STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255301	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON, LLC D/B/A THE CARRINGTON	**307 REED RD BOX 908, STARKVILLE, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 12/01/25 through 12/03/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited, F656, F677, F689, and F812. The census at the time of the survey was 54 and the facility is licensed for 60 beds.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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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F0656 SS = D	Continued from page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, family and staff interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive care plan for routine hair hygiene and facial hair removal for three (3) of 19 care plans reviewed. Resident #1, Resident #25 and Resident #29 Findings Include: Review of the facility policy titled “Care Plans” revised 2/20/2020 revealed under, “Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care.” Resident #1 Record review of the “Care Plan Report” for Resident #1 revealed under, “Focus: I require extensive assist with all of my Activities of Daily Living (ADL) care related to physical and cognitive limitations secondary to absence left leg below the knee, and dementia.” There were no listed interventions/tasks to address personal hygiene care.	F0656		

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F0656 SS = D	Continued from page 2 During an observation of Resident #1 on 12/02/2025 at 8:50 AM, she was sitting in her wheelchair in the dining room. The resident had prominent gray facial hair growth along the upper lip and scattered coarse gray hairs on the chin measuring approximately (one-half) 1/2 inch in length. Further observation revealed the resident's hair was long and visibly oily. During an observation and interview with Certified Nurse Aide (CNA) #1 on 12/02/25 at 11:10 AM, she confirmed Resident #1's hair was "greasy and oily" and stated the resident's facial hair was also long and had been present on her face for some time. An interview with the Minimum Data Set (MDS) Nurse #1 on 12/03/25 at 10:45 AM revealed the purpose of Resident #1's care plan was to inform the staff of what specific care to provide. She confirmed the care plan was not developed for personal hygiene related to hair care and facial hair and stated it should have been. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/05/24 with medical diagnoses that included Unspecified Atrial Fibrillation and Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #1 was cognitively intact. Resident #25 Record review of Resident #25's "Care Plan Report" revealed that she had an ADL self-care deficit and/or mobility deficit related to Hemiplegia of the Right Dominant Side with interventions that included partial to moderate assistance with oral hygiene and facial care as desired by resident. On 12/02/2025 at 8:25 AM an observation and interview with Resident #25's spouse revealed the resident sitting up in her wheelchair eating breakfast with her spouse at her side. She had multiple white hairs to her chin and upper neck and scattered black hairs above her upper lip. Resident #25's spouse revealed that she was	F0656		

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F0656 SS = D	Continued from page 3 particular with her facial hair and liked to keep it shaved off. He stated, "She would feel a whole lot better if they would keep her shaved." On 12/02/25 at 11:33 AM during an observation and interview with LPN #1, in Resident #25's room, she confirmed that the resident had multiple white facial hairs on her chin, upper neck and had black hairs scattered above her top lip. LPN #1 revealed that her facial hair should be removed during her shower time and confirmed that Resident #25 had not been shaved in a while. LPN #1 asked Resident #25 if she wanted her facial hair removed and she stated, "Yes." An interview on 12/02/25 at 11:56 AM with MDS Nurse #2, revealed that she was responsible for updating care plans. She revealed that the purpose of the care plan was to identify resident-specific needs and wishes and to formulate the plan of care so that all staff members knew how to take care of each resident. MDS Nurse #2 observed Resident #25's care plan and confirmed that her care plan included the removal of facial hair, and that the care plan was not followed. Record review of Resident #25's "Admission Record" revealed an admission date of 01/08/19 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side and Aphasia Following Cerebral Infarction. Record review of Resident #25's MDS with ARD of 09/15/25 under Section C, revealed a BIMS Score of 10 which indicated that she had moderate cognitive deficits. Resident #29 Record review of Resident #29's "Care Plan Report" revealed that he required supervision assist with his ADL care related to Muscle Weakness. On 12/01/25 at 10:50 AM, an observation revealed Resident #29 sitting in his wheelchair alone in his bathroom in front of the mirror and he was shaving himself with a regular disposable razor.	F0656		

