coordinator will print the admit/discharge report to verify all discharge types prior to submission of all discharge MDS assessments. Director of Nursing will conduct an audit of MDS assessments on all current residents to include those on hospice, those with reported falls, and those discharged within the last 30 days for four (4) consecutive weeks beginning 12/02/24 and three months thereafter. Audited records will be reviewed at the Quality Assurance Meeting on 12/30/24 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 641	Continued From page 2	F 641		

lateral mid left ribs suspected .... Fractures of left seventh and eighth ribs..."

Record review of Resident #54's MDS with an ARD of 10-07-2024 revealed in Section J-Health Conditions. J1800 that the resident had no falls since admission or reentry or the prior assessment.

An interview on 11/19/24 at 1:00 PM, the Administrator (ADM) confirmed that she was aware that Resident #54 had a fall with an injury and any falls that a resident has should be coded on their MDS.

An interview on 11/19/24 at 1:45 PM, the MDS Coordinator confirmed that she was aware that Resident #54 had a fall on 8/10/24. She revealed that Section J1800 was not accurately checked, revealing that the resident had a fall. She revealed it must have been overlooked in error.

A record review of Resident #54's "Admission Record" revealed the resident was admitted to the facility on 2/24/2021 with medical diagnoses that included Chronic Obstructive Pulmonary Disease and a recent medical diagnosis on 8/10/24 of Multiple Fractures of Ribs, left side.

Resident #81

Record review of the Discharge-Return Not Anticipated MDS with an ARD of 10/17/24 for Resident #81 revealed Discharge Status was coded as Short-Term General Hospital.

Record review of "Progress Notes" for Resident #81, dated 10/17/24 revealed "Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 641	Continued From page 3 discharged to home." An interview with the MDS nurse on 11/20/24 at 10:40 AM confirmed that Resident #81 was discharged home and the MDS assessment was coded incorrectly. She stated that she is usually notified by Social Services of the resident's discharge location, but it must have fallen through the cracks. Record review of the "Admission Record" revealed the facility admitted Resident #81 on 9/13/24 with a diagnosis of Acquired Absence of Right Leg Above Knee.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow nursing standards of practice as evidenced by administering a resident's medication by the wrong route for eight (8) of 38 medication opportunities observed. Resident #30 Findings Include: Cross Reference F759 Review of the facility policy titled, "Medication Administration -General Guidelines" unrevised, revealed under, "Policy: Medications are	F 658	Resident #30 electronic medication administration record was reviewed identifying that the medication route was changed from Percutaneous Endoscopic Gastrostomy tube to oral. The correct route of administration of resident #30 was reviewed and verified by the Director of nursing (DON) with the Nurse Practitioner (NP). The NP observed medication administration of oral medication with resident #30 at the noon medication pass on 11/20/24 verifying tolerance of oral route and determined the oral route appropriate. The observed	12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 658	Continued From page 4 administered as prescribed in accordance with good nursing principles and practices ..." Also revealed under, "A. Preparation ... 4) Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away...B. Administration ...2) Medications are administered in accordance with written orders of the prescriber ..." On 11/20/24 at 7:45 AM, an observation during medication pass, with Licensed Practical Nurse (LPN) #1 revealed, she crushed and administered the following medications to Resident #30 via percutaneous endoscopic gastrostomy (PEG) tube: 1. Fenofibrate (lowers cholesterol)160 milligrams (mg) 1 tablet 2. Apixaban (blood thinner) 2.5 milligrams (mg) 1 tablet 3. Atorvastatin (lowers cholesterol) 20 milligrams (mg) 1 tablet 4. Carvedilol (lowers blood pressure) 6.25 milligrams (mg) 1 tablet 5. Ascorbic Acid (immune support) 500 milligrams (mg)/5 milliliters (ml) 5 milliliters 6. Allopurinol (gout) 100 milligrams (mg) 1 tablet 7. Potassium ER (potassium supplement) 20 milliequivalents (MEQ) 1 tablet 8. Multivitamin liquid (vitamin supplement) 15 milliliters (ml) Record review of the November 2024 Medication	F 658	nurse during medication pass was educated on the five rights of medication administration by the DON immediately upon notification of error. The facility has determined that all residents have the potential to be affected. An in-service education program was initiated 11/22/2024 by the Director of Nursing and the Unit Managers with all nurses addressing the five rights of medication administration. The Unit Managers will conduct medication administration observations of four residents weekly for four weeks beginning 12/2/2024 and monthly for three months. Audits will be reviewed at the Quality Assurance Meeting on 12/30/2024 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 658	Continued From page 5	F 658		

