STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #18778, MS #18743, MS #18706 at the facility from 5/10/22 through 5/12/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F609. The SA did not substantiate MS #18778 for pressure sores, MS #18743 for neglect, resident rights, left wet for extended periods, call bells not accessible, and MS #18706 for neglect, resident falls, care not received by physician orders, resident not groomed with odors, administration, resident oversedated, responsible party not notified, and physician not notified of resident change in condition. The facility held a license for 180 beds, with a census of 138.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		6/3/22

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

Electronically Signed | 05/27/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	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) COMPLETION DATE
F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy and procedure review, the facility failed to send the completed investigation in the time allotted to the Office of Licensure and Certification (L&C) for one (1) of eight (8) residents sampled. Resident #1 Findings include: Review of the facility's Policy and Procedure for "Investigation and Reporting of Violations of laws" dated "7/2003" revealed that "REPORTING: A. The Executive Director shall also notify the appropriate state agency in accordance with state law. B. The results of all investigations must be reported to the Executive Director of his/her designee and to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation." Record review of the facility's "Supervisor Investigation Summary Form" revealed an allegation of neglect was reported to the facility on 4/27/22 at 12:30 PM. The facility reported the	F 609	1. Resident 1 was discharged on 4/26/2022 and was not affected by this deficient practice. The failure to submit the timely investigation related to Resident 1 was identified on 5/06/2022 by the Vice president of Operations. The Vice President of Operations immediately provided an In-Service to the Executive Director and the Director of Nursing Services on ensuring to submit investigations timely to the State Agency. 2. All Residents who require investigations for Allegations of Abuse, Neglect, Explotation or Mistreatment have the potential to be affected. 3. The Vice President of Operations Re-In-serviced the Executive Director and the Director of Nursing Services on 5/12/2022 on ensuring to submit investigations timely to the State Agency. 4. The Executive Director will Audit Daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	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) COMPLETION DATE
F 609	Continued From page 2 allegation to L&C on 4/27/22. Record review of facility's transmittal form revealed the facility sent the completed investigation to "facilityreportedincidents@msdh.ms.gov" with the "Date" indicated as "5/6/2022, 3:49 PM". The completed investigation was transmitted to L&C nine (9) days after the event was first reported. Interview with the facility administrator on 5/10/22 at 9:10 AM revealed "We have two (2) hours to report to State Agency any allegations of abuse or neglect. We have 5 days from the phone call to send in the paperwork to the State Agency. That would be the complete investigation. Normally, I send these into Licensure and Certification (L&C). When the Director of Nurses (DON) got the phone call from L&C is when I realized the investigation was late.". He stated the investigation was started for the allegation of Neglect and unsubstantiated. This investigation was started when (name of local hospital) social worker called the director of nurses (DON) and stated the family of Resident #1 was alleging neglect. The social worker also told the DON that the family had called Adult Protective Services to report the facility Neglected Resident Lee. The allegation of neglect was not specific. "We just assumed it was wounds.". Interview with the Administrator Consultant, on 5/10/2022 at 9:08 AM revealed "I did an inservice with the administrator and director of nurses on 5/6/22 when I was notified the investigation had not been sent into Licensure and Certification timely." She then provided an inservice she had completed with the administrator and director of nurses on 5/6/22 regarding reporting allegations	F 609	for 4 weeks to ensure that completed investigations are submitted timely to the State Agency beginning 5/13/2022. Any concerns will immediately addressed and corrected. The Executive Director will forward the results of the audits to the Quality Assurance Committee. The Quality Assurance Committee will determine the frequency or the discontinuation of the Audits based upon the results achieved. This deficient practiced was discussed in the May Quality Assurance Meeting held and the corrective actions put into place to prevent reoccurrence. This meeting was held 05/31/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	**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) COMPLETION DATE
F 609	Continued From page 3 of abuse and neglect within two hours of being notified of the allegation.	F 609		