

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53TC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/21/2021
NAME OF PROVIDER OR SUPPLIER CARRINGTON, LLC D/B/A THE CARRINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
{M 000}	Initial Comments The State Agency (SA) conducted a complaint survey from 5-10-21 to 5-12-21. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for the Institutions for the Aged and Infirm. Based on an acceptable POC and desk review completed on 6/21/21, the facility is in substantial compliance effective 6.21.21.	{M 000}		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/02/21