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 _____	C 05/12/2021

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 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 requirements of participation in Medicare and Medicaid. The SA substantiated the complaint MS#17791 for Verbal Abuse and cited F600, and substantiated MS#16671 for Admission, Transfer and Discharge Rights with no deficiency cited. The following complaints were not substantiated, MS#17494 for residents left wet and callbells not answered, MS# 17731for physician and resident representative not notified of change in resident condition, and MS#17732 for resident representative not notified of change in resident condition. The facility's census was 55 at the time of the survey.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		6/21/21

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

Electronically Signed | 06/04/2021

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F 600	Continued From page 1 Based on resident interview, staff interview, record review and facility policy review, the facility failed to prevent the verbal abuse of one (1) of twenty-three (23) residents reviewed for abuse, Resident #1. Findings Include: Review of the facility's policy titled, "Abuse Program", dated 05-23-2017, revealed, "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect. Each resident has the right to be free of verbal, sexual, physical and mental abuse, neglect, exploitation, misappropriate of resident property, and involuntary seclusion... Definitions: ... Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident..." Review of Resident #1's Face Sheet revealed he was admitted to the facility on 10-22-2019 with diagnoses of Metabolic Encephalopathy, Pneumonia, Chronic Kidney Disease, Diabetes, History of Alcohol Abuse, Hyperlipidemia, and Hypertension. Review of Resident#1's most recent Minimum Data Set (MDS) dated 03-18-2021, revealed his Brief Interview of Mental Status (BIMS) score to be 15, which makes him cognitively intact and able to answer questions appropriately. He requires extensive assistance of one staff member for his Activities of Daily Living (ADL's).	F 600	1. Resident #1 was assessed on May 2, 2021 by the Registered Nurse Supervisor (RN) #1. Assessment revealed Resident #1 stated that he (Resident #1) had not been scared or felt threatened during the incident&just that he was mad that she (C.N.A. #1) had come in there like she did. Resident #1 continued his normal, daily routine without interruption. No sign or symptoms of any mental, emotional, or physical abuse noted. No adverse outcomes were identified to Resident #1 related to the alleged deficient practice of failure to prevent verbal abuse. An investigation was conducted by the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the allegation of verbal abuse that allegedly occurred between Resident #1 and the Certified Nursing Assistant (C.N.A.) #1 on May 2, 2021 at approximately 8:00 am. The RN #1 intervened and C.N.A. #1 was removed from the resident□s room and off the floor at the time of the incident. After interviewing Resident #1 regarding the incident, RN #1 interviewed C.N.A. #1. After C.N.A. #1□s interview, RN #1 escorted C.N.A. #1 to the time clock and out of the facility: C.N.A. #1□s time card shows she clocked out on May 2, 2021 at 8:30 am. As a result of the investigative findings by the NHA and DON, C.N.A. #1 was terminated on May 5, 2021. 2. The facility has determined that any resident has the potential to be affected by the identified practice.	

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F 600	Continued From page 2 Review of the facility's "Reportable Incident Form" dated 05-05-2021, revealed on 05-02-2021 at approximately 8:00 AM, Certified Nurse Aide (CNA)#2 and CNA#3 were in Resident #1's room assisting he and his roommate with their breakfast trays, when CNA#1 stepped into the room and stated the room "smelled like sh**". CNA#1 went to hand Resident #1 a cup of coffee, and he hit it out of her hand causing it to spill on the floor, and stated, "I don't want shit from you". A verbal exchange of words occurred between Resident #1 and CNA#1, and she stepped out into the hallway and yelled for the supervisor and said, "Y'all better come and get this M****** F*****before I beat his M***** F******* a**. Ima be on his a** like white on rice." Registered Nurse (RN) #1 arrived in the room, escorted CNA#1 out and down the hallway, and came back to interview Resident #1. CNA#1 was suspended and walked out to the time clock and out the door. CNA#1 was terminated following the complete investigation and not allowed back on the property. On 05-11-2021 at 11:15 AM, during an interview with the Administrator, concerning this incident, she stated CNA #2, and CNA#3 were passing out breakfast trays. CNA#1 came into the room with a cup of coffee and on her way in the door, told Resident #1 his room "smelled like sh**". He got upset and offended at what she said, and hit the cup of coffee out of her hands and onto the floor. He told her he "didn't want sh** from her." There was a verbal exchange between the two of them, and CNA#1 stepped outside the doorway into the hallway and starting yelling for the RN Supervisor stating, "Y'all better come and get this M*****F***** before I beat his M***** F****** a**.	F 600	3. Facility staff were in-serviced on May 2, 2021 by the Nursing Home Administrator (NHA) regarding Abuse and Neglect including a pre and post test. Local Ombudsman to provide a directive in-service re: Free from Abuse and Neglect to facility staff by June 11, 2021. 4. The Director of Nursing Services or Social Service Director will conduct weekly audits consisting of one (1)resident who resides on the 100 Hall, of two (2) residents who resides on the 200 Hall, and of two (2) residents who resides on the 300 Hall for four (4) consecutive weeks beginning the week of June 7, 2021. These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. Findings of this audit and this plan of correction will be monitored at the monthly Quality Assurance meeting starting June, 2021 then x3 months thereafter or until such time Quality Assurance Committee determines consistent substantial compliance is met . 5. Corrective action completion date: June 21, 2021.	

