Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/10/2026**

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
M0000	Initial Comments The State Agency (SA) conducted four (4) Complaint Investigations on 2/09/26 through 2/10/26. CI MS #2736315 related to nursing services and residents' rights, CI MS #2734858 related to infection control, CI MS #2711879 related to abuse and residents' rights and CI MS #2704391 related to quality of care and residents' rights. During the survey, the SA determined the facility was in compliance with Minimum Standards for Institutions for the Aged and Infirm state licensure requirements. There were no deficiencies cited.	M0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE