

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
NAME OF PROVIDER OR SUPPLIER MANHATTAN NURSING AND REHABILITATION CENTER LLC			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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI), MS #24910 related to accidents for falls, CI MS #24950 regarding resident left wet for extended periods, call light not answered, resident assessment, and facility not clean, CI MS #25059 regarding Quality of Care/Treatment for resident left wet for extended periods and CI MS#25058 regarding resident abuse at the facility from 5/14/24 through 5/16/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and F656 and F690 were cited related to CI MS #25059 and F558 was cited related to CI MS #24950.	F 000			
F 558 SS=D	The facility held a license for 180 beds, with a census of 154. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were provided call light access for communication and resident requests as evidenced by, call lights were out of the reach of residents for two (2) of nine (9) sampled residents. Resident #4 and Resident #5. Findings include:	F 558	Please consider this Plan of Correction as Manhattan Nursing and Rehabilitation, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility		6/25/24

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

TITLE

(X6) DATE

Electronically Signed

06/06/2024

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.

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F 558	Continued From page 1 Resident #4 On 5/14/24 at 9:00 AM, during a telephone interview with the facility Ombudsman, she revealed that during her visits she had identified concerns related to call light availability, which she said she had reported to the facility Administrator. On 5/14/24 at 9:25 AM, in a telephone interview with a family member of Resident #4, she revealed she continued to have concerns related to the resident's call light not being available and the resident not receiving assistance as required. The family member stated she was concerned that with the resident not having access to her call light could increase the resident's potential for falls or injury. On 5/14/24 at 3:35 PM, during an observation and interview with Resident #4 revealed she was seated in her wheelchair in her room next to her bed with floor mat between her and her bed. The resident's call light was laying on her nightstand behind her and out of her reach. Resident #4 stated that she needed assistance with incontinence care. When the resident attempted to reach the call light, she was unable to do so. During an interview on 5/14/24 at 3:40 PM, with Certified Nurse Aide (CNA) #4, she confirmed that Resident #4's call light was not within reach, and all resident's call lights should be within their reach while in their rooms to summon assistance if needed. CNA #4 confirmed that Resident #4 needed her call light to request incontinence care. Record review of the Face Sheet, for Resident	F 558	agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. 1. On 5/16/2024, Call lights were audited and within resident's reach for access for communication and resident's requests for Resident #4 and Resident #5. No resident had any ill effects from this deficient alleged practice 2. All residents had the potential to be affected by this alleged deficient practice. 3. An In-service was done by the Executive Director on 5/17/2024 for all Department Heads and staff on ensuring that residents were provided call light access for communication and resident requests. An 100% audit of all call lights was conducted on 05/17/2024. Any call lights out of residents reach were placed within reach of the resident. 4. Beginning 05/17/24, the Executive Director will audit 15 Resident call lights 2x/day for 3 weeks and then 1x/day for 3 weeks to ensure residents are provided call light access for communication and resident requests. The Executive Director will review the call light audit daily and any issues will be addressed immediately. The Executive Director will forward the results of the call light audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will monitor		

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F 558	Continued From page 2 #4, revealed the facility admitted the resident on 3/29/24. The resident's diagnoses included Hemiplegia following Cerebral Infarction, Affecting Left Nondominant Side and Cerebellar Stroke Syndrome. Record review of the 5 Day Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/05/24, for Resident #4, Section GG revealed the resident had been assessed as requiring set-up assistance for eating, substantial/maximal assistance for toileting hygiene, dressing and personal hygiene and total dependence on staff for surface-to-surface transfers. Section H revealed she was always incontinent of bowel and bladder. Resident #5 An observation on 5/14/24 at 11:31 AM, revealed Resident #5 was sitting in her wheelchair next to her bed. The resident's call light was hung over the wall mounted light fixture on the side of the room opposite the resident's bed and out of her reach. Resident #5 confirmed that she could not reach her call light. Record review of the Face Sheet, for Resident #5, revealed the facility admitted the resident on 7/21/11, with diagnoses of Major Depressive disorder and Osteoarthritis. Record review of the Annual MDS with ARD 3/23/24, for Resident #5, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.	F 558	results of call lights for 2 months. The Quality Assurance Committee met on 05/20/24. The next Quality Assurance Meeting will be held 06/21/24. The Quality Assurance Committee will recommend changing the frequency of audits based upon the results achieved.		

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F 558	Continued From page 3 On 5/16/24 at 3:00 PM, during an interview with the Director of Nurses (DON), stated that it was very important for all residents to have access to their call lights and that it was the responsibility of each staff member to place call lights within the residents' reach upon exiting their rooms. On 5/16/24 at 4:45 PM, an interview with the Administrator revealed she was surprised that call lights were positioned out of reach of residents. She confirmed staff were supposed to make rounds daily to ensure residents had call lights within reach. She stated that it was unacceptable for call lights to be positioned over the wall-mounted light fixtures. The Administrator stated that the facility did not have a policy specific to call lights or call light placement, however, it was common knowledge that according to current standards of practice, residents' call lights were to be placed within their reach to ensure residents could summon assistance as needed.	F 558			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		6/25/24	

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F 656	Continued From page 4 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that the comprehensive care plans were implemented for two (2) of nine (9) sampled residents. Residents #4 and #5	F 656	1. On 5/17/2024, the plan of care was reviewed and implemented for Resident #4 and Resident #5. No resident had ill effects from this alleged deficient practice.		

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F 656	Continued From page 5 Findings include: Record review of the facility policy titled, "CARE PLANS," reviewed 1/15, revealed, "Each resident will have a plan of care to identify problems, needs and strengths that will identify how the team will provide care..." Resident #5 Record review of the Care Plan for Resident #5 with a problem onset date of 6/10/22 revealed, "Problem/Need: Potential for occasional episodes of urinary incontinence ...Approaches ...Encourage resident to call for assistance with toileting. Keep call light within reach of resident..." Record review of the Care Plan with a problem onset date of 6/10/22 revealed, " Problem/Need: Potential for falls related to (R) (right) lower leg pain, and a hx (history) of fall ... Approaches ... Keep call light within reach of resident ..." On 5/14/24 at 11:31 AM, an observation revealed Resident #5 was sitting in her wheelchair next to her bed. The call light was hung over the wall mounted light fixture on the side of the room opposite the resident's bed and out of her reach. Resident #4 Record review of the Care Plan with a problem onset date of 3/29/24 revealed "Problem/Need: Potential for UTI (urinary tract infection) r/t (related to) bowel and bladder incontinence... Approaches: Call light in reach ... Incontinent checks/care every two hours. Encourage resident to call for assistance when needed..."	F 656	2. All Residents have the potential to be affected by this alleged deficient practice . 3. An In-service was done by the Executive Director on 5/17/2024 for all Department Heads and staff on ensuring that the comprehensive care plans were implemented. A 100% audit of care plans was completed on 5/20/2024. 4. The Director of Nursing and /or Assistant Director of Nursing will audit 5 care plans a day starting 5/20/24 for 6 weeks starting 5/20/24 to ensure problem/need areas and approaches identified in the plan of care are implemented and in place. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will monitor results for 2 months. The Quality Assurance Committee met on 05/20/24. The next Quality Assurance Meeting will be held 06/21/24. The Quality Assurance Committee will recommend the frequency of audits based upon the results achieved monthly.		

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F 656	Continued From page 6 Record review of the Care Plan with a problem onset date of 3/29/24 revealed, "Problem/Need: Potential for falls ... Approaches ...Call light in reach ...Bed in lowest position..." On 5/14/24 at 3:35 PM, an observation and interview with Resident #4 revealed she was seated in her wheelchair in her room next to her bed. The resident's call light was lying on her nightstand next to her bed, out of her reach. Resident #4 stated that she needed assistance with incontinence care and attempted to reach her call light, but was unable to do so. On 5/14/24 at 3:40 PM, during an interview with Certified Nurse Aide (CNA) #4, she confirmed that Resident #4 needed access to her call light to call for assistance with incontinence care, however, the call light was out of her reach. On 5/15/24 during a continuous observation of Resident #4 from 10:35 AM until 1:30 PM, revealed the resident was sitting in her wheelchair in the day room when CNA #1 assisted the resident to her room. On 5/15/24 at 1:35 PM, an observation revealed CNA #1, with the assistance of CNA #2 transferred the Resident #4 to her bed and provided incontinence care. However, after providing care, the CNAs left the resident in bed, with the bed elevated and not in the lowest position. On 5/15/24 at 2:28 PM, during an interview with CNA #1, she confirmed that the bed of Resident #4 should have been lowered to the lowest position prior to leaving the resident's room for safety.	F 656			

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F 656	Continued From page 7 On 5/16/24 at 3:00 PM, during an interview with the Director of Nurses (DON), she confirmed that resident care plans were developed to address abilities and needs of each resident, and it was very important for the care plans be followed to meet the needs of each resident. Additionally, the DON commented that prior to leaving a resident's room, it is the responsibility of each staff member to place call lights within a resident's reach, to allow access to their call lights. On 5/16/24 at 4:45 PM, during an interview with the Administrator, she expressed that she expected each resident's care plan to be followed to ensure appropriate care for each resident.	F 656			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		6/25/24	

