Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA investigated the complaint for abuse and cited M500. The census at the time of the survey was 58 with a license held for 60 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be	M0500		

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

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M0500	Continued from page 1 limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the	M0500		

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M0500	Continued from page 2 emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M0500		

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M0500	Continued from page 3 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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 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	M0500		

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M0500	Continued from page 4 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.	M0500		