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	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Community Care Center	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews and facility policy review the facility failed to ensure call lights were within reach for one (1) of six (6) residents sampled. Resident #2.Findings Included:Record review of the facility policy titled, CALL LIGHT/CALL PAGER SYSTEMS with Revision Date 9/09/22, revealed, Purpose To provide a means of communication to staff for notification of resident needs and a system of communication among staff in the facility; including emergency notifications.All staff.The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.On 5/11/26 at 12:40 PM, observation revealed the call light for Resident #2 was placed under his bed and came up and over the headboard of his bed, so that the call button was behind the headboard and out of the resident's reach.On 5/11/26 at 2:00 PM, interview with Certified Nursing Assistant (CNA) #2 revealed that each resident was to have their call light in reach to summon assistance as needed.On 5/12/26 at 4:05 PM, an interview with the Director of Nursing (DON) revealed that she expected call lights to be left within reach of residents and answered in a timely manner. On 5/12/26 at 4:10 PM, an interview with the Administrator revealed that he expected call lights to be left within reach of residents and answered in a timely manner.Record review of the admission Record for Resident #2 revealed the resident was admitted on [DATE] with diagnoses that included dysphagia following cerebral infarction (stroke), diabetes mellitus, gastrostomy status, heart disease, pressure ulcer of the sacral region, and malignant neoplasm of the prostate.Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/27/26 for Resident #2 revealed the facility assessed the resident as severely cognitively impaired skills for daily decision making, with memory problems and was dependent for all activities of daily living (ADLs) and with all functional abilities.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, record review and interviews, the facility failed to provide adequate bed linens to maintain a comfortable, homelike environment for one (1) of three (3) floors. Second Floor.Findings Included:Record review of the facility policy titled, Departmental (Environmental Services) - Laundry and Linen Revised January 2014, revealed, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing and storage of linen .On 5/12/26 at 3:30 PM, observation and interview revealed the Resident Representative (RR) for Resident #4 was assisting Resident #4 by changing the linens on her bed and there were no pillowcases available on the second floor. Interview with the RR revealed that she had experienced lack of clean linens available for the care of Resident #4 several times in the past. On 5/12/26 at 3:55 PM, observation revealed Resident #2 had no top sheet on his bed. He was laying on a fitted sheet under a bedspread.On 5/12/26 at 3:58 PM, interview with Certified Nursing Assistant (CNA) #1 revealed she was aware that Resident #2 had no top sheet on his bed. She stated that he did not have one because there were not any available. She confirmed that the facility did not use clean linen carts and that the CNAs retrieved clean linens from the linen closet as needed. She stated that it was not unusual for the linen closet to be empty of clean linens. She stated that resident's call lights were supposed to be within reach to provide a way for them to summon assistance as needed.On 5/12/26 at 4:00 PM, observation revealed there were no clean pillowcases, fitted or flat sheets, towels or wash clothes in the second-floor linen closet.On 5/12/26 at 4:05 PM, interview with the Director of Nurses (DON) revealed that there had been issues with maintaining clean linens in the clean linen closet.On 5/12/26 at 4:52 PM, interview with the Laundry Supervisor stated, We had emergency linen and an employee was supposed to put it out and didn't. He stated that he was aware that it was the responsibility of the laundry staff to ensure adequate clean linens were delivered to the clean linen closets on each floor for the care of the residents.On 5/12/26 at 4:57 PM, interview with the Administrator revealed he confirmed that it was the responsibility of the laundry staff to ensure adequate clean linens were delivered to the clean linen closets on each floor and he expected them to provide adequate clean linens for the care of the residents. Record review of the admission Record for Resident #2 revealed the resident was admitted on [DATE] with diagnoses including dysphagia following cerebral infarction (stroke), diabetes mellitus, gastrostomy status, heart disease, pressure ulcer of the sacral region, and malignant neoplasm of the prostate.Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/27/26 revealed the resident had no Brief Interview for Mental Status (BIMS) score recorded, had memory impairment and severely impaired cognitive skills for daily decision making, and was dependent on staff for all activities of daily living (ADLs) and functional abilities.Record review of the admission Record for Resident #4 revealed the resident was admitted on [DATE] with diagnoses including dysphagia following nontraumatic subarachnoid hemorrhage, hypertension, and pressure ulcer of the sacral region.Record review of the Quarterly Minimum Data Set (MDS) assessment for Resident #4 with an Assessment Reference Date (ARD) of 12/29/23 revealed the resident had no Brief Interview for Mental Status (BIMS) score recorded, had memory impairment and severely impaired cognitive skills for daily decision making, and was dependent on staff for all activities of daily living (ADLs) and functional abilities.

