STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255307	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	**2901 HIGHWAY 82 EAST P O DRAWER 1670, GREENWOOD, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an onsite complaint investigation for (CI MS # 477344) related to abuse and injury of unknown origin and (2) facility incident investigations (Incident # 2563831 and Incident #477346) related to abuse at the facility on 9/03/25-9/04/25. During the survey, SA determined that the facility was not compliance with the requirements of participation in Medicare and Medicaid Services for (Incident # 2563831 and Incident #477346) and cited F585, F602, and F609. The investigated CI # 477344 with no deficiencies cited. The census at the time of the survey was 83 with a bed capacity of 95 beds.	F0000		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance	F0585		

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 reverse for further 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

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F0585 SS = D	Continued from page 1 policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility	F0585		

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F0585 SS = D	Continued from page 2 as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident's grievances related to missing property were investigated and resolved. This deficient practice was identified for three (3) of seven (7) residents reviewed for grievances (Residents #1, #2, and #3) Findings include: Review of the facility policy titled, Resident and Family Grievances, dated April 2017, revealed: “The facility will make prompt efforts to resolve grievances… The written decision will include a minimum: a summary of the pertinent findings or conclusions regarding the resident’s concerns… any corrective action as a result of the grievance.” Resident #1 Record review of a Missing Item Report Form dated 6/27/25 documented Resident #1’s iPhone with a pink case as missing. The follow-up/results section was blank. In an interview with the Administrator (ADM) on 9/3/25 at 8:40 AM, she confirmed Resident #1 reported her phone missing on 6/27/25. Staff tracked it with her iPad, which pinged at Housekeeper #1’s address. Video footage showed Housekeeper #1 entering Resident #1’s room at 1:27 PM, discarding the phone case, concealing the phone in her bra, and leaving the room. Police were notified the same day, and the housekeeper was terminated and later arrested. She confirmed the facility did not reimburse or replace the phone.	F0585		

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F0585 SS = D	Continued from page 3 In an interview with Resident #1 on 9/3/25 at 9:20 AM, she stated she spoke to her daughter on her phone at 11:30 AM, dozed off after lunch, and woke to find it missing. She stated she reported it to staff, who tracked it and confirmed the location. She stated she was told the housekeeper was fired but the facility never reimbursed or replaced the phone, and her daughter purchased one for her. Record review of the “Admission Record” revealed Resident #1 was admitted on 6/7/25. Record review of a Brief Interview for Mental Status (BIMS) for Resident #1 dated 6/7/25 revealed a score of 15 indicating the resident was cognitively intact. Resident #2 Record review of a Missing Item Report Form dated 6/11/25 documented Resident #2’s red iPhone 11 as missing. The follow-up/results section was blank. During an interview with Resident #2 on 9/3/25 at 12:10 PM, he stated he reported his phone missing in June, staff searched but never found it, and “it doesn’t seem like I will be getting another one.” During an interview with Resident #2’s representative on 7/2/25 at 4:00 PM, she confirmed she was notified of the missing phone but stated the facility never offered reimbursement or replacement. Record review of the “Admission Record” revealed Resident #2 was admitted on 7/26/24. Record review of a BIMS for Resident #2 dated 8/14/25 revealed a score of 12 indicating the resident was moderately cognitively impaired. Resident #3 Record review of a Missing Item Report Form dated 6/5/25 documented Resident #3’s black iPhone 16 as missing. The follow-up/results section was blank. During an interview with Certified Nursing Assistant (CNA) #1 on 9/3/25 at 12:00 PM, she stated she reported Resident #3’s phone missing after it was not located. She confirmed the resident used it regularly, but it had not been replaced. In an interview with the ADM on 9/4/25 at 8:35 AM, she confirmed the cell phones for Residents #1, #2, and #3 were never located or replaced. She stated she reviewed	F0585		

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F0585 SS = D	Continued from page 4 video footage of Residents #2 and #3's rooms but could not substantiate misappropriation. During an interview with the Social Worker on 9/4/25 at 8:40 AM, she confirmed she searched for the phones of Residents #1, #2, and #3 but did not find them. She stated all three residents used their cell phones regularly and kept them within reach. She also confirmed the Missing Item Reports for all three residents contained no documentation of a resolution. Record review of the "Admission Record" revealed Resident #3 was admitted on 7/17/24. Record review of the BIMS dated 7/22/25 revealed a score of 11, indicating Resident #3 was moderately cognitively impaired.	F0585		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to ensure residents were free from misappropriation of property for one (1) of four (4) residents reviewed (Resident #1). Findings include: Review of the facility policy titled, "Abuse, Neglect, Exploitation," revised August 2018, revealed: "Each resident has the right to be free from... misappropriation of property...Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings without the resident's consent..." An interview on 9/3/25 at 8:40 AM with the Administrator (ADM) revealed that Resident #1 had reported her phone missing on 6/27/25. She confirmed	F0602		

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F0602 SS = D	Continued from page 5 that a facility-reported incident dated 6/27/25 had been completed regarding the reported missing phone, staff used the resident's iPad to track the phone, which pinged at the address of Housekeeper #1. She further stated video footage showed Housekeeper #1 entering Resident #1's room at 1:27 PM, discarding the phone case, concealing the phone in her bra, and leaving the room. The Administrator confirmed that police were notified the same day, that Housekeeper #1 was terminated on 6/27/25, and that the housekeeper was later arrested. She acknowledged the facility did not reimburse or replace the resident's stolen phone. Review of a payroll change form confirmed Housekeeper #1's termination on 6/27/25 related to "stealing resident property." During an interview with Resident #1 on 9/3/25 at 9:20 AM, she stated that on 6/27/25 she spoke to her daughter on the phone around 11:30 AM. After lunch she dozed off, and upon waking her cell phone was missing. She stated she always kept it nearby in case her family called. She reported the loss to staff who used her iPad to locate it. She stated the police came and confirmed her phone was taken, and she was later informed the housekeeper was fired. Resident #1 stated, however, the facility did not replace her phone, and her daughter had to buy her a new one. Review of the "Admission Record" revealed Resident #1 was admitted on 6/7/25. Review of the Brief Interview for Mental Status (BIMS) dated 6/7/25 revealed a score of 15, indicating the resident was cognitively intact.	F0602		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not	F0609		

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F0609 SS = D	Continued from page 6 result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure that allegations of abuse and misappropriation were reported immediately to the State Agency within required timeframes. This deficient practice was identified for two (2) of seven (7) residents reviewed for reporting of allegations (Residents #1 and #4). Findings include: Review of the facility policy titled, “Abuse, Neglect, Exploitation” (revised August 2018), revealed: “Response and Reporting of Abuse, Neglect, and Exploitation...13...ensure all alleged violations involving abuse, neglect, are reported immediately, but no later than two (2) hours after the allegation is made if the events that cause the allegation involve abuse or result in bodily injury, and no later than 24 hours if the events do not involve abuse or bodily injury. Allegations involving licensed staff will be reported to the appropriate licensing authority.” Resident #1 – Misappropriation of Property During an interview with the Administrator (ADM) on 9/3/25 at 8:40AM regarding a facility-reported incident, she confirmed that on 6/27/25 Resident #1 reported her cell phone missing. Staff used the resident’s iPad to track the phone, which pinged at the address of Housekeeper #1. She stated video footage showed Housekeeper #1 entering Resident #1’s room at 1:27 PM, discarding the phone case, concealing the phone in her bra, and leaving the room. The Administrator confirmed police were notified the same day, Housekeeper #1 was terminated, and the housekeeper was later arrested. However, she acknowledged that the	F0609		

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F0609 SS = D	Continued from page 7 State Agency was not notified until 6/30/25, when the final report was submitted. She confirmed the allegation should have been reported immediately on 6/27/25 once misappropriation was substantiated. Record review of the "Admission Record" revealed Resident #1 was admitted on 6/7/25 with a diagnosis of polyneuropathy. Record review of the Brief Interview for Mental Status (BIMS) dated 6/7/25 revealed a score of 15, indicating the resident was cognitively intact. Resident #4 – Alleged Abuse During an interview with the Director of Nursing (DON) on 9/2/25 at 2:47 PM regarding a facility-reported incident, she confirmed that an alleged incident of verbal/physical abuse occurred on 7/13/25 at approximately 6:00 PM involving Resident #4. She stated she was not notified until 7/14/25 when she found a note under her office door. She confirmed staff should have immediately reported the allegation to her or the ADM. She also confirmed she did not report the allegation to the State Agency until 7/14/25, after receiving the note. The DON further stated that the purpose of immediate reporting of all allegations of abuse or misappropriation is to ensure resident safety and allow for a timely investigation. Record review of a written statement provided by Licensed Practical Nurse (LPN) #1 revealed that on 7/13/25 a Certified Nursing Assistant (CNA) orientee #2 gave her a note regarding the allegation. She stated she handed the note to the House Supervisor, Registered Nurse (RN) #1, who instructed her to place it under the DON's door for the next morning. Record review of a written statement from RN #1 dated 7/15/25 confirmed she read the note and instructed LPN #1 to leave it under the DON's door. Record review of an in-service dated 7/14/25 revealed both LPN #1 and RN #1 attended training on immediately reporting allegations of abuse. The in-service emphasized: "Abuse must be reported to MSDH within two hours by Administration. … Remember to always report any suspicion of abuse and neglect immediately. … When in doubt, report it." Record review of the "Admission Record" revealed Resident #4 was admitted on 12/5/19 with a diagnosis of dementia, unspecified severity with agitation.	F0609		

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F0609 SS = D	Continued from page 8 Record review of the BIMS dated 5/9/25 revealed a score of 99, indicating the resident was rarely/never understood.	F0609		