

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25MA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/03/2023
NAME OF PROVIDER OR SUPPLIER MANHATTAN NURSING AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
M 000	Initial Comments TheState Agency (SA) conducted a Complaint Investigation (CI), MS #20823, #21147, #21371, and #21401 at the facility from 5/1/23 throught 5/3/23. 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. The SA investigated MS #20823 for accidents, MS #21147 for smoking an illegal substance, MS #21371 for resident abuse, and MS #21401 for residnet abuse, and cited no deficiencies.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

03/01/24