Clichés about only being as old as you feel are starting to have scientific backing
~By Marlene Cimons (Originally published in The Washington Post)
~Submitted By Donna Cassani, Resident Services Director

We’ve heard all the cliches about aging: “You’re as young [or old] as you feel.” “Age is just a number.” “You’re not getting older, you’re getting better.” “Seventy is the new 50.” Well-intentioned, perhaps. Offensive, to some. Patronizing, to be sure. But could they be true?

Maybe science has started to catch up with these tired phrases. Researchers have discovered that many people feel good about themselves as they get older.

One study, for example, found that as people get older, they consistently say they feel younger — much younger — than their actual age. Another study examining the attitudes of the offspring of centenarians concluded that the centenarians’ children — if they, too, were healthy and long-lived — have a strong sense of purpose and meaning to their lives, compared with the general population. Finally, there is evidence that positive attitudes about aging may reduce the risk of dementia, among the most dreaded consequences of aging.

The results are compelling in the context of negative messages about aging from the media, in the workplace and elsewhere, messages that are far more prevalent than positive communications, according to the researchers.

“Children as young as 3 or 4 have already taken in the age stereotypes of their culture,” says Becca Levy, a professor of psychology at Yale whose study found that older adults with positive beliefs about old age were less likely to develop dementia, including those who are genetically disposed. “These age stereotypes are communicated to children through many sources, ranging from stories to social media. Individuals of all ages can benefit from bolstering their positive images of aging.”

William Chopik, an assistant professor of psychology at Michigan State University, agrees. “Negative views about aging are communicated to us early in life, through media, books and movies, and what our friends and family tell us,” Chopik says. “These attitudes are present and pervasive already in childhood, so naturally it’s hard to enact meaningful change to these attitudes — but that’s what we’re trying to do at the moment.”

Chopik’s study, which surveyed more than half a million Americans via the Internet, found that as people got older they nevertheless continued to feel younger than their chronological age.

“Sixty-year-olds felt like they were 46,” he says. “Seventy-year-olds felt like they were 53. Eighty-year-olds felt like they were 65. It looks like this is pretty consistent across age groups. People know that they are aging, but they are evaluating themselves and their lives and reporting feeling about 20 percent younger than their current age.”

He queried people from ages 10 to 89 and found that views change as they grow older. While people in their 70s and 80s reported feeling younger than their chronological years, teenagers and young adults equated turning 50 with hitting old age. This attitude persists into old age, according Chopik. When people turn 70, 80 seems old. When someone turns 80, 90 is old, he says. (Cont’d on page 2)
Cliches about only being as old as you feel are starting to have scientific backing (Cont’d)

“Part of that might arise from not wanting to be considered an older adult,” Chopik says. “As a result, people could be perpetually pushing what is considered an older adult into the future. It could also arise from people feeling good about themselves and their bodies, and coming to the realization that, because of their negative beliefs about what it must feel like to be an older adult that ‘I must not be old.’”

The centenarians’ offspring study used data from the New England Centenarian Study, which has followed nearly 4,000 centenarians, and some of their siblings and children, since 1994.

Researchers at the Boston University School of Public Health compared healthy and long-living children of centenarians — average age, 82 — with three groups: their spouses, their “birth cohort” (a group whose parents, though born at the same time as the centenarians, lived only into their early 70s) and participants in the Health and Retirement Study, a nationally representative study of more than 30,000 individuals older than 50.

Using a survey that measured psychological well-being, they asked respondents to agree or disagree with such statements as: “I enjoy making plans for the future and working to make them a reality” and “My daily activities often seem trivial and unimportant to me.” They found that children of centenarians expressed more purpose in life than any of the other three groups.

“Aging well is not only escaping or delaying disease,” says co-author Paola Sebastiani, a professor of biostatistics at the Boston University School of Public Health. “Feeling good about your life is important and should be considered an important aspect of healthy aging.”

