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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Nursing and Rehabilitation Center LLC	4540 Manhattan Rd Jackson, MS 39206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48669 Based on staff interview, record review, and facility policy review, the facility failed to implement a care plan intervention regarding one-on-one supervision for a severely cognitive impaired resident which resulted in an unsupervised fall, leading to an acute transverse fracture of the lower sacrum for one (1) of two (2) care plans reviewed for falls. Resident #1 Findings Include: A review of the facility's policy, Resident [NAME] of Rights, revised January 2023, revealed: Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life . A. Facility residents shall have the right to: 1 .7 .d. The right to receive the services and/or items included in the plan of care . A record review of Resident # 1's Comprehensive Care Plan, dated 1/27/25, revealed . one-on-one observation when family was not present . (continued on next page)

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.

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

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F 0656

Level of Harm - Actual harm

Residents Affected - Few

A record review of the facility's Supervisor Investigation Summary Form, dated 1/31/25, revealed, Briefly describe event: On 1/30/25 around 3:30 PM, (Proper Name of Resident #1) was found sitting in the day room, with his clothes on, in front of his wheelchair. The Licensed Practical Nurse (LPN) evaluated (proper name) with no injuries noted. (Proper name) did not reveal any pain. The LPN and a therapist assisted resident off the floor and placed him in his wheelchair. (Proper Name) continued to be confused and combative with staff attempting to bite them .The licensed nurse called and notified nurse practitioner regarding the fall with new orders to send to the ER for evaluation. While the nurse was on the phone with Nurse Practitioner (NP), (Proper Name) stood up from his wheelchair and started taking his clothes off . (Proper Name) pulled out his catheter with the bulb intact and started walking out of the day room and into the hallway with no clothes on and, with blood noted to bilateral legs and penis without his foley catheter . The LPN sat with (Proper Name) never reported pain and showed (no) signs or symptoms of pain. On 1/31/25, the facility requested a copy of the ER paper .admitted .with diagnosis emphysematous cystitis, prostate enlargement, and a nondisplaced transverse fracture of the sacrum between S4 and S5 . Investigation .On 1/30/25, around 3:00 PM .wife and son had just left the facility from visiting .The speech therapist then began working with (Proper Name) in the dining room, and reported he was agitated, hitting the table, and attempting to stand up. The therapist would redirect him to sit back down. After completing her therapy session, the therapist left him sitting at a table with his wheelchair moved close to the table. When the therapist walked down the hall and returned walking by the day room .was standing up with his shirt off. The therapist stopped by day room, put his shirt back on, and moved him back to the table. The nurse had started her medication pass. The therapist left the day room and when she walked back past the day room, (Proper Name) was sitting on the floor in the corner of the room. She alerted the nurse and they assisted him back into his wheelchair .

A record review of a handwritten statement, dated 1/30/25 at 3:30 PM and signed by LPN #1, revealed, Resident had a fall in dayroom .DON was called and stated that staff was suppose to be on way to do a one on one with resident.

A record review of the acute hospital information for Resident #1, dated 1/30/25, revealed, Impression .3. Acute transverse fracture of the lower sacrum .

A record review of Resident #1's Admission Record revealed that the facility admitted him on 01/17/2025 and his admitting diagnoses included Dementia with behavioral disturbances and Osteoarthritis.

A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2025 revealed that Resident #1 required a staff interview to assess cognition and his short-term and long-term memory was impaired.

During an interview on 02/26/2025 at 10:54 AM, the Speech Therapist stated that she encountered Resident #1 at approximately 3:00 PM and observed him agitated, yelling, attempting to hit, and attempting to get up from his chair. She stated that she redirected him, which was sometimes effective, but upon completing therapy, she noted that he remained in an agitated state and continued exhibiting the same behaviors. She admitted that she did not notify nursing staff about his behaviors before leaving because she assumed they were observing him through the window, leaving him unattended despite his documented care plan for one-on-one supervision.

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NAME OF PROVIDER OR SUPPLIER Manhattan Nursing and Rehabilitation Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4540 Manhattan Rd Jackson, MS 39206	

