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	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington, LLC D/B/A the Carrington	307 Reed Rd Starkville, MS 39759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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 #1Findings 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 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.

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 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