In her dementia research, Levy evaluated 4,765 older people — average age, 72 — who were free of dementia at the start of the study and followed them for four years. The participants answered a series of questions about their beliefs about aging. “We found [that] those who expressed more-positive age beliefs at baseline were less likely to develop dementia . . . than those who expressed more-negative age beliefs,” Levy said.

This protective effect was found for all participants, including those who carry the E4 variant of the gene APOE, which raises their dementia risk. About a quarter of Americans carry this variant, although only 47 percent of them develop dementia, she said. The reason the remaining 53 percent never develop dementia is unknown.

The APOE E4 carriers with positive beliefs about aging had a 2.7 percent risk of developing dementia, compared to a 6.1 percent risk for carriers with negative beliefs, according to the study. (Twenty-six percent of the study participants were carriers.)

“We know . . . that exposing older individuals to negative age stereotypes exacerbates stress, whereas exposing them to positive age stereotypes can act as a buffer against experiencing stress,” Levy says. “It is also known that about half the people with the APOE E4 never develop dementia. Therefore, we thought that it is possible that those who have more-positive age stereotypes — which can reduce stress levels — may have altered genetic expression in later life that reduces the likelihood of developing dementia.”

The results bolster the case “for implementing a public health campaign against ageism and negative age beliefs,” she says. Even “individuals in their 80s and 90s can strengthen their positive images of aging.”

Chopik agrees, pointing out that all too often attitudes about aging arise from anxiety over physical ability, appearance, loneliness or boredom. “However, many studies of older adults debunk these perceptions,” he says. “Older adults live enriching and very active lives — so these perceptions aren’t rooted entirely in reality.”
New Medicare Cards Are Coming and Here's What You Should Know...

~By Dr. Ann Mecherikunnel, Falcons Landing Medical Director

If you have Medicare, you can expect to receive a new card between April 2018 and April 2019. You may not get it at the same time as your neighbor’s but if the Social Security Administration has your correct address this will be mailed to you automatically.

What Changes:

The new card will not have your SSN as your ID. There will be a new Medicare Beneficiary Identifier (MBI) unique to you. There will be 11 characters both numbers and uppercase letters.

What does not change:

Your benefits remain the same.

How do you get the new card?

You will receive this automatically in the mail. You do not need to apply for it.

When Do You Use It?

Once you get the new card you may destroy your old card and begin using the new card right away. Please provide the Wellness Center and all your providers offices with the new card at your next visit.

Beware:

Scammers are already targeting Medicare beneficiaries- You will never be called by phone from Medicare asking for your personal or financial information to receive a new card and you will not be charged for a new card.
Alzheimer’s Association Education Sessions at Falcons Landing
~By Donna Cassani, Resident Services Director

Because many of our residents have recently requested greater education about Alzheimer’s disease and related-dementias, we invited the National Capital Area Chapter of the Alzheimer’s Association to Falcons Landing to conduct this important training. We are very fortunate that they will be able to offer these sessions in our Ballroom in May, June and July. Part of the Association’s mission is to educate families, individuals diagnosed with dementia or those who seek to learn more about the disease. We hope that many of you will be able to attend any or all of these upcoming sessions. They will also be broadcast on Channel 1970 and filmed for future viewing.

Monday, May 14 – 3 pm  “About Dementia”

This session will define dementia and its symptoms; discuss how these symptoms affect the ability of people to function; and describe some basic ways to help people with dementia.

Monday, June 11 – 3 pm  “Effective Communication Strategies”

As people with dementia progress in their journey and their ability to use words is lost, family and friends need new ways to connect. This session explores how communication takes place when someone has dementia, how to decode the verbal and behavioral messages delivered to someone with dementia and identify strategies to help you connect and communicate at each stage of the disease.