Administration Record (MAR) for Resident #30 revealed the following orders, "Allopurinol tablet 100 mg (milligrams) give 1 tablet by mouth in the morning, Apixaban oral tablet 2.5 mg (milligrams) give 1 tablet by mouth every morning and at bedtime, Atorvastatin Calcium oral tablet 20 mg (milligrams) give 1 tablet by mouth in the morning, Carvedilol tablet 6.25 mg (milligrams) give 1 tablet by mouth every morning and at bedtime, Fenofibrate oral tablet 160 mg (milligrams) give 1 tablet by mouth one time a day, Multivitamin Oral Liquid give 15 ml (milliliters) by mouth in the morning, Potassium Chloride ER oral tablet extended release give 1 tablet by mouth in the morning, Ascorbic Acid 500 mg (milligrams) give 5 ml (milliliters) by mouth in the morning".

An interview with LPN #1 on 11/20/24 at 8:40 AM, revealed she had reviewed Resident #30's MAR and confirmed she gave the resident's medication by the wrong route. LPN #1 revealed she was fixated on giving the right medication and dosage and did not read the rest of the order. She confirmed that she did not follow the nursing principles on the 5 (five) rights of medication administration. She confirmed giving the medication by the wrong route was a medication error.

On 11/20/24 at 8:50 AM, an interview with the Director of Nursing (DON) revealed, her expectations were for the nurses to follow the physician orders and the 5 (five) rights of medication administration to prevent potential errors.

