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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 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. 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 [DATE] with medical diagnoses that included Alzheimer's Disease and Anxiety Disorder. Resident #54 (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 [DATE] 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. 47158 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 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47874 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 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) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 11/9/24 with medical diagnoses that included Cerebral Infarction and Gastrostomy Status.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47158 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 (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 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.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 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 [DATE]. 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 [DATE] with medical diagnoses that included Alzheimer's Disease and Anxiety Disorder. 47157 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 . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Record review of the Admission Record revealed the facility admitted Resident #49 on 12/05/2019 with diagnoses of Restlessness, Agitation and Anxiety Disorder.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47874 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 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) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47874 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. 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. 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.