Monday, July 16 – 3 pm  “Understanding and Responding to Dementia-Related Behavior”

Behavior is a powerful form of communication and is one of the primary ways for people with dementia to communicate their needs and feelings as the ability to use language is lost. This session will identify common behavior triggers and teach strategies to help intervene with some of the most common behavioral challenges of dementia.

Save the Date

2018 Walk to End Alzheimer's—Northern Virginia
Sunday, September 23, 2018
3:00 P.M.
Reston Town Center
Stay Tuned for More Information
New Shingles Vaccine: SHINGRIX
~By Dr. Ann Mecherikunnel, MD and Lisa DeGilio, ANP

Recently, many of you have asked about the “new shingles vaccine”. On January 25, 2018, Centers for Disease Control and Prevention, made its formal recommendations for the use of a new vaccine called Shingrix that they feel will provide substantially long, persistent protection, compared to the approximately 5-year protection of the current Zostavax shingles vaccine. (In fact, some research suggests that Zostavax may actually wane after only three years.)

What is Shingles?

Shingles, also known as Herpes Zoster, is a viral disease characterized by a painful skin rash with blistering eruptions in a localized area. Typically, the rash occurs in a single, wide stripe either on the left or right side of the body or face. It is caused by the varicella-zoster virus — the same virus that causes chickenpox. After you’ve had chickenpox, the virus lies inactive in nerve tissue near your spinal cord and brain. Years later, the virus may reactivate as shingles. It typically affects people older than 50 years old. According to the CDC, the infection strikes about 1 million people in the U.S. each year and nearly one in three adults will experience a bout of shingles in their lifetime. The typical 2-4 weeks of symptoms can be difficult enough, but about 1 in 5 people with shingles go on to develop postherpetic neuralgia, a nerve pain that can linger for months or even years.

Vaccines can help reduce the risk of developing shingles, while early treatment can help shorten a shingles infection and lessen the chance of complications.

Who should get the Shingrix vaccine?

CDC is recommending that Shingrix—a two-dose vaccine with the second given 2-6 months after the first, —be given to people starting at age 50, a full 10 years earlier than its advice for getting Zostavax. They also recommend that people who have already received Zostavax should now get Shingrix as well and that Shingrix is officially the preferred vaccine over Zostavax, a single-dose vaccine. Those who’ve had shingles, which can occasionally recur, should also receive Shingrix.

Because Shingrix is not a live vaccine like Zostavax, it is presumed safe for immunocompromised individuals who are at an increased risk of developing shingles. However, the studies are still being conducted, on people with confirmed or suspected immunosuppressive conditions (eg, cancer or HIV infection) or immunosuppressive therapy (eg, chemotherapy, organ transplantation medications, or autoimmune dis order treatment). The CDC Advisory committee on Immunization practices, recommends that Shingrix can be administered to patients taking low-dose immunosuppressive therapy (eg, less than 20 mg/day of prednisone or equivalent or using inhaled or topical steroids) and individuals anticipating immunosuppression or those who have recovered from an immunocompromising condition. Patients with chronic medical conditions should receive Shingrix.

Side effects

Evidence suggests that Shingrix is safe, with the most common adverse effects being pain, redness, and swelling at the injection site, muscle pain, drowsiness, headache, fever, and upset stomach. The side effects may affect your ability to do normal daily activities for 2 to 3 days. Patients can receive both Shingrix and the influenza vaccine concomitantly.

Severe allergic reactions to any vaccine are very rare. Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination. If you have a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or go to the nearest hospital. Otherwise, call your doctor. (Cont’d on page 6)
Dear Michele:  *What is a social worker?*

**Who am I?**  *Inspired by a poem from Terricka Hardy, LCSW, ACSW*

Who am I? I’m glad you asked  
I’m the one who’s willing to advocate, no matter how hard the task  
To some I’m an educator, to others a broker  
I wear many hats, I’m a Social Worker!  
Many fail to realize the impact of this great profession  
Promoting human well-being, Social Work has contributed to our world’s progression  
Held to strong ethical standards, inspired to serve  
Social Workers fight hard to promote the social justice everyone deserves  
Valuing the human relationship, respecting the worth of the individual  
A true Social Worker is selfless; putting people first is a ritual  
Vowing to remain competent in all we do, we strive to uphold integrity by staying committed to you.  
So, who am I, again? Well, I’m glad you asked  
I’m a proud, dedicated Social Worker, that’s who.

