MSDH - Health Facilities Licensure and Certification

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 02/27/2025

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 Complaint Investigations (CIs), MS #27683 and CI MS #27828 at the facility from 2/25/25 to 2/27/25. 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. CI MS # 27828 was investigated regarding assessing, monitoring, and resident safety and M640 was cited. CI MS #27683 was investigated regarding neglect, resident rights and quality of care and there were no citations regarding that investigation.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent accidents and failed to ensure continuous one-on-one supervision resulting in a fall that caused an acute transverse fracture of the lower sacrum, leading to hospitalization for one (1) of two (2) residents reviewed for falls. Resident #1. Findings Include: A review of the facility's policy, "Resident Bill of Rights", revised January 2023, revealed: "Each	M 640	1. Resident # 1 was placed on one to one supervision starting 01/27/2025 was discharged from facility 01/31/2025. Education was provided to certified nursing assistant by the director of nursing on 01/31/2025 to not leave a resident who needs one to one supervision per the plan of care until the next certified nursing assistant is present. 2. All residents at risk for falls who needs one to one supervision are identified as having the potential to be affected by the alleged deficient practice.	3/20/25

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M 640	Continued From page 1 resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life... A. Facility residents shall have the right to: 1...34. A safe environment." A record review of the facility ' s "Supervisor Investigation Summary Form", dated 1/31/25, revealed, "Briefly describe event: On 1/30/25 around 3:30 PM, (Proper Name of Resident #1) was found sitting in the day room, with his clothes on, in front of his wheelchair. The Licensed Practical Nurse (LPN) evaluated (proper name) with no injuries noted. (Proper name) did not reveal any pain. The (LPN) and a therapist assisted resident off the floor and placed him in his wheelchair. (Proper Name) continued to be confused and combative with staff attempting to bite them...The licensed nurse called and notified nurse practitioner regarding the fall with new orders to send to the ER for evaluation. While the nurse was on the phone with Nurse Practitioner (NP), (Proper Name) stood up from his wheelchair and started taking his clothes off... (Proper Name) pulled out his catheter with the bulb intact and started walking out of the day room and into the hallway with no clothes on and, with blood noted to bilateral legs and penis without his Foley catheter...The LPN sat with (Proper Name)..never reported pain and showed (no) signs or symptoms of pain. On 1/31/25, the facility requested a copy of the ER paper...admitted...with diagnosis emphysematous cystitis, prostate enlargement, and a nondisplaced transverse fracture of the sacrum between S4 and S5...Investigation...On 1/30/25, around 3:00 PM...wife and son had just left the	M 640	3. Licensed nurses and certified nursing assistants were inserviced starting 03/07/2025 by the RN supervisor/staff development regarding failure to provide one to one supervision to prevent incidents. 4. Quality Assurance (QA) meetings are held monthly starting 03/20/2025 to review resident falls, interventions in place for residents with falls. The director of nursing will audit residents with falls weekly during falls risk meetings starting 02/27/2025 for completion, interventions, care plan, and kardex weekly times four weeks, every other week times four weeks, then monthly thereafter times six months. Fall audit results will be discussed by the director of nursing at QA meetings monthly times six months with the plan evaluated and recommendations for change to the plan if indicated.	

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facility from visiting...The speech therapist then began working with (Proper Name) in the dining room, and reported he was agitated, hitting the table, and attempting to stand up. The therapist would redirect him to sit back down. After completing her therapy session, the therapist left him sitting at a table with his wheelchair moved close to the table. When the therapist walked down the hall and returned walking by the day room...was standing up with his shirt off. The therapist stopped by day room, put his shirt back on, and moved him back to the table. The nurse had started her medication pass. The therapist left the day room and when she walked back past the day room, (Proper Name) was sitting on the floor in the corner of the room. She alerted the nurse and they assisted him back into his wheelchair..."

A record review of a handwritten statement, dated 1/30/25 at 3:30 PM and signed by LPN #1, revealed, "Resident had a fall in dayroom...DON was called and stated that staff was suppose to be on way to do a one on one with resident."

A record review of the acute hospital information for Resident #1, dated 1/30/25, revealed, "Impression...3. Acute transverse fracture of the lower sacrum..."

A record review of Resident #1's Admission Record revealed that the facility admitted him on 01/17/2025 and his admitting diagnoses included Dementia with behavioral disturbances and Osteoarthritis.

A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2025 revealed that Resident #1 required a staff assessment for cognition, and he

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had short- and long-term memory problems.

On 02/26/2025 at 10:54 AM, during an interview, the Speech Therapist stated that she encountered Resident #1 at approximately 3:00 PM on 1/30/25 and observed him agitated, yelling, attempting to hit, and attempting to get up from his chair. She stated that she redirected him, which was sometimes effective, but upon finishing therapy, she noted that he remained in an agitated state and continued exhibiting the same behaviors. She explained that she did not notify staff about his behaviors before leaving because she assumed they were observing him through the window and that supervision was being provided.

On 02/26/2025 at 12:20 PM, during a phone interview, Certified Nursing Assistant (CNA) #1 stated that when she arrived for her shift on the morning of 01/30/2025, the staffing coordinator assigned her to one-on-one supervision with Resident #1 on the first floor due to increased agitation and behavioral disturbances. She was later informed that Resident #1 would be moved to the second floor and continued her one-on-one supervision until the end of her shift. CNA #1 stated that before leaving for the day, she informed LPN #1 on the second floor that Resident #1 needed continuous one-on-one supervision, as per instructions from the staffing coordinator.

On 02/26/2025 at 12:55 PM, during a phone interview , LPN #1, who was working the 3:00 PM to 11:00 PM shift on 1/30/25, stated that upon first observing Resident #1, he was in the dayroom with other residents and was supposed to be on one-on-one supervision. However, she did not see any staff member supervising him. She

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M 640	Continued From page 4 stated that she called the Director of Nursing (DON) to inquire about his assigned staff and was informed that CNA #2 was scheduled to provide one-on-one supervision but had not yet arrived. While she was observing the dayroom through the window, she witnessed Resident #1 fall. On 02/26/2025 at 2:14 PM, during a phone interview, CNA #2, who normally worked the 11:00 PM to 7:00 AM shift, stated that he was asked to come in early for the 3:00 PM to 11:00 PM shift to provide one-on-one supervision for Resident #1. However, he did not arrive until 4:08 PM. He stated that another CNA was supposed to stay with Resident #1 until he arrived to ensure continuous supervision, but no staff remained with the resident. On 02/27/2025 at 12:02 PM, during an interview, the DON stated that the fall occurred around or before 3:30 PM on 01/30/2025 in the dayroom on the second floor. She confirmed that Resident #1 was assigned to one-on-one supervision on the first floor earlier that day and that staff were supposed to monitor him in the dayroom until CNA #2 arrived. The DON acknowledged that CNA #2 was late, and no other staff remained to supervise Resident #1, resulting in a lapse in supervision at the time of his fall.	M 640		