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F0656 SS = D	Continued from page 4 On 12/02/25 at 10:26 AM during an observation and interview with Licensed Practical Nurse (LPN) #1, she confirmed that there were two disposable razors in Resident #29's bathroom. She revealed that he should not have regular razors in the room with him due to a risk of cutting himself or the risk of other residents coming in and taking them. She also revealed that Resident #29 required supervision with shaving, he was on blood thinners and had a risk for bleeding. On 12/02/25 at 10:40 AM an interview with Registered Nurse (RN) Supervisor, revealed that the residents did not shave themselves at all with a regular razor and that the CNAs should do that during ADL care when they showered. An interview with MDS Nurse #2 on 12/02/25 at 11:56 AM reviewed Resident #29's Care Plan and confirmed that he required supervision assistance with his ADLs and she confirmed that since he shaved himself without supervision, his care plan was not followed. Record review of Resident #29's "Admission Record" revealed an admission date of 04/30/25 and that he had diagnoses that included Stage 5 (five) Kidney Disease, Type II Diabetes Mellitus, and Unspecified Atrial Fibrillation. Record review of Resident #29's "Order Summary Report" revealed an order dated 05/05/25 for Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 (one) tablet by mouth two times a day related to Unspecified Atrial Fibrillation. Record review of Resident #29's MDS with ARD of 11/03/25 under Section C, revealed a BIMS Score of 99 which indicated that he was unable to complete the interview.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by:	F0677		

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F0677 SS = D	Continued from page 5 Based on observation, family and staff interview, record review, and facility policy review, the facility failed to provide personal grooming, including removal of facial hair and routine hair care for two (2) of four (4) residents reviewed for activities of daily living (ADLs). Resident #1 and #25 Findings Include: Review of the facility policy "Activities of Daily Living (ADLs)" with revised date of 01/19/15 revealed, "Policy Explanation and Compliance Guidelines: ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." Resident #1 An observation of Resident #1 on 12/02/2025 at 8:50 AM revealed she was sitting in her wheelchair in the dining room. The resident had prominent gray facial hair growth along the upper lip and scattered coarse gray hairs on the chin measuring approximately (one-half) 1/2 inch in length. Further observation revealed the resident's hair was long and visibly oily. An observation and interview with Certified Nurse Aide (CNA) #1 on 12/02/25 at 11:10 AM revealed Resident #1 was scheduled to receive a shower during the evening shift. CNA #1 stated it was the responsibility of the aides to wash the resident's hair and address any facial hair during bathing. She described Resident #1's hair as "greasy and oily" and stated the resident's facial hair was long and had been present for some time. An observation and interview with the Director of Nursing (DON) on 12/02/25 at 11:17 AM revealed her expectations were for the aides to shampoo residents' hair and remove or trim female facial hair during bathing. She confirmed Resident #1 had facial hair and her hair appeared greasy at the time of observation. Record review of the "Restorative Nursing Screener/GG Evaluation" dated 10/15/25 revealed Resident #1 was dependent on staff for bathing and required substantial/maximal assistance with personal hygiene.	F0677		

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F0677 SS = D	Continued from page 6 Record review of the “Admission Record” revealed the facility admitted Resident #1 on 9/05/24 with medical diagnoses that included Unspecified Atrial Fibrillation and Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/25 revealed under section C a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #1 was cognitively intact. Resident #25 An observation and interview with Resident #25's spouse on 12/02/2025 at 8:25 AM revealed Resident #25 sitting up in her wheelchair eating breakfast with her spouse at her side. She had multiple white hairs to her chin and upper neck and had scattered black hairs above her upper lip. Resident #25's spouse revealed that she was particular with her facial hair and liked to keep it shaved off. He stated, "She would feel a whole lot better if they would keep her shaved." During an observation and interview on 12/02/25 at 11:33 AM with Licensed Practical Nurse (LPN) #1 in Resident #25's room, she confirmed that Resident #25 had multiple white facial hairs on her chin and upper neck and that she had black hairs scattered above her top lip. LPN #1 revealed that Resident #25's facial hair should be removed during her shower time and confirmed that the resident had not been shaved in a while. LPN #1 also revealed that no one had ever reported to her that Resident #25 refused for her facial hair to be removed. An interview on 12/02/25 at 11:36 AM with the CNA Supervisor, revealed that Resident #25's facial hair should be removed during her shower time and stated, "I wouldn't want to be seen like that with facial hair", and it should be removed. An interview on 12/02/25 at 11:41 AM with Registered Nurse (RN) Supervisor, revealed that personal hygiene included removal of facial hair and that it should be completed during the residents' shower.	F0677		

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F0677 SS = D	Continued from page 7 Record review of Resident #25's "Admission Record" revealed an admission date of 01/08/19 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side and Aphasia Following Cerebral Infarction. Record review of Resident #25's MDS with ARD of 09/15/25 under Section C, revealed a BIMS Score of 10 which indicated that she had moderate cognitive deficits.	F0677		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the environment was free of accident hazards when a resident room was mopped and the floor was left wet, without use of a caution sign for one (1) of 31 occupied rooms and failed to provide adequate supervision for a resident on a blood thinner who was shaving with a disposable razor for one (1) of 19 sampled residents. Resident #29 Findings Include: The facility provided a statement on letterhead that read, “(Proper name of the facility) does not have a specific policy that addresses hazards within the facility.” ROOM 106 An observation during initial tour on 12/01/25 at 10:42 AM revealed Housekeeping #1 mopping the floor inside room 106. After mopping the entire room floor, she moved onto another room and did not place a caution sign to notify the residents, staff, and visitors that	F0689		

