STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN COMMUNITY CARE CENTER	**4540 MANHATTAN RD P. O. BOX 1688, JACKSON, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #2703037, CI MS #266694, CI MS # 2670261 at the facility on 12/29/25 thru 12/30/25. CI MS #2703037 and MS #2670261 were investigated for Resident/Patient/Client Abuse. No citations were issued related to CI MS# 2703037. There was a citation related to abuse issued related to CI MS #2670261. CI MS # 266691 was investigated for Resident/Patient Rights and Quality of Care, and no citations were issued. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and deficiency F0607 was cited.The facility held a license for180 beds, with a census of 164.	F0000		
F0607 SS = E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F0607		

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 reverse for further 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

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F0607 SS = E	Continued from page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement its abuse prevention policy to protect residents from potential abuse, ensure proper reporting procedures were followed, and prohibit continued staff contact with residents following credible allegations. Specifically, the facility failed to (1) remove the Certified Nursing Assistant (CNA) from all resident care following multiple potential abuse allegations, (2) conduct a timely and complete investigation into resident and family reports of abuse, and (3) implement interventions to protect residents from further potential abuse. This deficient practice affected two (2) of four (4) residents reviewed for abuse (Residents #1 and #2). Findings include:A review of the facility's "Abuse Components Plan Elder Just Act and Affordable Care Act", dated 10/24/22, revealed, "…The purpose of this policy is to facilitate appropriate… investigation…of actual and/or suspected incidents of abuse…Investigation: Any report of suspected and/or actual resident mistreatment…abuse…will be promptly and thoroughly investigated by facility Administrator or their designee…If an accusation…of resident abuse…is reported, the Administrator or designee will…Identify and interview all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations…Providing complete and thorough documentation of the investigation…Defining how care provision will be changed and/or improved to protect residents receiving services..."At 11:29 AM on 12/29/25, in a phone interview with the Resident Representative (RR) revealed when entering the room on 11/13/25 Resident #1 was very upset indicating he is tired of the people pushing and pulling on him when he asked them to stop. She said he told her the CNA who came to get him up that morning was hurting him, and she that she was pushing on him and hit him in the chest. RR#1 explained that she went to the desk and informed the Licensed Practical Nurse (LPN) Charge	F0607		

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F0607 SS = E	Continued from page 2 Nurse #1 who called the CNA's assigned to him and he then identified the CNA who had done it. She left the facility shortly after and revealed no one from the facility ever followed up to let her know anything about the allegation. At 11:52 AM on 12/29/25, in an interview with the niece of Resident #1, she revealed being in the room when Resident #1 identified CNA #1 as being the one that hit him. She points out that before leaving the facility she asked the nurse to call Rr#1 to give her an update about the incident but says no one called them. At 12:34 PM on 12/29/25, in an initial interview with the LPN Charge Nurse, revealed that when a resident makes any type of complaint about a CNA, her role requires that she moves that CNA away from the resident especially in instances of alleged abuse. She said there are no circumstances that would warrant her not removing the CNA from the resident and allowing them to go back in the resident's room. She said it is important to remove the CNA during the initial allegation even before an investigation because it shows that you respect the resident and makes them feel safe. She said allowing the resident to still have contact with the CNA can cause them to feel afraid as it is the residents right to feel safe. At 12:50 PM on 12/29/25, in an interview with Resident #2 she revealed there is one CNA, who she can't remember her name, that was rough and mean with her on more than one occasion and she has asked that that CNA does not come back to her room because she is afraid the CNA will do something to her. She added, she thought the CNA was banned completely since it was reported to the nurse. However, the CNA still comes in to assist the roommate. Therefore, Resident #2 says she does not sleep while the CNA is in the room caring for her roommate because she does not know what she may try to do to her. At 1:01 PM on 12/29/25, in an interview with Resident #1 he revealed that CNA #1 with the red hair came in his room that morning being rough and mean to him. He said he was cussing at her and getting smart and she was doing the same thing. He said he was telling her that he is tired of the way she keeps pulling and jerking on him when getting him up. He said that is when the CNA balled up her fist and jumped at him like she was going to hit him trying to intimidate him. He said he did not like that and she should not be doing that to him as it is just not right. He adds he weighs only like fourteen pounds and she is much bigger so he can't fight her off of him. He points out that she did	F0607		

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F0607 SS = E	Continued from page 3 not hit him but explained that she motioned she like she was going to as trying to scare him. He says that CNA#1 does still come in his room. At 1:15 PM on 12/29/25, in another interview with the LPN Unit Nurse revealed that it is CNA#1 that Resident #2 said she does not want back in her room. She explained that she can tell when talking with the resident that she afraid of CNA #1. At 1:27 PM on 12/29/25, in an interview with CNA #1 revealed later during her shift, the LPN Charge Nurse called her to Resident #1 room stating the family said she "hit" him. CNA #1 said although that happened, she is currently still going in the resident room to help him. During this same conversation she revealed that she stills goes into Resident #2 room despite how that resident feels to help the roommate. At 1:47 PM on 12/29/25, in a follow-up interview with the LPN Charge Nurse she confirmed that she reported to the Director of Nursing (DON) that the resident and his family indicated CNA #1 was being mean to him. In the same in interview, she confirmed that CNA#1 was still going in Resident #1's room because the resident had not made any more complaints. She also confirmed with the State Agency (SA) that it is part of her role to make the daily CNA assignments, and that she was not aware that CNA #1 was still going into Resident #2's room. At 3:34 PM on 12/29/25, the DON in an interview said does recall that the LPN Charge Nurse reported to her that the resident said the CNA #1 was mean to him like she was in a rush when transferring him to the bed. She indicated that since there are two residents complaining about the same CNA, it should have been better addressed. At 4:00 PM on 12/29/25, in an interview with the RR#2 who is the daughter of Resident #2 she revealed that her mom reported to her that CNA#1 on two separate occasion was rough and mean to her. She added, she asked the LPN Charge Nurse to no longer allow the CNA to enter room and she agreed to do so. RR#2 reports that her mom said CNA#1 is still going in there despite their wishes. At 2:08 PM on 12/30/25, in an interview with CNA #2 she recalled on 11/13/25 while standing up at the nurse's desk with CNA#1 the niece of Resident #1 came up saying Resident #1 told her he was being abused or that we were hitting him.	F0607		

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F0607 SS = E	Continued from page 4 On 12/30/25 at 5:03 PM, In an interview with the Administrator he explained that he encourages all staff to call in reportable allegations. However, he is the facility abuse coordinator. He added that the facility wants their residents to be happy and feel they have a good quality of life so if they feel intimated, afraid or mistreated it is not right. Resident #1 A record review of the Admission Record" reveals the facility admitted the resident on 8/19/25 with diagnosis including Malignant Neoplasm of Unspecified Part of Unspecified Bronchus or Lung, Pain unspecified and Gout. A review of the Minimum Date Set (ARD) with Assessment Reference Date (ARD) of 11/24/25 revealed a Brief Interview Mental Score (BIMS) of three (3). Resident #2 A record review of the "Admission record" reveals the facility admitted the resident on 7/14/25 with diagnoses including Flaccid Hemiplegia Affecting Right Dominant Side and Osteoarthritis of Hip, Unspecified. A review of the Minimum Date Set (ARD) with Assessment Reference Date (ARD) of 10/10/25 reveals a Brief Interview Mental Score (BIMS) of ten (10). A record view of the written statement regarding the allegations from Resident #1 of CNA#1 that was dated 11/13/25 revealed "...Later that evening he told a family member I hit him..."	F0607		