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/27/2025 at 12:02 PM, the Director of Nursing (DON) stated that the Speech Therapist should have informed staff about Resident #1's increased agitation before leaving the dayroom. She acknowledged that Resident #1 was assigned one-on-one supervision on the first floor earlier that day, and staff were expected to continue monitoring him in the dayroom until Certified Nursing Assistant (CNA) #2 arrived. However, CNA #2 was late, and no one else was assigned to supervise him. During a follow-up interview on 02/27/2025 at 1:01 PM, the DON stated that the care plan is intended to serve as a roadmap for providing care, and failure to follow it means the resident is not receiving the planned interventions necessary for their safety and well-being. During an interview on 02/27/2025 at 1:29 PM, the MDS Coordinator /LPN #3 emphasized that the care plan is essential for guiding staff in delivering appropriate care. She stated that failure to follow the care plan places the resident at risk for harm, particularly in cases requiring close supervision.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48669 Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent accidents and failed to ensure continuous one-on-one supervision resulting in a fall that caused an acute transverse fracture of the lower sacrum, leading to hospitalization for one (1) of two (2) residents reviewed for falls. Resident #1. Findings Include: A review of the facility's policy, Resident [NAME] of Rights, revised January 2023, revealed: Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life . A. Facility residents shall have the right to: 1 .34. A safe environment. A record review of the facility ' s Supervisor Investigation Summary Form, dated 1/31/25, revealed, Briefly describe event: On 1/30/25 around 3:30 PM, (Proper Name of Resident #1) was found sitting in the day room, with his clothes on, in front of his wheelchair. The Licensed Practical Nurse (LPN) evaluated (proper name) with no injuries noted. (Proper name) did not reveal any pain. The (LPN) and a therapist assisted resident off the floor and placed him in his wheelchair. (Proper Name) continued to be confused and combative with staff attempting to bite them .The licensed nurse called and notified nurse practitioner regarding the fall with new orders to send to the ER for evaluation. While the nurse was on the phone with Nurse Practitioner (NP), (Proper Name) stood up from his wheelchair and started taking his clothes off . (Proper Name) pulled out his catheter with the bulb intact and started walking out of the day room and into the hallway with no clothes on and, with blood noted to bilateral legs and penis without his Foley catheter . The LPN sat with (Proper Name) never reported pain and showed (no) signs or symptoms of pain. On 1/31/25, the facility requested a copy of the ER paper .admitted .with diagnosis emphysematous cystitis, prostate enlargement, and a nondisplaced transverse fracture of the sacrum between S4 and S5 . Investigation .On 1/30/25, around 3:00 PM .wife and son had just left the facility from visiting .The speech therapist then began working with (Proper Name) in the dining room, and reported he was agitated, hitting the table, and attempting to stand up. The therapist would redirect him to sit back down. After completing her therapy session, the therapist left him sitting at a table with his wheelchair moved close to the table. When the therapist walked down the hall and returned walking by the day room .was standing up with his shirt off. The therapist stopped by day room, put his shirt back on, and moved him back to the table. The nurse had started her medication pass. The therapist left the day room and when she walked back past the day room, (Proper Name) was sitting on the floor in the corner of the room. She alerted the nurse and they assisted him back into his wheelchair . A record review of a handwritten statement, dated 1/30/25 at 3:30 PM and signed by LPN #1, revealed, Resident had a fall in dayroom .DON was called and stated that staff was suppose to be on way to do a one on one with resident. A record review of the acute hospital information for Resident #1, dated 1/30/25, revealed, Impression .3. Acute transverse fracture of the lower sacrum . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident #1's Admission Record revealed that the facility admitted him on 01/17/2025 and his admitting diagnoses included Dementia with behavioral disturbances and Osteoarthritis. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2025 revealed that Resident #1 required a staff assessment for cognition, and he had short- and long-term memory problems. On 02/26/2025 at 10:54 AM, during an interview, the Speech Therapist stated that she encountered Resident #1 at approximately 3:00 PM on 1/30/25 and observed him agitated, yelling, attempting to hit, and attempting to get up from his chair. She stated that she redirected him, which was sometimes effective, but upon finishing therapy, she noted that he remained in an agitated state and continued exhibiting the same behaviors. She explained that she did not notify staff about his behaviors before leaving because she assumed they were observing him through the window and that supervision was being provided. On 02/26/2025 at 12:20 PM, during a phone interview, Certified Nursing Assistant (CNA) #1 stated that when she arrived for her shift on the morning of 01/30/2025, the staffing coordinator assigned her to one-on-one supervision with Resident #1 on the first floor due to increased agitation and behavioral disturbances. She was later informed that Resident #1 would be moved to the second floor and continued her one-on-one supervision until the end of her shift. CNA #1 stated that before leaving for the day, she informed LPN #1 on the second floor that Resident #1 needed continuous one-on-one supervision, as per instructions from the staffing coordinator. On 02/26/2025 at 12:55 PM, during a phone interview , LPN #1, who was working the 3:00 PM to 11:00 PM shift on 1/30/25, stated that upon first observing Resident #1, he was in the dayroom with other residents and was supposed to be on one-on-one supervision. However, she did not see any staff member supervising him. She stated that she called the Director of Nursing (DON) to inquire about his assigned staff and was informed that CNA #2 was scheduled to provide one-on-one supervision but had not yet arrived. While she was observing the dayroom through the window, she witnessed Resident #1 fall. On 02/26/2025 at 2:14 PM, during a phone interview, CNA #2, who normally worked the 11:00 PM to 7:00 AM shift, stated that he was asked to come in early for the 3:00 PM to 11:00 PM shift to provide one-on-one supervision for Resident #1. However, he did not arrive until 4:08 PM. He stated that another CNA was supposed to stay with Resident #1 until he arrived to ensure continuous supervision, but no staff remained with the resident. On 02/27/2025 at 12:02 PM, during an interview, the DON stated that the fall occurred around or before 3:30 PM on 01/30/2025 in the dayroom on the second floor. She confirmed that Resident #1 was assigned to one-on-one supervision on the first floor earlier that day and that staff were supposed to monitor him in the dayroom until CNA #2 arrived. The DON acknowledged that CNA #2 was late, and no other staff remained to supervise Resident #1, resulting in a lapse in supervision at the time of his fall.