

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>25MA</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/25/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTAN NURSING AND REHABILITATION CENTE</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>COMPLETE<br>DATE                                           |
| M 000                                                                                 | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI MS #20436) for an injury of unknown origin, (CI MS #19913) for pressure sores, and MS #19895 for improper infection control practices and pressure sores at the facility from 1/24/23 through 1/25/23. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and no deficiencies were cited. | M 000                                                                                         |                                                                                                                          |                                                                    |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

02/16/23