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	09/18/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review the facility failed to provide needed care and services that would meet the resident's physical needs as evidenced by wound care not provided in one (1) of two (2) sampled residents with wounds. Resident #4. Findings include:Record review of the facility policy titled Wound Care Treatment Protocol (no review date) revealed the policy instructed staff to: Evaluate the wound daily for signs and symptoms of infection and for signs of healing. Document/Report Findings. Provide treatment as per physician's order.On 09/17/2025 at 9:22 AM, during an interview Resident #4 stated My wound care should be done every 3 days. It was done on 09/11/25 but not on 09/14/25. They just wipe it with wet gauze and cover it up. It's supposed to be irrigated with Dial soap. There's a doctor who sees wounds, but he's never looked at mine.Record review of Resident #4's electronic Treatment Administration Record (eTAR) for September 2025 revealed a physician order for treatment with a start date of 9/8/2025 Mupirocin External Ointment 2% Apply to left lateral ankle topically every day shift every (3) days for wound. Clean left lateral ankle with normal saline, pat dry, apply Mupirocin, cover with Mepilex every 3 days. The eTAR indicated wound care was provided on 09/11/2025, but not documented as provided on 09/14/2025, as evidenced by the absence of staff initials in the designated treatment box for that date.On 09/17/2025 at 9:34, during an interview the Director of Nursing (DON) revealed that the facility physician typically evaluates wounds, however, Resident #4 refuses the facility physician and instead is seen weekly at the Wound Clinic.On 09/17/2025 12:12 PM, in an interview Licensed Practical Nurse (LPN) #1/ Unit Manager reported that a as needed (PRN) order had been obtained for the prescribed wound care and that she administered the dressing on 09/15/2025. She added that the dressing she removed was not signed, dated, or timed, contrary to protocol.During an interview on 09/17/2025 at 3:15 PM, LPN #2/Treatment Nurse revealed that she was unaware why the wound care was missed on 09/14/2025 and stated that she only works weekdays.During a joint interview on 09/18/2025 at 3:15 PM, the Administrator and Director of Nurses (DON) acknowledged that wound care had not been completed on 09/14/2025 and confirmed their understanding of the importance of adhering to physician orders.Record review of Resident #4's admission Record revealed he was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Non-pressure Chronic Ulcer of Unspecified Lower Limb, and Vascular Dementia. Record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/22/2025 indicated in Section M the presence of a non-pressure ulcer. Section C indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of six (6) sampled residents, Resident #9.On 9/08/25 a newly admitted respite resident with diagnoses of restlessness and agitation, dementia and senile degeneration of brain and history of exit seeking behaviors and falls was assisted to exit the facility by staff, was outside unsupervised for twenty-five (25) minutes until a staff member observed the resident lying on the ground next to the iron fence that encircled the facility premises, approximately three hundred seventy-five (375) feet from the facility entrance.The facility's failure to provide adequate supervision to prevent the elopement of Resident #9 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. While Resident was out of the facility unsupervised in the parking lot and driveway area of the facility at shift change, she was observed laying on the ground.The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to Resident #9's elopement and placed all residents who were admitted with or developed wandering/exit seeking behaviors at risk. This failure resulted in Immediate Jeopardy and Substandard Quality of Care (SQC) which began on 9/08/25. The SA notified the facility's Administrator of the IJ and SQC on 09/17/2025 at 4:15 PM and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 9/9/25, the State Agency (SA) determined the IJ and SQC to be Past Non-compliance (PNC) and the IJ removed on 9/10/25, prior to the entrance of the SA on 9/15/25. Findings include:Record review of the facility policy titled, MISSING RESIDENT/ELOPEMENTS with a review date of 1/15 (January 2015) revealed POLICY: The Unit charge Nurse is responsible for knowing the location of their residents.RESPONSIBILITY: The Charge Nurses and all other staff. PROCEDURE: 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge nurse/CMT as soon as practical. 2. Should an employee observe a resident leaving the premises, he/she should: a. Attempt to prevent the departure; b. Obtain assistance from other staff members in the immediate vicinity, if necessary.Record review of the Progress Notes for Resident #9 dated 9/08/25 revealed that the Director of Nurses (DON) documented, Resident assisted outside by staff.Resident is a new admission to facility 9/08/25. MD/RP notified. New order for wander guard and one on one monitoring.Record review of the Supervisor Investigation Summary Form: (facility investigation) and 9/16/25 observation at 2:06 PM during interview with Certified Nurses' Aide (CNA) #1 revealed that on 9/08/25 at approximately 2:53 PM the (former) Receptionist assisted Resident #9 out the front door. The resident walked around the grounds, sat on a bench for a while and then walked to and up the northwestern driveway toward the street and was located at approximately 3:30 PM laying on the ground on the west side of the northwest driveway, next to the iron fence that circumvented the facility property, approximately fifty-five (55) feet from the street and approximately three hundred seventy-five feet from the facility's front entrance. According to CNA #1 and the facility investigation, Resident #9 was assisted to stand and walk up the incline to a grassy area on the side of the driveway with a wheelchair brought to return the resident into the facility. On 9/16/25 at 2:06 PM, during an observation of the area Resident #9 was located in on 9/8/25 and interview with CNA #1 revealed that on 9/08/25 at approximately 3:15 PM she had gotten into her car after clocking out and was leaving the premises when she observed what she described as looked like a pile of clothes at first laying on the ground inside the northwest corner of the black metal fence that encircled the facility. She stated that as she looked, she realized it was a person lying on the ground. She stated she stopped and summoned assistance. She and CNA #2 assisted Resident #9 to stand and walk to the grassy area uphill and next to the driveway from the area she initially saw her. CNA #1 said that she and CNA #2 routinely worked on the second floor of the facility and were not familiar with the resident, so they asked questions to determine if she was a facility resident. She said that Resident #9 told them that she did not live at the facility, had driven herself to the facility and that her car was on the second floor with her daughter. CNA #1 said that she then summoned the DON and Assistant Director of Nursing (ADON), who identified Resident #1. Staff assisted the resident to return to the facility at approximately 3:25 PM. CNA #1 reported that the weather was clear, dry and warm temperature. CNA #1 described Resident #9 as wearing blue pants, a red/white/blue stripped shirt and a red sweater and house slippers. She said she received in-service training provided by the facility following the elopement and participated in elopement