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F 600	Continued From page 3	F 600		

Ima be on his a** like white on rice." RN#1 arrived in the room, and removed CNA#1, and took her down the hallway. She came back and asked Resident #1 what had happened. Once she heard the whole story, she escorted CNA#1 to get her things, and then took her to the time clock and escorted her out of the building. The Administrator stated CNA#1 had worked for her before and she never acted out like that. She never had any complaints about her care or attitude.

On 05-12-2021 at 10:30 AM, during an interview with CNA#2, she stated, she and CNA#3 were passing out breakfast trays in Resident #1's room.They were helping pass out the trays, however, that room was not on their assignment sheets, it was CNA#1's room. While they were setting up the trays, CNA#1 walked into the room with a cup of coffee and said the room "smelled like sh**." Resident #1 and CNA #1 were going back and forth at each other, and CNA#3 told them to stop. CNA#1 had coffee and Resident #1 hit it out of her hand. CNA#1 went to the doorway and hollered down the hall to the supervisor, "Y'all better come and get this M***** F***** before I whoop his a**." RN#1 came and got CNA#1 and took her out of the room. CNA#2 stayed with the resident until she came back to talk to him and see what happened.

On 05-12-2021 at 1:00 PM, during an interview with CNA#3, she stated, they were passing out breakfast trays in Resident #1's room for CNA#1, because they were not their residents to take care of that day. They were helping CNA #1 out. "I was fixing a tray and heard bickering back and forth and heard something hit the wall. It was the cup of coffee. I told CNA#1 to leave the room and

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F 600	Continued From page 4	F 600		

calm down. She went out into the hall and called the supervisor and said, "Y'all better come and get this fat M***** F*****, looking like Uncle Phil, before I whoop his M***** F****** a**." The supervisor came to the room and took CNA#1 out and down the hallway, and we didn't see her again after that.

On 05-12-2021 at 2:30 PM, during an interview with Resident #1, he stated another CNA was helping him set up his breakfast tray when CNA #1 walked into the room and told him his room "smelled like pee and sh**." He states he told her, "it didn't smell that way till you came in and if you don't like it, you can leave." Resident #1 stated, she tried to hand him a cup of coffee after that and he hit it to the floor and told her he "didn't want sh** from her now", and to "get her ugly a** out of here." He stated the supervisor had come in because of all the yelling and cussing, and got CNA#1 out of his room. He didn't see her again after that. When asked by the SA if he heard what CNA#1 was yelling about while she was in the hallway, he stated, "yeah, she said somebody better come get me cause she was gonna whip my M****** F******* a**." He stated he was not afraid of her, and didn't feel threatened during the exchange of words. He was just not going to allow her to do him like that and it made him mad that she came in running her mouth.

The SA attempted several times and left voicemail for CNA#1 to return a call for interview. She had not responded and the SA did not recieve a call back from her.

The SA attempted to reach RN #1 for interview, as she was not scheduled to work until the weekend. She had a written statement for the

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F 600	Continued From page 5	F 600		

investigation that revealed, "I was at the nurses station at approximately 8:00 am and heard someone yell from B hall, "Somebody better come get this man." I went down the hall and CNA #1, was standing in resident's room yelling, "he slapped that coffee out of my hand!" I told her to step out of the room and explained to her that's not how to handle the situation appropriately and if there's a problem she needs to come to me." I then asked the resident, (Formal name) Resident #1 what happened. He stated, "she came in here and said it smelled like sh**. It didn't smell like that until she got in here. Yeah, I slapped that coffee out of her hand. I'm not mad about it. I'm not scared of that girl." While in the resident's room, I turned my back and messaged the DON to inform her of (formal name) CNA#1's attitude. I was told to fire her. (Formal name) CNA #1 began to yell while standing outside the resident's room, "I'll beat that M***** F*****'s a**. If he does it again Ima be on his like white on rice!" While standing between the resident and (formal name) CNA #1, I told her she cannot speak to a resident that way and to stay out of that room. She was pushing meal trays at this time back to the dining room. I spoke with the resident and roommate to ensure they weren't upset about the situation. They both stated they weren't bothered about it. I closed the room door. (Formal Name) Licensed Practical Nurse (LPN) #1 and I met CNA #1 coming out of the dining room and told her to come with us to the front office. I explained to her that her attitude and threatening a resident cannot be tolerated and she is fired. (formal name) LPN #1 and I accompanied her down to the nurse's station to gather her belonging. We then walked her to the time clock to clock out and to the front door to exit the facility. She did not make any inappropriate comments at this time. At

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F 600	Continued From page 6 8:35 AM the administrator was notified of the situation." A review of CNA#1's employee file revealed a "Personnel Termination Notice" dated 05-02-2021 which stated, "dc' d (discharged) due to staff to res. (resident) verbal abuse, cursing a resident - verbiage "s--t", "M-F", and threatened to whip his black "a-s"." This form was signed by the administrator on 05-05-2021.	F 600		