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**New Shingles Vaccine: SHINGRIX (Cont’d)**

**Cost**

Shingrix, offered by our local pharmacies, is expected to cost $280 for the 2 doses.

**Medicare**

- Medicare Part D plans cover the shingles vaccine, but there may be a cost to you depending on your plan. There may be a copay for the vaccine, or you may need to pay in full then get reimbursed for a certain amount.
- Medicare Part B does not cover the shingles vaccine.

**Private health insurance**

Many private health insurance plans will cover the vaccine. Contact your insurer to find out.
NOSEBLEED: CAUSES, FIRST AID & INTERVENTION

~By Joan Sweeney, BSN, RN, Wellness Coordinator

Nosebleeds can be dramatic & frightening. Fortunately most nosebleeds are not serious & can be managed at home, although sometimes medical intervention may be necessary. Nosebleeds are one of the most common problems treated in an ER.

Nosebleeds are categorized based on where they originate & are described as either ANTERIOR (originating from the front of the nose) or POSTERIOR (originating from the back of the nose).

ANTERIOR Nosebleeds make up most nosebleeds. The bleeding usually originates from a blood vessel on the nasal septum where networks of vessels converge. Anterior nosebleeds are usually easy to control by measures at home.

POSTERIOR Nosebleeds are less common & tend to occur more often in elderly people. The bleeding usually originates from an artery in the back part of the nose. These nosebleeds are more complicated & usually require intervention at the hospital & management by an otolaryngologist (ENT specialist).

OTHER NOSEBLEED SYMPTOMS: Bleeding usually occurs only from one nostril. If the bleeding is heavy enough, blood can fill up the affected nostril & overflow into the other nostril as well. Blood can also drip into the back of the throat or down into the stomach, causing the person to spit up or vomit blood. Signs of excessive blood loss include dizziness, weakness, confusion, & fainting.

WHAT CAUSES NOSEBLEEDS Common causes are prolonged exposure to warm dry air, sinus infections, allergic rhinitis, vigorous nose blowing, deviated septum, foreign body, nasal surgery.

Less commonly, an underlying disease process or taking certain medications can cause a nosebleed or make it difficult to control.

Inability of the blood to clot is most often due to blood-thinning meds such as Warfarin, Plavix, NSAIDS, or Aspirin. Liver disease, chronic alcohol use, kidney disease, platelet disorders can also interfere with blood clotting & predispose to nosebleeds.

HOW TO STOP A NOSEBLEED *Remain calm. *Sit up straight & lean slightly forward. *Lean your head forward. Tilting your head back will only cause you to swallow blood. *Pinch the nostrils together & apply direct pressure with the thumb & index finer for 10 minutes. Time it to make sure the nostrils are not released earlier. *Spit out any blood in the mouth. Swallowing may cause vomiting. This technique will stop the majority of simple nosebleeds.

Nasal saline sprays or other lubricating ointments or gels such as “AYR” may also be useful afterward to promote tissue healing & keep the nasal passages moist.

IT IS TIME TO GO TO THE HOSPITAL WHEN THE PERSON WITH THE NOSEBLEED * is still bleeding after pinching the nose for 30 minutes, * is having repeated episodes of nosebleeds over a short time or if a large amount of blood is lost, * feels dizzy or light-headed, or feels that they are going to pass out,* has a rapid heartbeat or trouble breathing,* is vomiting blood, *has a rash or temperature greater than 101.4, * if a health care practitioner instructs you to go to the ER.
For many of us, driving is a key aspect of maintaining our independence as we age. But it is normal for our driving abilities to change as we get older. By reducing risk factors and incorporating safe driving practices, you may be able to continue driving safely long into your senior years. Even if you find that you need to reduce your driving or give up the keys, it doesn’t mean the end of your independence. Seeking alternative methods of transportation can offer health and social benefits, as well as a welcome change of pace to life.