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F0689 SS = D	Continued from page 8 the floor was wet. The floor was visibly wet from the doorway entrance and posed a fall hazard. An interview with Housekeeping #1 on 12/01/25 at 10:58 AM revealed when she mopped the resident rooms, she never left a caution sign in place and stated she was not trained to do that. During an interview with the Housekeeping Supervisor on 12/02/25 at 2:53 PM, she revealed Housekeeping #1 was a new employee, but she had been trained to always use caution signs anytime they were mopping, and the floor was wet. She confirmed this should be done so that "nobody falls." RESIDENT #29 An observation on 12/01/25 at 10:50 AM, revealed Resident #29 sitting in his wheelchair in his bathroom in front of the mirror and he was shaving himself with a regular disposable razor. An observation on 12/02/25 at 8:30 AM revealed two disposable razors in Resident #29's bathroom setting on the right corner of the countertop next to the sink. During an observation and interview on 12/02/25 at 10:26 AM with Licensed Practical Nurse (LPN) #1, she confirmed that there were two disposable razors in Resident #29's bathroom. She confirmed that he should not have regular razors in the room with him due to the risk of cutting himself and that he was on blood thinners and had a risk of bleeding. An interview on 12/02/25 at 10:40 AM with Registered Nurse (RN) Supervisor, revealed that the residents did not shave themselves at all with a regular disposable razor. She revealed that the residents were assisted with shaving during shower times and that he should not have regular disposable razors in his bathroom and confirmed that he cannot shave himself unsupervised because he is on a blood thinner. She also revealed that she wasn't sure why he was shaving himself or how he got those razors. RN Supervisor confirmed that having regular razors in his room was hazardous and an accident waiting to happen and they needed to get him an electric razor that he could use safely.	F0689		

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F0689 SS = D	Continued from page 9 During an interview on 12/02/25 at 3:35 PM with the Administrator, he confirmed that it was a hazard for Resident #29 to have access to regular razors to shave himself. He also confirmed that Resident #29 required supervision while shaving due to his risk of bleeding from being on anticoagulants. Record review of Resident #29's "Admission Record" revealed an admission date of 04/30/25 and that he had diagnoses that included Stage 5 (five) Kidney Disease, Type II Diabetes Mellitus, and Unspecified Atrial Fibrillation. Record review of Resident #29's "Order Summary Report" revealed an order dated 05/05/25 for Eliquis Oral Tablet 2.5 MG (milligrams) (Apixaban) Give 1 (one) tablet by mouth two times a day related to Unspecified Atrial Fibrillation. Record review of Resident #29's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/03/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) Score of 99 which indicated that he was unable to complete the interview.	F0689		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812		

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F0812 SS = F	Continued from page 10 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review the facility failed to properly store and label opened food items in the refrigerator for one (1) of three (3) kitchen tours. Findings Include: Review of the facility policy "Storage of Refrigerated Food" with revised date of 10/08 revealed "...5. All non-hazardous, opened foods are labeled with name of food, date stored and use-by date. 6. All hazardous foods are labeled with name of food and date to be discarded or the date stored..."An observation during the initial tour of the kitchen on 12/01/25 at 10:25 AM, revealed three (3) six- ounce packages containing lunch meat that were opened and not labeled or dated. During an interview on 12/01/25 at 10:30 AM with Dietary Cook, she confirmed that the three packages of lunch meat were not dated or labeled. She identified the meat as one package of roast beef, one package of turkey bologna, and one package of turkey ham. She revealed that the meat packages were opened a couple days ago but she could not recall the exact date. Dietary Cook revealed that the kitchen staff were supposed to label and date food items when they opened them and supposed to dispose of opened meat within four days of opening. She revealed that failing to label and date food items when opened could cause residents to receive spoiled food which could cause food poisoning and other food borne illnesses. An interview on 12/01/25 at 10:40 AM with Dietary Manager revealed that they were supposed to date and label any food items when they were opened. She confirmed that there were three packages of undated, unlabeled lunch meat in the refrigerator and stated, "This could cause residents to get sick." Dietary Manager revealed that they had in-serviced kitchen staff on dating and labelling open food items and they had signage up reminding them to do so, but sometimes it still got missed. She revealed that the purpose of dating and labeling opened stored foods was to keep track and know when to dispose of food items that might be spoiled, containimg bacteria growth to prevent food bourn illnesses throughout the facility. She revealed that she would do better about checking behind the kitchen staff to ensure foods are properly dated, stored and labeled.	F0812		