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F 690	Continued From page 8 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review the facility failed to ensure a resident admitted with incontinence of bladder received appropriate treatment and services in a manner to prevent a possible urinary tract infection for one (1) of nine (9) sample residents. Resident #4 Findings include: Record review of the facility policy titled, "INCONTINENT CARE," reviewed 1/15, revealed, "...Procedure ... 11. When washing perineal area, wash the entire area moving from front to back ...while using a clean area of the washcloth for each stroke. 12. Rinse the perineal area and other skin surfaces washed with warm water and a washcloth from front to back ..." On 5/15/24 during a continuous observation of Resident #4 from 10:35 AM through 1:30 PM, revealed the resident was seated in her	F 690	1. On 5/16/2024 Resident #4 was assessed and received incontinent care. Resident #4 did not have any ill effects from the alleged deficient practice. The CNA #2 was inserviced immediately on 5/16/24 by the Staff Development and Infection Preventionist related to provision of incontinent care to prevent infection. 2. All Residents have the potential to be affected by this alleged deficient practice. 3. An In-service was done by the Executive Director, Staff Development Coordinator, and Infection Preventionist starting on 5/16/24 for all Department Heads and licensed nursing staff ensuring that a resident admitted with incontinence of bladder received appropriate treatment and services in a manner to prevent a possible urinary tract infection.		

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F 690	Continued From page 9 wheelchair in the day room. The resident was not taken to her room for incontinence check/care until 1:30 PM. On 5/15/24 at 1:35 PM, observation revealed Certified Nurse Aide (CNA) #1 brought a mechanical lift into Resident #4's room and at 1:40 PM, CNA #1 and CNA #2 assisted Resident #4 with transfer from wheelchair to bed to provide incontinence care. During incontinence care, CNA #2 used the same side of the same disposable cleansing cloth and wiped back to front three (3) times, with the resident laying on her back, then disposed of the visibly soiled cloth. After assisting the resident to turn on to her right side, CNA #2 used the same side of another disposable cleansing cloth to wipe three (3) times before disposing of the soiled cloth. On 5/15/24 at 2:28 PM, an interview with CNA #1 she confirmed she was assigned to the care of Resident #4 for the 7:00 AM through 3:00 PM shift on 5/15/24. CNA #1 stated that she had "checked" Resident #4 prior to 10:30 AM on 5/15/24, after which incontinence care had not been provided for Resident #4 until approximately 1:35 PM. CNA #1 stated that incontinent residents required incontinence care every two (2) hours and as needed. She reported that resident care instructions were available to the CNAs on the Daily Care Guide. On 5/15/24 at 2:33 PM, an interview with CNA #2 revealed the facility provided in-service training and competency checkoffs on incontinence care during orientation at the time of hire and at least annually thereafter. She confirmed that each cleansing cloth should be used for one wipe, especially if obviously soiled, and that cleansing	F 690	4. Beginning 05/17/24 the Director of Nursing and Assistant Director of Nursing will conduct incontinent care rounds on 5 residents x5 days for 6 weeks. The results of the rounds will be reviewed with the Executive Director and any care issues will be corrected immediately to ensure appropriate treatment and services are provided to residents receiving bowel/bladder incontinent care. Beginning 05/20/24, incontinent care competencies will be conducted with CNA staff to ensure appropriate treatment and services are provided to residents receiving bladder/bowel incontinence care. The Executive Director will forward the incontinent care audit results to the monthly Quality Assurance Committee. The Quality Assurance Committee will monitor results of incontinence care audits for 2 months. The Quality Assurance Committee met on 05/20/24. The next Quality Assurance Meeting will be held 06/21/24. The Quality Assurance Committee will recommend the frequency of audits based upon the results achieved monthly.		

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F 690	Continued From page 10 should always be done front to back during incontinence care to prevent the risk of infection. On 5/16/24 at 3:00 PM, during an interview with the DON, she confirmed incontinence care was to be provided for residents with incontinence every two hours and as needed. She also confirmed that the facility provided in-service training to all nursing staff that included the facility approved procedure for incontinence care, which included wiping with a clean surface in a front to back manner for each wipe/stroke to prevent urinary tract infection. The DON confirmed that the Create Date documentation of care and on the Elimination Report were automatically entered upon input and did not represent the time care was provided. She also confirmed that documentation entered at 11:02 AM for Resident #4 indicated one episode of incontinence care provided. On 5/16/24 at 4:45 PM, an interview with the Administrator revealed that she expected each CNA to follow facility procedure for incontinence care in a manner to prevent urinary tract infections. She confirmed that the facility provided in-service training for nursing staff regarding appropriate procedure for incontinence care and provision of care in a timely manner. Record review of the Daily Care Report revealed documentation that Resident #4 received incontinence care one time on 5/15/24 prior to 11:00 AM, the time at which the documentation was entered into the computer software program by CNA #1. Record review of the 5 Day Minimum Data Set (MDS) with an Assessment Reference Date	F 690			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2024
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 690	Continued From page 11 (ARD) 4/05/24, revealed in Section H that Resident #4 was always incontinent of bowel and bladder.	F 690			