Everyone ages differently. There is no arbitrary cutoff as to when someone should stop driving. However, older adults are more likely to receive traffic citations and get into accidents than younger drivers. Physical impairments such as neck pain or stiffness, leg pain that makes it difficult to move your foot from the gas to the brake pedal, diminished arm strength, slower reaction times, and lessening ability to effectively divide your attention between multiple activities. Even with a lifetime of driving with a safe record you may feel shocked or overwhelmed at the prospect of losing some of your independence, but by keeping your mind open to new possibilities, you can still maintain an active, vibrant and rewarding lifestyle without a car.

**Warning Signs of Unsafe Driving:**

- **Frequent close calls** as in almost crashing, dents and scrapes on the car or on garage doors and curbs.
- **Increased Citations**, traffic tickets or “warnings”.
- **Trouble with fundamentals of driving**, such as making sudden lane changes, drifting into other lanes, and braking or accelerating suddenly without reason. Failing to use the turn signal or keeping the signal on without changing lanes.
- **Eyesight problems** like not seeing traffic lights and street signs or having to drive closer and closer to them to see them clearly.
- **Hearing problems** such as not hearing emergency sirens or horns honking.
- **Problems with memory** including missed exits that used to be second nature. While everyone has occasional lapses, if there’s an increasing pattern, it’s time to get evaluated by a doctor.
- **Problems with reflexes and range of motion** such as slow reaction time for braking, confusing the gas and brake pedals, feeling flustered while driving or being quick to anger when behind the wheel.

At Falcons Landing every effort is made to ensure a safe environment both indoors and out for pedestrians, staff and visitors. Please obey the traffic rules on the campus as you would off-site.

**FULL STOP AT STOP SIGNS**
**15 MPH SPEED LIMIT**
**SLOW DOWN APPROACHING BLIND CORNERS**

*******************************************************************************
Was it a broken heart that landed George H.W. Bush, the 41st president, in the hospital just a day after the funeral of his wife, Barbara? The Bushes were married for 73 years — they were allies, confidantes and the anchors of a political dynasty. Speculation swirled that Mrs. Bush’s death must have sent him into a downward medical spiral.

Failing health that accompanies grieving, especially the loss of a spouse, has been reported by some medical researchers. The phenomenon is due largely to selective memory. We all know examples where husband and wife die within a week of each other. They stick in our minds — we remember them.

That is not to say that deep grief on rare occasions can’t send the body into free fall. The best known of these reactions, and a model for understanding them, is what’s aptly called broken-heart syndrome. Japanese doctors were the first to describe the reaction in detail, and their name for it was even more evocative: Takotsubo syndrome, after the Japanese term for “octopus trap.” On scans of the grief-stricken, the heart may look as if it being squeezed from below, its upper chambers swelling as if straining to break free. The sudden loss of a spouse, child or parent, “releases an outpouring from the sympathetic nervous system, the fight-or-flight response, which is what seems to damage the heart in broken-heart syndrome,” said Dr. Anne Curtis, chairwoman of medicine at the University at Buffalo. “The heart rate goes up sharply, blood pressure goes up,” she said. “This is why people can also have a stroke in situations like this.”

The octopus trap can ensnare any heart, healthy or not, young or old. The flash-flood of stress hormones causes a temporary weakening of the heart muscle itself. The rush may also precipitate a classic heart attack, in which a clot blocks blood flow, or an arrhythmia, in which the heart revs wildly. The latter two consequences are more rare than the first, and deadlier. If what felled Mr. Bush was a worsening infection, as reported, then a tide of grief in theory could have worsened his condition. Studies have linked elevated levels of cortisol, a stress hormone, to increased risk of contracting flu, colds and other sicknesses.

