STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 two (2) Complaint Investigations (CI MS #23812 and CI MS #23791), at the facility from 1/8/24 through 1/9/24. MS #23812 was investigated related to resident neglect regarding medication administration with no deficiencies cited. CI MS #23791 was investigated related to incontinent care, staffing, and resident neglect. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500, as the facility was unable to resolve grievances related to CI MS #23791 in a manner to prevent them from reoccurring.	M 000		
M 500	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	M 500		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 1	M 500		

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 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 2 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 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;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 3 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 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 Statute is not met as evidenced by: Level II	M 500	Please consider this Plan of Correction as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 4 Based on facility grievance logs, in-service records, staff interviews, and facility policy review, the facility failed to resolve grievances in a manner that would prevent them from reoccurring as evidenced by four (4) out of six (6) months of resident grievance logs of documented residents' grievances related to call lights not being answered and Certified Nurse Aides (CNAs) not making timely rounds to respond to resident needs. Findings include: Review of the facility's policy titled, "Complaint/Grievance Missing Property," undated, revealed, "All residents have the right to voice concerns or complaints, which affect their lives at this facility ... Complaint may be presented to any staff member; the staff member may resolve the issue immediately. If unable to resolve immediately, follow the Complaint Procedure ... The Grievance/Complaint/Missing Property Monthly Tracking Log will be completed by Executive Director on a monthly basis. Any trends, problems identified will be addressed and an action plan initiated." Review of the September Grievance Log revealed a grievance on 9/5/23, regarding call light not being answered timely and staff not making rounds every two (2) hours. Review of the Immediate Response section on the "Grievance Intake/Decision Form" revealed the ED (Education Director) and DON (Director of Nurses) were made aware of the concerns. Review of the section on Summary of Findings, revealed education was provided on customer service and call lights. Further review of the Grievance Log revealed a grievance on 9/18/23	M 500	Manhattan Nursing and Rehabilitation, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission of this plan of Correction is not an admission that a deficiency exists or that the facility agrees that they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. F585 1. Cognitive residents were immediately interviewed on January 9, 2024 by _Activities Director to assess for any concerns or grievances. A total of _72__ were interviewed and there were no grievances voiced or any concerns of unresolved grievances. No Resident had any ill effect from this deficient practice. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was done by the Regional Clinical Operations Nurse on _1/09/2024_ for the Executive Director and Department Head on resolving grievances in a manner that would prevent them from reoccurring. 4. A 100% on audit all grievances within the last 3 months was completed on _1/09/2024_ by Executive Director. Any unresolved issues were immediately addressed. The Executive Director will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 5 regarding customer service and call lights. However, review of the "Grievance Intake/Decision Form," only addressed a resident's request for a shower. Review of the "Educational In-Service Record," dated 9/18/23, revealed an in-service was conducted on answering call lights and customer service. Review of the October Grievance Log revealed a grievance on 10/17/23, regarding a resident in bed, being left with BM (bowel movement) on her. Review of the "Grievance Intake/Decision Form" regarding the 10/17/23 grievance, revealed a resident in bed with BM on her and having to wait a while and having to ask for assistance twice. Review of the Immediate Response section revealed the CNA (certified nurse aide) eventually took care of the resident and the nurse was counseled to provide care if the aide is busy. The Summary of Findings section revealed the resident was soiled and needed incontinent care, the aide was assisting another resident, the nurse made the aide aware of the resident's needs, however, the nurse did not initiate care. The resident received care after the aide finished with the resident she was assisting. On 10/31/23, the Grievance Log revealed another grievance related to resident care, regarding ADL (activities of daily living) care. Review of the "Grievance Intake/Decision Form", dated 10/31/23, revealed a daughter stating that her mother was dirty/wearing a gown and the roommate of the resident complained that nobody checks on them. The Immediate response section, as well as the Summary of Findings sections revealed staff were in-serviced on ADL care. Review of the "Educational In-Service Record,"	M 500	review grievances 5x week x6 weeks beginning 01/09/24 to ensure that grievances are resolved in a manner to prevent them from reoccurring and a follow up is completed for each. Any concerns will be immediately addressed. New interventions will be implemented for reoccurring grievances. Beginning 02/06/2024, Director of Nursing/Assistant Director of Nursing will conduct incontinent rounds on 5 residents 5 times per week for 3 weeks. On January 09, 2024, a 100% call light audit was completed. The Executive Director will begin call light audit 01/09/24, 5x week x3 weeks. The Executive Director will forward the results of the audits to the Quality Assurance Committee. The Quality Assurance Committee will monitor grievances and call lights for 3 months. The Quality Assurance Committee met on 01/22/2024. The next Quality Assurance Meeting will be held 02/27/24 to discuss findings. 5. Completed: February 27, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 6	M 500		

dated 10/31/24, revealed an in-service was conducted on Infection Control and ADLs.

Review of the November Grievance Log revealed a grievance on 11/6/23, related to ADL care and call lights. Review of the "Grievance Intake/Decision form" revealed the resident's family complained that the resident was not being changed timely. The family member stated that on a previous visit on 10/30/23, when she pressed the resident's call, a CNA came into the room, turned the light off and said they would get her CNA, and nobody came back. The Summary of Findings revealed an individual in-service was conducted with a CNA and the Corrective Action section revealed an in-service was conducted on staff making two (2) hour rounds on making rounds. The November Grievance Log also included a grievance, dated 11/14/23, in which a resident complained that her CNA did not check on her during the day. The "Grievance Intake/Decision Form," dated 11/14/23, revealed the resident complained that on 11/13/23, her assigned CNA did not see her much on her shift. The resident stated that her CNA brought in her dinner, and that as all. She stated that her bed was wet, and she was not going to beg for help. The Immediate Response section, as well as the Corrective Action sections revealed that the staff were in-serviced on rounding every two (2) hours and that the assigned Agency CNA would not be allowed to return.

Review of the "Education In-Service Record," dated 11/7/23, revealed an in-service was conducted that included call light response, being sure to answer call lights in a timely manner.

Review of December Grievance Log revealed a grievance dated, 12/18/23, related to call light not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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 500	Continued From page 7	M 500		

being answered. Review of the "Grievance Intake/Decision Form" revealed a resident and her family member complained that her CNA was rude and did not answer her call light timely and was not given water and a shower or bed bath when requested. The Immediate Response revealed that the nurse provided water for the resident and the resident told the Social Worker that she preferred a bed bath for now and was given one on the evening shift. The Corrective Action section revealed that an in-service was conducted on customer service and the CNA was reassigned.

Review of the "Educational In-Service Record," dated 12/20/23, revealed an in-service was conducted on customer service.

In an interview on 1/9/24 at 11:45 AM, with the Licensed Social Worker (LSW), she commented that resident grievances/complaints can be handled by any staff member, as the goal is to resolve the complaint as soon as possible. The Social Worker revealed that during the facility's monthly Quality Assurance (QA) meetings, the staff review the grievances, and the facility generally responds to grievances with in-services and counseling of employees as needed.

In an interview with the Administrator on 1/9/24 at 12:15 PM, she confirmed that she had reviewed the grievances related to call lights, asking for assistance, and residents not being checked on, and that each month, the same resolution was used, that included in-servicing and counseling of staff. The Administrator also confirmed that the grievances are reviewed each month in their QA meetings.