Record review of the "Admission Record" revealed the facility admitted Resident #30 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 658	Continued From page 6 11/9/24 with medical diagnoses that included Cerebral Infarction and Gastrostomy Status.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to implement interventions to maintain nutritional status for one (1) of eight (8) residents reviewed for nutritional status. Resident # 20. Findings include: A typed statement on company letter head dated 11/20/24 and signed by the Director of Nursing	F 692	Resident #20□s Registered Dietitian recommendation was reviewed by Director of Nursing and Nurse Practitioner on 11/20/24 but was no longer applicable as her wounds had healed. A complete audit of November 2024 Dietary recommendations was reviewed by DON and the missing recommendations were discussed with Nurse Practitioner and those still applicable were implemented	12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 692	Continued From page 7 (DON) revealed that the facility did not have a policy related to following the Registered Dietitian's (RD) recommendations. A record review of the "Registered Dietitian Assessment Summary" for Resident #20, dated 10/16/24, revealed a weight loss of -2.4 percent (%) in 30 days and -6.5% over 180 days, with weight documented below normal limits for the resident's height. The nutrition diagnosis noted "Increased needs related to skin breakdown." The recommended interventions included: Zinc 220 milligrams (mg) once daily for 14 days, Vitamin C 500 mg once daily, and Pro-Stat Advanced Wound Care 30 milliliters (ml) once daily. The goals indicated were to achieve weight stability and meet nutritional needs for wound healing. The recommendations were signed and approved by the Nurse Practitioner (NP) on 10/18/24. A record review of the "Order Summary" with active orders as of 10/1/2024, for Resident #20 revealed no new orders reflecting the RD recommendations dated 10/16/24. A record review of the "Monthly Weight Report" for Resident #20 revealed: 5/2024 weight 116.0 pounds (Lbs.), 6/2024 weight 114.0 Lbs., 7/2024 weight 114.6 Lbs., 8/2024 weight 112.5 Lbs. , 9/2024 weight 109.2 Lbs., 10/2024 weight 106.6 Lbs., and 11/2024 weight 103.0 Lbs. During an interview with the DON on 11/19/24 at 12:45 PM, she confirmed that she had received the RD's recommendations and forwarded them to the NP for review. She stated that the NP typically indicates approval on the form, which is then sent to the floor nurse to initiate the orders. She retains a copy to follow up and ensure the	F 692	on 11/20/24. The facility determined that all residents have the potential to be affected. An in-service education program was initiated on 11/22/2024 by the Director of Nursing and Unit Managers with all nurses addressing entering Registered Dietitian (RD) recommendations once received. Director of Nursing will give monthly RD recommendations to Provider for review once received from Registered Dietitian. Provider will review recommendations and return to Unit Managers for orders to be entered. Director of Nursing will conduct an audit of all Registered Dietitian recommendations monthly beginning with December contingent on date of Registered Dietitian visit ensuring all orders are entered correctly monthly for three months. The audit of December dietary recommendation will be reviewed at the QA meeting 12/30/24 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 692	Continued From page 8 recommendations are implemented. However, the DON acknowledged that the RD recommendations dated 10/16/24 for Resident #20 were not initiated, despite the NP's approval. She was unsure why the recommendations were not followed. The DON agreed that failure to implement the RD recommendations could result in further weight loss and delayed wound healing. Record review of the "Admission Record" revealed that the facility admitted Resident #20 on 10/17/19 with diagnoses that included Vitamin Deficiency and Benign Neoplasm of Meninges.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 758	Continued From page 9 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure an as-needed (PRN) psychotropic medication had a stop date for two (2) of five (5) residents reviewed for unnecessary medications. Resident #18 and Resident #49 Findings include: A typed statement on company letterhead revealed that the facility does not have a policy for Ativan/Lorazepam order stop dates and was signed by the Director of Nurses (DON), dated Nov 19, 2024.	F 758	On 11/22/24 the Director of Nursing (DON) reviewed all as needed (PRN) Psychotropic medication orders for resident #18 and #49 and stop dates were added per provider order. The DON and Nurse Practitioner also conducted an audit of all PRN Psychotropic medications including those ordered on Hospice residents to ensure a 14-day review was conducted and a stop date added to the order. The facility has determined that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 758	Continued From page 10 Resident #18 Record review of the "Order Summary Report" for Resident #18 revealed an order dated 7/23/2024, "Ativan Oral Tablet 1 mg (Lorazepam) Give 1 tablet by mouth every 6 (six) hours as needed" with no stop date. During an interview on 11/19/24 at 12:30 PM, Registered Nurse (RN) #2 confirmed that Resident #18 had an order for Ativan one milligram (mg) every 6 hours as needed. She revealed the resident has had to take it several times and confirmed that there was no stop date for the Ativan. An interview on 11/20/24 at 10:03 AM, with the facility's Pharmacy Consultant revealed he was aware that a PRN psychotropic medication needed a stop date, had recommended it, but was not sure why there wasn't one. Record review of the October 2024 "Interdisciplinary Psych Dashboard" revealed Resident #18 with an order for Ativan 1 mg Q6H (every 6 hours) PRN and the pharmacy consultant recommendation of ... "PRN psychotropic orders require a 14 day stop order and resident must be evaluated prior to continuing." A record review of Resident #18's "Admission Record" revealed the resident was admitted to the facility on 7/15/2024 with medical diagnoses that included Alzheimer's Disease and Anxiety Disorder.	