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 04/09/2026

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 a Facility Reported Incident Compliant Investigation (CI MS #2801232) at the facility from 4/8/26 through 4/9/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA investigated the complaint for abuse and cited F550 related to resident rights. The census at the time of the survey was 58 with a license held for 60 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F0550		

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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F0550 SS = D	Continued from page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation of video footage, staff and resident interviews, record review, and facility policy review, the facility failed to honor a resident's right to be treated with dignity and respect for one (1) of seven (7) residents sampled. Resident #1 Findings include: Record review of facility policy titled, “Resident Rights” dated 10/24/22, revealed, “...The resident has a right to be treated with respect and dignity...” Review of video footage of the incident dated 3/10/26 at 10:07 AM revealed Resident #1 was propelling his wheelchair near the front door in the main hallway, and he turned to go back down the hall. He was on the same side of hall as Certified Nursing Assistant (CNA) #1, who was standing in the beauty shop doorway which was located approximately halfway down that hall past multiple offices. The resident approached the beauty shop door where CNA #1 was standing. He slowed his speed and looked into the doorway. Both hands of Resident #1 were on the wheelchair wheels. As he slowed, CNA #1 hit the brim on his cap with a light to moderate force which caused the resident’s head to be pushed down towards his chest slightly. Both of his hands were still on his wheelchair wheels and at that point, the resident removed his right hand from the wheel and used his arm to elbow CNA #1 in her thigh/hip area. The video revealed the resident did not touch CNA #1 until she popped his cap brim. During a phone interview on 4/8/26 at 2:13 PM, CNA #1 revealed that Resident #1 hit or brushed against her butt and grabbed her shirt and bra strap and she tapped his cap brim to get him to let go. She acknowledged she had been in-serviced on abuse, neglect, resident	F0550		

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F0550 SS = D	Continued from page 2 rights, and dementia care and she should have used her dementia training and backed up from the resident rather than agitating him. She stated she watched the video footage, but still thought Resident #1 was in the wrong by hitting her butt, even though video footage revealed his hands did not leave the wheels of his wheelchair until after his cap was hit by CNA #1. An interview with Resident #1 on 4/8/26 at 2:10 PM, revealed he had an altercation with CNA #1 when she hit the brim of the cap he was wearing and she blamed him for initiating the altercation. When speaking of the event with CNA #1, Resident #1 revealed that “She always does things like that and I don’t like it and she knows I don’t play like that, but she keeps doing it”. He stated “I should be treated right, and it wasn’t right for her to do that to me”. He stated that CNA #1 blamed the altercation on him even though she was the one that started it and he was glad there was camera footage that proved what occurred. He acknowledged he did not feel abused, but he felt that she failed to treat him with respect. During an interview on 4/9/26 at 11:40 AM, the Director of Nursing (DON) acknowledged that each resident had the right to be treated with dignity and respect and when CNA #1 initiated an altercation with Resident #1, the facility failed to honor this right. An interview with the Administrator on 4/9/26 at 11:50 AM, revealed each resident has the right to be treated with dignity and respect. He acknowledged that a staff member initiated an altercation with a resident which did not honor the resident’s rights. He confirmed the facility failed to honor the rights of Resident #1 to be treated with dignity and respect. Record review of in-service titled “Resident Rights” revealed CNA #1 completed this training on 1/30/26. Record review of Resident #1’s “Admission Record” revealed the facility admitted resident on 10/22/19, with diagnoses that included surgical amputation of leg and Type 2 Diabetes Mellitus. Record review of Resident #1’s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was intact cognitively.	F0550		