“A lot of things happen when people are overcome with sadness — neuroendocrine changes, which include an increase in cortisol levels, can suppress immune response,” Dr. Wittstein said. Yet tracing a straight line between the death of a spouse and the subsequent physical decline of a survivor is no easy task. Cause and effect are difficult to prove. That ailing spouses in their early 90s might die within a short time of each other is quite possible even if there were no such thing as broken-heart syndrome, simply because of their age and health.

The actress Debbie Reynolds died one day after her beloved daughter Carrie Fisher. Quarterback Doug Flutie’s parents died on the same day, both of heart attacks. Johnny and June Cash died within months of each other, after a long marriage.

A version of this article appears in print on April 25, 2018, on Page A18 of the New York edition with the headline: Can You Get Ill From a Broken Heart?
Do you love cheese…but then feel guilty when you enjoy it so much?

If so, you’re not alone in thinking of food as “good” or “bad.” The truth about cheese nutrition is instead all about balance. Like every food, cheese has pluses and minuses. But cheese can certainly work into a healthy diet, whether your goal is managing your weight, strengthening your bones or protecting your heart. It’s loaded with nutrition and great taste. Cheese naturally has less lactose or none at all, so people who are lactose intolerant can still enjoy dairy. The calcium in cheese helps prevent kidney stones by binding compounds in food that cause them. Cheese works into special diets, like gluten free, low lactose, lower fat, higher protein, DASH, Mediterranean, vegetarian and more.

The Good Stuff

Cheese is packed with nutrients. It’s also high in protein, a nutrient that helps preserve our muscle to prevent falls. Cheese is the second top food source of calcium, a critical nutrient for all ages, since four out of five of us don’t get the recommended amount. Plus, cheese is more than calcium, as it delivers essential nutrients including phosphorus, vitamin A and zinc.

Cheese is full of flavor. The Dietary Guidelines for Americans recognizes that since most people love cheese, alone or in other foods, cheese fills in some of our nutrient gaps. Three servings a day of dairy foods (milk, cheese and yogurt) are recommended, not just for better bone health but also for lowering the risk of type 2 diabetes/metabolic syndrome, high blood pressure and heart disease.

Cheese “plays well with others.” Paired with whole grains, fruits and veggies, cheese can entice us to eat more of other foods we don’t get enough of. Try a cheese drizzle over broccoli; feta with watermelon, cucumber and mint; or fresh mozzarella with sliced tomatoes and basil.

The “good bacteria” used in culturing cheese may help boost our immune system and health. A hot topic of research today is the idea that the bacteria in our digestive systems may help prevent chronic diseases.

Cheese is made with milk and salt, plus an enzyme (rennet) and good bacteria to get it all going.

Balancing Act

It takes ten pounds of milk to make each pound of cheese. Cheese is concentrated, so that means that its calories, fat and sodium in cheese can add up. A little goes a long way. Moderating portion size is the way to find personal balance, to meet your own health needs for calcium, sodium and calories.

- A strong cheese adds more flavor without having to go overboard with the amount. In a casserole dish, sprinkle a little strong cheddar instead of a lot of a mild cheddar. Or enjoy blue cheese with a whole grain bread.
- Use grated cheese. An ounce of cheese (about the size of your thumb) make ¼ cup when grated. Freshly grated cheese is fluffier and more flavorful. Try grated parmesan or Romano. A microplaner or box grater makes grating easy.
- One serving of cheese is 1.5 ounces of natural cheese (like Swiss or Colby) or 2 ounces of processed cheese (like Velveeta or American). That's about the size of 4 dice.
Walking with a Purpose
~By Alvah Tharp, Fitness Manager

Walking is an important part of our lives. While those that are able walk to go to the places that they need to go, we can also walk as a way to maintain and improve our fitness. Certainly the walking that we do to as part of our normal activities is helpful, but we can also walk with the sole purpose of physical benefit.

