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 **05/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN COMMUNITY CARE CENTER	**4540 MANHATTAN RD , 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 On 5/11/26 through 5/12/26 the State Agency (SA) conducted five (5) Complaint Investigations (CI MS #2800605, CI MS #2975060, CI MS #2975992, CI MS #2993783, and CI MS #2998565). 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 requirements. CI MS #2800605 was investigated related to resident rights and quality of care with no deficiency citations noted. CI MS #2975060 was investigated related to nursing services, accidents/fall and quality of care with no deficiency citations noted. CI MS #2993783 was investigated related to neglect with no deficiency citations noted. CI MS #2975992 was investigated related to nursing services and quality of care and M615 were cited. CI MS #2998565 was investigated related to quality of care and nursing services and M500 was cited.	M0000		
M0500	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 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	M0500		

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

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M0500	Continued from page 1 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, 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	M0500		

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M0500	Continued from page 2 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; 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	M0500		

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M0500	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews and facility policy review the facility failed to ensure call lights were within reach for one (1) of six (6) residents sampled. Resident #2 Findings Included: Record review of the facility policy titled, “CALL LIGHT/CALL PAGER SYSTEMS” with Revision Date 9/09/22, revealed, “Purpose To provide a means of communication to staff for notification of resident needs and a system of communication among staff in the facility; including emergency notifications…All staff…The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.” On 5/11/26 at 12:40 PM, observation revealed the call light for Resident #2 was placed under his bed and came up and over the headboard of his bed, so that the call button was behind the headboard and out of the resident’s reach. On 5/11/26 at 2:00 PM, interview with Certified Nursing Assistant (CNA) #2 revealed that each resident was to have their call light in reach to summon assistance as needed. On 5/12/26 at 4:05 PM, an interview with the Director of Nursing (DON) revealed that she expected call lights to be left within reach of residents and answered in a timely manner. On 5/12/26 at 4:10 PM, an interview with the Administrator revealed that he expected call lights to be left within reach of residents and answered in a timely manner. Record review of the Admission Record for Resident #2 revealed the resident was admitted on 3/20/26 with diagnoses that included dysphagia following cerebral infarction (stroke), diabetes mellitus, gastrostomy status, heart disease, pressure ulcer of the sacral region, and malignant neoplasm of the prostate.	M0500		

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M0500	Continued from page 4 Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/27/26 for Resident #2 revealed the facility assessed the resident as severely cognitively impaired skills for daily decision making, with memory problems and was dependent for all activities of daily living (ADLs) and with all functional abilities.	M0500		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review and interviews the facility failed to ensure ordered wound treatments were administered as prescribed by the physician for one (1) of six (6) residents reviewed for existing skin impairments. Resident #1 Findings Included: Record review of the facility policy titled, “Wound Care” dated 1/09/22 revealed the policy stated, “The purpose of this procedure is to provide guidelines for the care of wounds to promote healing…After completing a thorough evaluation, the interdisciplinary team should develop a relevant care plan that includes measurable goals for prevention and management of PU/PIs with appropriate interventions…Orders should include…Frequency of dressing change…Document dressing change in medical record...” During an interview and observation on 5/11/20/26 at 2:00 PM, an observation with Licensed Practical Nurse (LPN) #1 and Nurse Practitioner (NP) #1 revealed Resident #1 had wound dressings on his sacrum, left lateral calf and left ankle dated 5/09/26. LPN #1 confirmed she had provided wound care for Resident #1 and that the dressings were those she had applied on 5/09/26. LPN #1 confirmed that physician orders specified that the dressings were to be changed daily. Following removal of the dressings, NP #1 stated that the sacral wound appeared to have more slough than it usually did, “when it was changed every day”.	M0615		

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M0615	Continued from page 5 Record review of the Treatment Administration Record (TAR) for May 2026 for Resident #1 revealed no documentation of any wound care for 5/10/26. During an interview on 5/12/26 at 4:05 PM, the Director of Nurses (DON), stated that there were adequate licensed nurses on duty on 5/10/26, including two (2) wound care nurses and a Registered Nurse (RN) Supervisor. She confirmed that based on the dressings identified by LPN #1 dated 5/09/26 and lack of documentation on May 2026 TAR for Resident #1 wound care was not provided for Resident #1 on 5/10/26. She confirmed that the wound care would have “triggered” on the TAR, to notify the wound care nurse for the Second Floor that the resident required wound care on 5/10/26. She confirmed she expected wound care nurses to monitor the TARs and provide wound care as ordered by each resident’s physician and care plan, and that nursing staff would follow each resident’s care plan in the delivery of care. During an interview on 5/12/26 at 4:57 PM, the Administrator revealed he expected wound care nurses to monitor the TARs and provide wound care as ordered by each resident’s physician and care plan, and that nursing staff would follow each resident’s care plan in the delivery of care. Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 4/01/26 and he had diagnoses of dysphagia, hemiplegia and hemiparesis following cerebral infarction (stroke), and stage 4 pressure ulcer of sacral region. Record review of the 5 Day Minimum Data Set (MDS) With Assessment Reference Date (ARD) 3/17/26 for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. Further MDS review revealed the resident had impairment of both arms and legs (upper and lower extremities) and was dependent for all activities of daily living. Record review of the "Order Summary Report" for Resident #1 revealed the resident had physician orders to “Clean stage 4 to (L) (left) lateral ankle...every day shift for wound with a start date of 4/30/26...Clean stage 4 to (L) lateral calf... every day shift for wound with a start date of 4/30/26 and Santyl External Ointment 250 Unit/GM (Collagenase) apply to sacrum topically every day shift... daily… with a start date of 4/26/26."	M0615		