STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255301	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON, LLC D/B/A THE CARRINGTON	307 REED RD STARKVILLE, MS 39759

(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 recertification survey at the facility from 2/6/24 through 2/8/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and deficiencies were cited at F584 and F880. The census at the time of the survey was 54, and the facility was licensed for 60 beds at the time of survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		4/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2024

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 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.

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide a safe homelike environment in resident rooms as evidenced by furniture being in poor condition observed on one (1) of three (3) halls during the survey. Findings include: Record review of a statement on facility letterhead, undated and signed by the facility Administrator revealed "(Proper Name of Facility) does not have a written policy at this time on environmental cleanliness or maintenance of the environment fixtures within the facility that would support providing a homelike environment." An observation, on 2/6/24 at 1:15 PM, revealed the bedside tables, dresser, and closet doors were scuffed and in poor condition in Room 105. The furniture was medium brown in color. The	F 584	F584 I. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility has repaired and refinished the furniture in resident room 105to be a safe, homelike environment. There were no negative outcomes from this alleged deficient practice. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. III. What measures will be put into place	

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F 584	Continued From page 2 edges of the top of the A bedside tables were worn to a a light beige color and had rough areas. The B bedside table corner was rough with tiny splinters and the drawer pull for the top drawer was missing. The closet doors had numerous areas where varnish was scuffed off and the lower edge of the closet doors had an area that measured two (2) feet from the bottom that had rough gouges. The dresser in the room had numerous 1 to 3 inch scuffs and scrapes over it. An observation and interview, on 2/7/24 at 12:20 PM, with Certified Nursing Assistant (CNA) #1 confirmed the rough edges on the bedside table. She stated that the rough edges could cause an abrasion or someone could get a splinter from it. An observation and interview on 2/7/24 at 3:15 PM, with the Administrator (ADM) confirmed the condition of the furniture and stated that all of the furniture in the building needed to be replaced to provide the residents with a nice and safe homelike environment. An interview, on 2/8/24 at 10:30 AM, with the ADM revealed the facility did not a have a policy at this time on environmental cleanliness or maintenance of environmental fixtures within the facility that would support providing a homelike environment and provided a statement reflecting there was not a policy for environmental cleanliness.	F 584	or systemic changes made to ensure that the deficient practice will not recur? On February 26, 2024, the facility repaired and refinished the identified furniture in resident room 105. On February 26, 2024, a complete inspection of all furniture in resident rooms of the facility was done by the housekeeping supervisor and administrator. Any furniture found to not provide for a safe, homelike environment was addressed for repairs and refinishing to be completed by March 08, 2024, by the Housekeeping and Maintenance supervisor. An inservice was held with all staff on February 23, 2024, instructing all staff to notify the maintenance director or administrator anytime they see furniture in need of repair by logging the needed repairs on the maintenance log located at the nurse□s station. The Maintenance Director will check the maintenance log daily (Monday □ Friday) beginning February 26, 2024, and will make repairs daily as reported. The facility will sign a contract by March 15, 2024 for the purchase of new furniture for all resident rooms throughout the facility. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Beginning February 26, 2024, the administrator and housekeeping	

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F 584	Continued From page 3	F 584	supervisor will make rounds throughout resident rooms on a weekly basis for twelve weeks or until new furniture arrives to ensure all resident room furniture is maintained and safe for resident use. All negative findings will be brought to the Quality Assurance Committee monthly beginning March 19, 2024, for three months.	
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 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 §483.70(e) 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:	F 880		4/1/24

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F 880	Continued From page 4 (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 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:	F 880		

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F 880	Continued From page 5 Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the possible spread of infection as evidenced by placing a pulse oximeter in a nurse's uniform pocket during a medication pass for one (1) of three (3) nebulizer treatments observed. Resident #31 Findings include: Record review of the facility policy titled, "Cleaning and Disinfection of Resident Care Equipment", undated, revealed "Policy: Resident care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations in order to break the chain of infection..." An observation, during medication pass, on 2/7/24 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #1 administered a nebulizer treatment to Resident #31. LPN #1 entered Resident #31's room with medications on a tray. She placed the tray on the over bed table and then removed a pulse oximeter from her uniform pocket and checked the resident's oxygen saturation level and pulse. She then removed the oximeter and placed it back in her uniform pocket. She removed the meter from her pocket and rechecked the oxygen saturation when the nebulizer treatment was complete. She put the pulse oximeter back in her pocket and continued with her medication pass. LPN #1 did not clean the pulse oximeter before or after use on the resident. Upon return to the medication cart, LPN #1 cleaned the medication tray and placed it back	F 880	F880 I. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice. On February 8, 2024, the Assistant Director of Nursing performed an inservice with nursing staff on infection control and the cleaning of equipment between residents. LPN #1 signed that she attended the inservice. On February 16, 2024, LPN #1 was given another 1:1 inservice on infection control and the importance of cleaning equipment between residents. Resident #31 was assessed by the Nursing Supervisor on February 8, 2024. There were no adverse outcomes identified by this alleged deficient practice. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. The facility has determined that any residents, who receive pulse oximeter checks, have the potential to be affected. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On February 8, 2024, the Assistant Director of Nursing performed an inservice with nursing staff on infection control and the cleaning of equipment	

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F 880	Continued From page 6 in the cart but left the pulse oximeter in her pocket. A telephone interview on 02/08/24 at 8:50 AM, with LPN #1 confirmed the pulse oximeter was in her pocket. She stated that she keeps it in her pocket until she gets in the room. When asked by the surveyor if that could cause any problems, she stated it could if her pockets were dirty. She stated she remembered gloves should not be in your pockets, but she didn't think about the pulse oximeter. She stated that could pass germs to the resident. An interview, with LPN #2 on 02/08/24 at 08:56 AM, revealed that she cleans the pulse oximeter at the beginning of her shift and then cleans it between each resident. She stated that she never puts it in her pocket because they are dirty and would contaminate it. An interview, on 02/08/24 at 09:07 AM with the Director of Nursing (DON) stated the pulse oximeter should be cleaned and ready for use at the beginning of the shift and cleaned again when staff exit the resident's room after use and stored on the cart. It should not be in the staff's pocket at anytime. Record review of the Physician Orders List for Resident #31 revealed an order date of 2/1/14 under "Special Requirements with Brief Instructions: ... Document O2 (oxygen) Sat (saturation) before and after respiratory treatment..." Review of the In-service Form dated 11/06/23, titled "Weekly Infection Control-Nurses and CNA's" revealed "...Maintain clean and operable	F 880	between residents. LPN #1 signed that she attended the inservice. On February 16, 2024, LPN #1 was given another 1:1 inservice on infection control and the importance of cleaning equipment between residents. Beginning February 26, 2024, weekly observations of pulse oximeter checks will be done by the Director of Nursing, Assistant Director of Nursing or Registered Nurse Supervisor with three nurses and findings documented for twelve weeks. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Beginning February 26, 2024, weekly observations of pulse oximeter checks will be done by the Director of Nursing, Assistant Director of Nursing or Registered Nurse Supervisor with three nurses and findings documented for twelve weeks. Any negative findings will be brought to the Quality Assurance Committee monthly beginning March 19, 2024, for three months.	

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F 880	Continued From page 7	F 880		

equipment and to prevent growth and spread of bacteria in our facility ..." Review of the list of attendees revealed LPN #1 attended the in-service.

Review of the in-service form dated 11/06/23, titled "Weekly Infection Control-Nurses and CNA's" revealed it's purpose was to maintain clean and operable equipment and to prevent growth and spread of bacteria in the facility. Review of the list of attendees revealed LPN #1 attended the in-service.

Review of the facility Face Sheet for Resident #31 revealed an admission date of 10/25/2019 with diagnoses that included Chronic Obstructive Pulmonary Disease.

Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #31 was cognitively intact.