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F 0656 Level of Harm - Minimal harm or potential for 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. Based on observations, record review, and interviews the facility failed to implement the comprehensive, person-centered care plan for one (1) of six (6) sampled residents. Resident #1. Findings Included:Record review of the Care Plan Detail report for Resident #1 revealed Problem: I have stage 4 pressure ulcer to sacrum.Approaches.that included cleanse sacrum with normal saline pat dry apply Santyl cover with dry dressing daily.An additional care plan revealed Problem: I have a stage 4 pressure ulcer to left lower leg.Approaches. cleanse left lateral leg with normal saline pat dry apply Santyl cover with calcium alginate secure with dry dressing daily. On 5/11/20/26 at 2:00 PM, during an observation of Resident #1 and interview with Licensed Practical Nurse (LPN) #1 and Nurse Practitioner (NP) #1 revealed Resident #1 had wound dressings on his sacrum, left lateral calf and left ankle dated 5/09/26. LPN #1 confirmed she had provided wound care for Resident #1 and that the dressings were those she had applied on 5/09/26. LPN #1 confirmed that the resident's care plan specified that the dressings were to be changed daily. Following the removal of the dressings, NP #1 stated that the sacral wound appeared to have more slough than it usually did, when it was changed every day according to the resident's care plan.Record review of the Treatment Administration Record (TAR) for May 2026 for Resident #1 revealed no documentation of any wound care for 5/10/26.On 5/12/26 at 4:05 PM, during an interview the Director of Nurses (DON) stated that there were adequate licensed nurses on duty on 5/10/26, including two (2) wound care nurses and a Registered Nurse (RN) Supervisor. She confirmed that based on the dressings identified by LPN #1 dated 5/09/26 and lack of documentation on May 2026 TAR for Resident #1 wound care was not provided for Resident #1 on 5/10/26. She confirmed that the wound care would have triggered on the TAR, to notify the wound care nurse for the second floor that the resident required wound care on 5/10/26 and that all nurses had access to each resident's care plan. She confirmed she expected nurses to follow each resident's care plan in the delivery of care. On 5/12/26 at 4:57 PM, during an interview the Administrator said he expected nurses to follow each resident's care plan. Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 4/01/26 and he had diagnoses of dysphagia, hemiplegia and hemiparesis following cerebral infarction (stroke), and stage 4 pressure ulcer of sacral region.Record review of the 5 Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/26 for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. Further MDS review revealed the resident had impairment of both arms and legs (upper and lower extremities) and was dependent for all activities of daily living.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, facility policy review and interviews the facility failed to ensure ordered wound treatments were administered as prescribed by the physician for one (1) of six (6) residents reviewed for existing skin impairments. Resident #1.Findings Included:Record review of the facility policy titled, Wound Care dated 1/09/22 revealed the policy stated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.After completing a thorough evaluation, the interdisciplinary team should develop a relevant care plan that includes measurable goals for prevention and management of PU/PIs with appropriate interventions.Orders should include.Frequency of dressing change.Document dressing change in medical record .During an interview and observation on 5/11/20/26 at 2:00 PM, an observation with Licensed Practical Nurse (LPN) #1 and Nurse Practitioner (NP) #1 revealed Resident #1 had wound dressings on his sacrum, left lateral calf and left ankle dated 5/09/26. LPN #1 confirmed she had provided wound care for Resident #1 and that the dressings were those she had applied on 5/09/26. LPN #1 confirmed that physician orders specified that the dressings were to be changed daily. Following removal of the dressings, NP #1 stated that the sacral wound appeared to have more slough than it usually did, when it was changed every day.Record review of the Treatment Administration Record (TAR) for May 2026 for Resident #1 revealed no documentation of any wound care for 5/10/26.During an interview on 5/12/26 at 4:05 PM, the Director of Nurses (DON), stated that there were adequate licensed nurses on duty on 5/10/26, including two (2) wound care nurses and a Registered Nurse (RN) Supervisor. She confirmed that based on the dressings identified by LPN #1 dated 5/09/26 and lack of documentation on May 2026 TAR for Resident #1 wound care was not provided for Resident #1 on 5/10/26. She confirmed that the wound care would have triggered on the TAR, to notify the wound care nurse for the Second Floor that the resident required wound care on 5/10/26. She confirmed she expected wound care nurses to monitor the TARs and provide wound care as ordered by each resident's physician and care plan, and that nursing staff would follow each resident's care plan in the delivery of care. During an interview on 5/12/26 at 4:57 PM, the Administrator revealed he expected wound care nurses to monitor the TARs and provide wound care as ordered by each resident's physician and care plan, and that nursing staff would follow each resident's care plan in the delivery of care. Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 4/01/26 and he had diagnoses of dysphagia, hemiplegia and hemiparesis following cerebral infarction (stroke), and stage 4 pressure ulcer of sacral region.Record review of the 5 Day Minimum Data Set (MDS) With Assessment Reference Date (ARD) 3/17/26 for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. Further MDS review revealed the resident had impairment of both arms and legs (upper and lower extremities) and was dependent for all activities of daily living.Record review of the Order Summary Report for Resident #1 revealed the resident had physician orders to Clean stage 4 to (L) (left) lateral ankle .every day shift for wound with a start date of 4/30/26; Clean stage 4 to (L) lateral calf . every day shift for wound with a start date of 4/30/26 and Santyl External Ointment 250 Unit/GM (Collagenase) apply to sacrum topically every day shift . daily. with a start date of 4/26/26.