For most adults, the naturally selected walking speed is 2.8 mph. This speed is likely selected by the central nervous system to lessen the body’s energy expenditure. Also, for most people, at speeds at or below 2.8 mph the body uses fat as its primary fuel source, as opposed to higher speeds where a higher % of carbohydrates are used. With an uptick in breakdown of carbohydrates as an energy source comes a perceived increase in effort.

Aging and or inactivity bring about a reduction in strength, balance, and endurance in lower body musculature. Less strength may require the body to recruit different motor units and perhaps more muscle fibers, which would make walking less economical than before. A reduction in balance can lead to a shortened gait pattern so that more ground contact can be made with each foot. These factors will lead to a reduced naturally selected walking speed and perhaps an altered gait pattern.

When we walk with a purpose, we would want to walk at an intensity that is beyond what our natural pace is. Walking intensity can be influenced certainly be walking speed, but also duration and environment. Our walking intensity definitely goes up when we are walking up cardiac hill at Falcons! Increasing the amount that we walk can certainly have a positive effect on health. Many studies that track physical activity use the amount of steps walked, as it is an easy way to track the duration of your walk. A common number of steps that several publications list as a goal for healthy living is 10,000 steps a day. While 10,000 steps may be a good goal, just doing a little bit more than you have been doing will make a difference.

When we are deciding how much to walk, the ACSM recommendation of 30-60 minutes of moderate intensity exercise at least 5 days of week could be useful. But what is walking at a moderate intensity? The intensity level is relative to your ability level. What might be a leisurely pace for some might be hard for others. A moderate intensity walk could also be described as a “brisk” walk. This is a pace that is beyond what we would normally do in our everyday activities. If orthopedic or balance issues prevent walking at a pace that is somewhat challenging, walking up a hill or using an incline on the treadmill is an effective way of increasing exercise intensity.

When walking with a purpose, it is important to consider safety. Don’t go at a pace that is beyond your ability and comfort, or walk in an environment that challenges our balance too greatly. You can try to progress over time by walking longer durations with a pace that is slightly above the speed in which you normally walk.

Fun Fact: The distance from Building 1-Building 5 in the hallway is 1172 feet, which means that 4.5 lengths of the hallway is roughly a mile. The hallway is a great avenue to walk with a purpose, as it is easy to keep track of the distance you cover!
Aging Prayer
~By Sister Carole Kimes
~Submitted By Chaplain Jeff Payne

Oh, God, awaken within me the gift of these years.
Teach me to trust so I can face my fears.
Teach me to “be” so I can live.
Teach me to receive as in this I also give.

Let me slow down, savor the moment
Then I can hear your whispers spoken.
Help me to embrace this “sage-ing”
And share it with the youthful aging.

Grace me with humility
And lead me to your tranquility.
For in this utter surrender,
I come to accept your grace so tender.

Give me courage to face my unanswered questions.
Guide me to the soul-filled suggestions.
Balance has always been a challenge.
Create it in me as my life re-arranges.

Loosen my grip, set my spirit free
So I can discover who I’m called to be.
It’s not easy to lose independence.
But I want to trust it’s for greater transcendence.

How grateful am I for the gifts I receive?
Deepen my faith so I can always believe.

Aging well has no map.
Just be my source to bridge the gap.

Amen.

(Originally published in the Fall 2015 issue of HOPE magazine.)

The prayers included on this website are the creative property of the Sisters of Providence, unless otherwise noted. Permission for sharing these prayers in small groups is granted. Please credit the individual or the Sisters of Providence of Saint Mary-of-the-Woods, Ind. Website for Sisters of Providence of St. Mary of the Woods, Indiana: https://spsmw.org/prayer/aging-prayer/