

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255115		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/08/2025	
NAME OF PROVIDER OR SUPPLIER MANHATTAN NURSING AND REHABILITATION CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4540 MANHATTAN RD , JACKSON, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigations for Complaint Numbers 2576950, 2678591, 2573423, 2567254 and 478034, at the facility from 8/06/25 through 8/07/25. Complaint 2576950 was investigated related to physical environment and accidents. Complaint 2678591 was investigated regarding physical environment and neglect. Complaint 2573423 was investigated regarding resident neglect. Complaint 2567254 was investigated regarding resident rights, physical environment, neglect and misappropriation of property. Complaint 478034 was investigated regarding abuse, resident's rights and quality of care. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and there were no deficiencies cited. The facility held a license for 180 beds, with a census of 166.			F0000			

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 reverse for further 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
---	-------	-----------