F 758	residents have the potential to be affected. In-service education was started on 11/22/2024 by Unit Managers with all nurses, facility providers, and hospice providers on unnecessary use of PRN psychotropic medications and the necessity of review in 14-days and including stop dates on all orders. DON will print and review all new orders weekly to ensure that all new psychotropic orders are complete with an initial 14-day stop date. The Director of Nursing will conduct an audit beginning 12/2/2024 of all PRN psychotropic medications to ensure review after 14-days from start date and stop date is included on all orders for four weeks and three months thereafter. The audits will be reviewed at the Quality Assurance Meeting on 12/30/2024 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 758	Continued From page 11 Resident #49 Record review of the Order Summary Report for Resident #49 revealed an order dated 8/9/24 for Lorazepam Tab 0.5 MG (1) one tablet orally every 4 (four) hours as needed for Terminal Agitation related to Restlessness and agitation with no stop date. Record review Interdisciplinary Psych (psychotropic) Dashboard for October 2024, revealed, Pharmacist Comments for Resident #49: "PRN psychotropic orders require a 14-day stop order and resident must be evaluated prior to continuing..." In an interview with Licensed Practical Nurse #1 on 11/19/24 at 12:50 PM, she revealed Resident #49 did not have a stop date for the PRN Lorazepam and does have to take it sometimes. In an interview with the Director of Nursing on 11/19/24 at 1:00 PM, she revealed that she was aware that PRN Lorazepam required a stop date and confirmed that she was unaware that Resident #18 and Resident #49 did not have a stop date on their Lorazepam. She then revealed the purpose of the PRN medication requiring a stop date was to assess the residents' need to continue the PRN psychotropic medication. She then stated that Residents #18 and #49 were on hospice services and thought that might be the reason the medication had no stop date. A phone interview with the Hospice Nurse on 11/19/24 at 2:33 PM revealed she was unaware that the as needed Lorazepam required a stop date.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 758	Continued From page 12 Record review of the "Admission Record " revealed the facility admitted Resident #49 on 12/05/2019 with diagnoses of Restlessness, Agitation and Anxiety Disorder.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was not five (5) percent (%) or greater for eight (8) of 38 medication opportunities. The medication error rate was 21.05%. Resident #30 Findings Include: Cross Reference F658 Review of the facility policy titled, "Medication Administration -General Guidelines" unrevised, revealed under, "A. Preparation ... 4) Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away ...B. Administration ...2) Medications are administered	F 759	Resident #30 electronic medication administration record was reviewed identifying that the medication route was changed from Percutaneous Endoscopic Gastrostomy tube to oral. The correct route of administration of resident #30 was reviewed and verified by the Director of nursing (DON) with the Nurse Practitioner (NP). The NP observed medication administration of oral medication with resident #30 at the noon medication pass on 11/20/24 verifying tolerance of oral route and determined the oral route appropriate. The observed nurse during medication pass was educated on the five rights of medication administration by the DON immediately upon notification of error. The facility has determined that all residents have the potential to be affected. An in-service education program was	12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 759	Continued From page 13 in accordance with written orders of the prescriber ..." An observation during medication pass, on 11/20/24 at 7:45 AM, with Licensed Practical Nurse (LPN) #1 revealed, she crushed and administered the following medications to Resident #30 via percutaneous endoscopic gastrostomy (PEG) tube: 1. Fenofibrate (lowers cholesterol)160 milligrams (mg) 1 tablet 2. Apixaban (blood thinner) 2.5 milligrams (mg) 1 tablet 3. Atorvastatin (lowers cholesterol) 20 milligrams (mg) 1 tablet 4. Carvedilol (lowers blood pressure) 6.25 milligrams (mg) 1 tablet 5. Ascorbic Acid (immune support) 500 milligrams (mg)/5 milliliters (ml) 5 milliliters 6. Allopurinol (gout) 100 milligrams (mg) 1 tablet 7. Potassium ER (potassium supplement) 20 milliequivalents (MEQ) 1 tablet 8. Multivitamin liquid (vitamin supplement) 15 milliliters (ml) Record review of the November 2024 Medication Administration Record (MAR) for Resident #30 revealed the following orders, "Allopurinol tablet 100 mg (milligrams) give 1 tablet by mouth in the morning, Apixaban oral tablet 2.5 mg (milligrams) give 1 tablet by mouth every morning and at bedtime, Atorvastatin Calcium oral tablet 20 mg (milligrams) give 1 tablet by mouth in the morning, Carvedilol tablet 6.25 mg (milligrams) give 1 tablet by mouth every morning and at bedtime, Fenofibrate oral tablet 160 mg (milligrams) give 1 tablet by mouth one time a day, Multivitamin Oral Liquid give 15 ml (milliliters) by mouth in the morning, Potassium	F 759	initiated 11/22/2024 by the Director of Nursing and the Unit Managers with all nurses addressing the five rights of medication administration. The Unit Managers will conduct medication administration observations of four residents weekly for four weeks beginning 12/2/2024 and monthly for three months. Audits will be reviewed at the Quality Assurance Meeting on 12/30/2024 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 759	Continued From page 14 Chloride ER oral tablet extended release give 1 tablet by mouth in the morning, Ascorbic Acid 500 mg (milligrams) give 5 ml (milliliters) by mouth in the morning". On 11/20/24 at 8:40 AM an interview with LPN #1 revealed she reviewed Resident #30's MAR and confirmed she gave the medication by the wrong route. LPN #1 revealed she did not read the entire order. She confirmed this was medication errors. An interview with the Director of Nursing (DON) on 11/20/24 at 8:50 AM revealed, Resident #30 had a recent order change from PEG medication administration to by mouth and she expected the nurses to follow the physician orders and the 5 rights of medication administration to prevent potential errors. Record review of the "Admission Record" revealed the facility admitted Resident #30 on 11/9/24 with medical diagnoses that included Cerebral Infarction and Gastrostomy Status.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 880	Continued From page 15	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 880	Continued From page 16 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to use enhanced barrier precautions (EBP) during wound care for one (1) of five (5) resident direct care opportunities during the survey. Resident #59 Findings Include: Review of the facility policy titled, "Enhanced Barrier Precautions" with a revision date of 5/24 revealed under, "Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities ...2. Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions will be obtained for residents with any of the following: i.	F 880	Resident #59 was immediately placed on enhanced barrier precautions by the Infection Preventionist upon notification of requirement on 11/20/24. On 11/20/24 all residents with wounds were assessed by the Infection Preventionist and those with pressure wounds staged 2 or greater were placed on enhanced barrier precautions. An enhanced barrier precautions policy was written and implemented to include all pressure wounds stage 2 or greater as a chronic wound. The facility determined that all residents have the potential to be affected. On 11/20/24 an In-service education was conducted by the Director of Nursing with the Infection Preventionist and all nurses on enhanced barrier precautions being added for all pressure wounds of Stage 2 or greater deemed chronic wounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 880	Continued From page 17 Wounds (e.g., chronic wounds such as pressure ulcers ..." Record review of Resident #59's "Wound Evaluation" dated 11/13/24 revealed, "Pressure -Stage 3 Sacrum" with measurements of 3 centimeters (cm) length, 1.95 centimeters (cm) width, and 0.2 centimeters (cm) deepest point. Record review of the November 2024 Treatment Administration Record (TAR), for Resident #59 revealed, an order dated 10/31/24, "Clean sacrum stage II pressure injury daily and PRN (as needed) with WW (wound wash) and pat dry. Apply collagen and cover with border gauze until resolved. One time a day related to pressure ulcer stage 3." An observation of wound care on 11/20/24 at 9:21 AM, with Registered Nurse (RN) #1 and Nurse Practitioner (NP) #1 revealed, they entered Resident #59's room and did not apply a gown for EBP. NP #1 assisted with wound care by turning the resident onto her side while RN #1 performed the wound care. Further observation revealed, there was not a sign posted to indicate the resident was on enhanced barrier precautions (EBP). An interview with RN #1 on 11/20/24 at 10:28 AM confirmed she did not apply a gown for Resident #59's wound care. RN #1 revealed she was familiar with EBP but did not practice it on wounds unless they were draining. She revealed the purpose of practicing EBP was to protect the residents from bacteria that they could be exposed to and explained that it made sense to wear a gown.	F 880	The Director of Nursing will conduct an audit of all wounds weekly beginning 12/2/2024 for four weeks and three months thereafter to ensure enhanced barrier precautions are implemented for those wounds staged 2 or greater by the Skilled Wound Care Physician during weekly wound rounds. Audits will be reviewed at the quality assurance meeting 12/30/24 and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 880	Continued From page 18 An interview with NP #1 on 11/20/24 at 11:10 AM, revealed she had not been made aware they must use EBP with pressure wounds. An interview with the Director of Nursing (DON) on 11/20/24 at 1:43 PM, revealed they had not received any guidance on using EBP with wounds unless the wound was draining. She confirmed the purpose was to protect the residents from infection. Record review of the "Admission Record" revealed the facility admitted Resident #59 on 1/10/24 with medical diagnoses that included Alzheimer's Disease and Pressure Ulcer of Other Site, Stage 3.	F 880		