

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2022  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  |                                                                                               |                                                                                                                          |                                                                    |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>255115</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                          |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>12/16/2021</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTAN NURSING AND REHABILITATION CENTER LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4540 MANHATTAN RD</b><br><b>JACKSON, MS 39206</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                                                      | <p>INITIAL COMMENTS</p> <p>The State Agency (SA) conducted a complaint survey, CI MS #18321, CI MS #18310, and CI MS #18371 at the facility from 12/15/21 to 12/16/21. During the survey, the SA did not substantiate the complaints for call lights not answered in a timely manner, water not provided to residents, insufficient staffing, residents being left wet for extended periods, and insects in the dining room. There were no deficiencies cited. However, the facility remains out of compliance due to deficiencies cited on a previous survey.</p> <p>The facility held a license for 180 beds, with a census of 159.</p> |                                                                            |  | F 000                                                                                         |                                                                                                                          |                                                                    |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/06/2022

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 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.