

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 C 01/02/2020
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, MS CI #16465 at the facility on 1/2/2020. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate the complaint for inappropriate discharge and Quality of Care issues related to residents being left soiled for extended periods of time and cited no deficiencies. The facility had a census of 56 at the time of the complaint survey. The facility held a license for 60 beds.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE